Rainy Lake Medical Center

International Falls, Minnesota

Rainy Lake MEDICAL CENTER

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution December 22, 2016[1]

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

Rainy Lake
MEDICAL CENTER

Dear Community Member:

At Rainy Lake Medical Center (RLMC), we have spent more than 70 years providing high-quality compassionate healthcare to the greater International Falls community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how RLMC will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

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

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

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

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

Thank You,

Bonnie Erickson
Chief Executive Officer
Rainy Lake Medical Center

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EXECUTIVE SUMMARY

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

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

The Significant Health Needs for Koochiching County are:

1. Mental Health/Suicide
2. Substance Abuse
3. Accessibility/Affordability
4. Alzheimer's
5. Pre-Existing Conditions
6. Emergency Room Services

The Hospital has developed implementation strategies for three of the six needs (Accessibility/Affordability, Pre-Existing Conditions, and Emergency Room Services) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

APPROACH

APPROACH

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

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

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

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

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

Project Objectives

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

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

Overview of Community Health Needs Assessment

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

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

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

[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602
[3] As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 schedule h instructions i990sh—dft(2) and tax form
[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule h (Form 990) V B 6 b

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

the health needs of the community;

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

conducting the CHNA."[7]

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

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

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

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

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

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

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

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

Other (please specify)

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

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

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

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

county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Koochiching County compared to all State counties	August 31, 2016	2012
www.cdc.gov/communityhealth	Assessment of health needs of Koochiching County compared to its national set of "peer counties"	August 31, 2016	2011
Truven (formerly known as Thompson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	August 31, 2016	2016
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	August 31, 2016	2015
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	August 31, 2016	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	August 31, 2016	2010
www.cdc.gov	To examine area trends for heart disease	August 31, 2016	2010

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

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

Website or Data Source	Data Element	Date Accessed	Data Date
	and stroke		
http://svi.cdc.gov	To identify the Social Vulnerability Index value	August 31, 2016	2010
www.CHNA.org	To identify potential needs from a variety of resources and health need metrics	August 31, 2016	2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	August 31, 2016	2015
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	August 31, 2016	2015

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

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 32 Local Expert Advisors. Survey responses started August 11, 2016 and ended with the last response on August 25, 2016.
- Information analysis augmented by local opinions showed how Koochiching County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons,
- low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
    - Low-income groups are prevalent in the community
    - Accessibility and transportation are issues given the rural nature of the area
    - Koochiching County has a growing number of older adults with comorbidities

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions

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

with additional comments of need, and new needs did emerge from this exchange.[14] Consultation with 21 Local Experts occurred again via an internet-based survey (explained below) beginning September 2, 2016 and ending September 22, 2016.

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

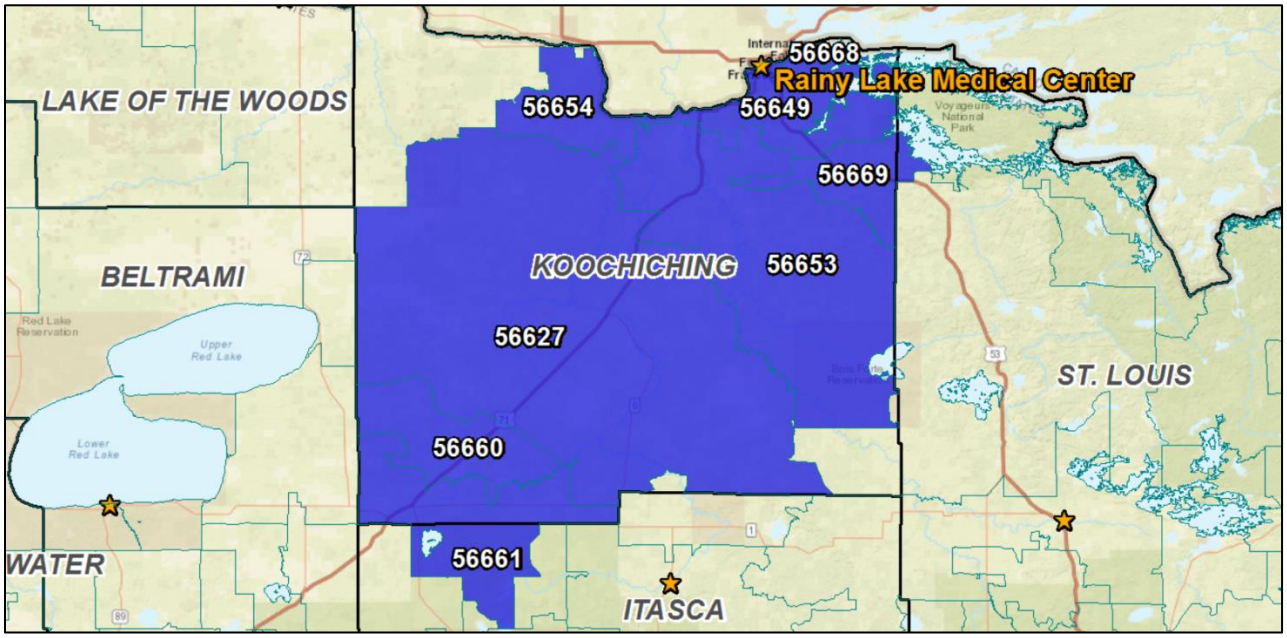
In the RLMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings.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

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

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



RLMC, in conjunction with Quorum, defines its service area as Koochiching County in Minnesota, which includes the following ZIP codes:[18]

56627 – Big Falls	56649 – International Falls	56653 – Littlefork	56654 – Loman
56660 – Mizpah	56661 – Northome	56668 – Ranier	56669 – Kabetogama

In 2014, the Hospital received 94.4% of its patients from this area.[19] Of that total, 83.9% came from International Falls.

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

Demographics of the Community[20] [21]

	Koochiching County	Minnesota	U.S.
2016 Population[22]	**13,026**	**5,512,137**	**322,431,073**
% Increase/Decline	**-1.4%**	**3.4%**	**3.7%**
Estimated Population in 2021	**12,843**	**5,701,935**	**334,341,965**
% White, non-Hispanic	**92.1%**	**80.8%**	**61.3%**
% Hispanic	**1.7%**	**5.3%**	**17.8%**
Median Age	**47.9**	**38.2**	**38.0**
Median Household Income	**$42,695**	**$64,322**	**$55,072**
Unemployment Rate (July 2016)*	**8.2%**	**3.7%**	**5.1%**
% Population >65	**22.3%**	**14.9%**	**15.1%**
% Women of Childbearing Age	**15.0%**	**19.2%**	**19.6%**

**Due to drastic changes in seasonal workers associated with tourism, farming, and logging, the unemployment rate my drop significantly in the summer months, but be much higher during the winter.*

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

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

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	13,536	308,745,538
2016 Total Population	13,026	322,431,073
2021 Total Population	12,843	334,341,965
% Change 2016 - 2021	-1.4%	3.7%
Average Household Income	$56,286	$77,135

	2016	2021	% Change
Total Male Population	6,524	6,419	-1.6%
Total Female Population	6,502	6,424	-1.2%
Females, Child Bearing Age (15-44)	1,958	1,962	0.2%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	2,010	15.4%	1,868	14.5%	19.0%
15-17	520	4.0%	488	3.8%	4.0%
18-24	1,022	7.8%	1,100	8.6%	9.8%
25-34	1,186	9.1%	1,267	9.9%	13.3%
35-54	3,017	23.2%	2,595	20.2%	26.0%
55-64	2,363	18.1%	2,332	18.2%	12.8%
65+	2,908	22.3%	3,193	24.9%	15.1%
Total	13,026	100.0%	12,843	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	1,036	17.7%	12.3%
$15-25K	778	13.3%	10.4%
$25-50K	1,530	26.2%	23.4%
$50-75K	1,013	17.3%	17.6%
$75-100K	647	11.1%	12.0%
Over $100K	836	14.3%	24.3%
Total	5,840	100.0%	100.0%

EDUCATION LEVEL

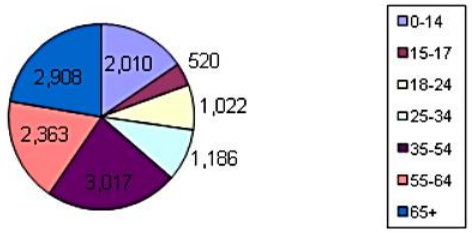
	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	345	3.6%	5.8%
Some High School	646	6.8%	7.8%
High School Degree	3,590	37.9%	27.9%
Some College/Assoc. Degree	3,253	34.3%	29.2%
Bachelor's Degree or Greater	1,640	17.3%	29.4%
Total	9,474	100.0%	100.0%

RACE/ETHNICITY

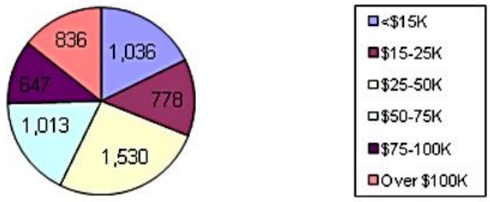
	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	11,998	92.1%	61.3%
Black Non-Hispanic	90	0.7%	12.3%
Hispanic	218	1.7%	17.8%
Asian & Pacific Is. Non-Hispanic	38	0.3%	5.4%
All Others	682	5.2%	3.1%
Total	13,026	100.0%	100.0%

2016 Demographic Snapshot Charts

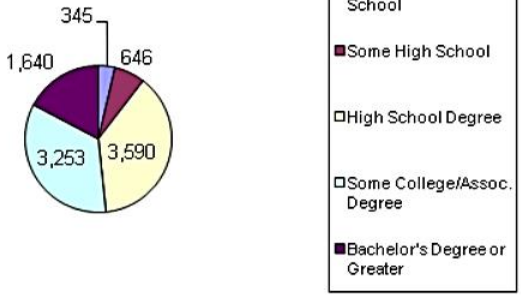
Population Distribution by Age Group



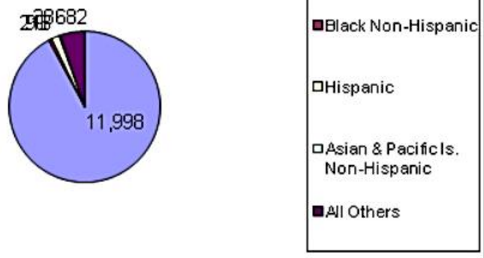
Current Households by Income Group



Population Age 25+ by Education Level



Population Distribution by Race/Ethnicity



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

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
Minnesota	3.4%	38.2	14.9%	18.2%	19.2%	2.3%	$63,322	$81,126	$200,022
Selected Area	-1.4%	47.9	22.3%	9.8%	15.0%	0.2%	$42,695	$67,904	$114,536

Demographics Expert 2.7
DEMO0003.SQP

Customer Segmentation

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

Claritas Prizm Segments	Characteristics
Segment #1 (21%)	America's once-thriving mining and manufacturing towns have aged--as have the residents in these communities. Today, the majority of residents are retired singles and couples, living on lower incomes in pre-1960 homes and apartments. For leisure, they enjoy gardening, sewing, socializing at veterans clubs, or eating out at casual restaurants.
Segment #2 (18%)	With many of its residents over 65 years old, Segment #2 is mostly a retirement lifestyle: a neighborhood of lower-middle-class singles and couples living in modestly priced homes. Many are high school-educated seniors who held blue-collar jobs before their retirement. And a disproportionate number served in the military, so many residents are members of veterans clubs.
Segment #3 (18%)	Segment #3 is mostly a retirement lifestyle, dominated by singles and couples over 65 years old. Found in small bucolic towns around the country, these high school-educated seniors live in small apartments on less than $35,000 a year; more than one in five reside in a nursing home. For these elderly residents, daily life is often a succession of sedentary activities such as reading, watching TV, playing bingo, and doing craft projects.

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

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	102.7%	31.0%	Mammography in Past Yr	106.6%	48.6%
Vigorous Exercise	92.4%	52.4%	Cancer Screen: Colorectal 2 yr	105.1%	26.8%
Chronic Diabetes	138.2%	17.0%	Cancer Screen: Pap/Cerv Test 2 yr	87.3%	52.4%
Healthy Eating Habits	98.3%	29.1%	Routine Screen: Prostate 2 yr	104.0%	33.4%
Ate Breakfast Yesterday	105.4%	71.0%	**Orthopedic**		
Slept Less Than 6 Hours	101.4%	16.0%	Chronic Lower Back Pain	107.0%	25.1%
Consumed Alcohol in the Past 30 Days	83.7%	45.6%	Chronic Osteoporosis	131.3%	12.9%
Consumed 3+ Drinks Per Session	103.9%	28.4%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.5%	91.4%
I Will Travel to Obtain Medical Care	94.6%	22.2%	Used Midlevel in last 6 Months	106.9%	44.3%
I am Responsible for My Health	95.9%	62.6%	OB/Gyn 1+ Visit	79.6%	36.8%
I Follow Treatment Recommendations	95.5%	49.6%	Medication: Received Prescription	104.6%	58.9%
Pulmonary			**Internet Usage**		
Chronic COPD	149.2%	5.9%	Use Internet to Talk to MD	67.0%	8.4%
Tobacco Use: Cigarettes	111.1%	28.3%	Facebook Opinions	100.0%	10.3%
Heart			Looked for Provider Rating	84.2%	12.0%
Chronic High Cholesterol	130.7%	28.7%	**Emergency Services**		
Routine Cholesterol Screening	97.9%	49.8%	Emergency Room Use	101.5%	34.4%
Chronic Heart Failure	153.0%	6.6%	Urgent Care Use	83.5%	19.5%

Leading Causes of Death

Cause of Death			Rank among all counties in MN (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
Koochiching Rank	MN Rank	Condition		MN	Koochiching	
1	2	Heart Disease	12 of 87	116.5	181.2	Lower than expected
2	1	Cancer	3 of 87	195.8	152.6	As expected
3	5	Stroke	7 of 87	34.0	52.6	As expected
4	3	Accidents	24 of 87	39.4	47.7	As expected
5	4	Lung	19 of 87	36.0	39.8	As expected
6	6	Alzheimer's	21 of 87	24.2	27.1	As expected
7	7	Diabetes	24 of 87	18.7	24.9	As expected
8	10	Flu - Pneumonia	15 of 87	9.8	18.5	As expected
9	9	Kidney	6 of 87	10.4	17.8	Higher than expected
10	8	Suicide	24 of 87	12.3	14.2	Higher than expected
11	11	Parkinson's	25 of 87	9.2	8.8	Higher than expected
12	12	Liver	27 of 87	7.9	7.4	Lower than expected
13	14	Blood Poisoning	27 of 87	6.5	5.7	Lower than expected
14	13	Hypertension	84 of 87	7.0	3.3	Lower than expected
15	15	Homicide	64 of 87	1.9	1.0	Lower than expected

Priority Populations[23]

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

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

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

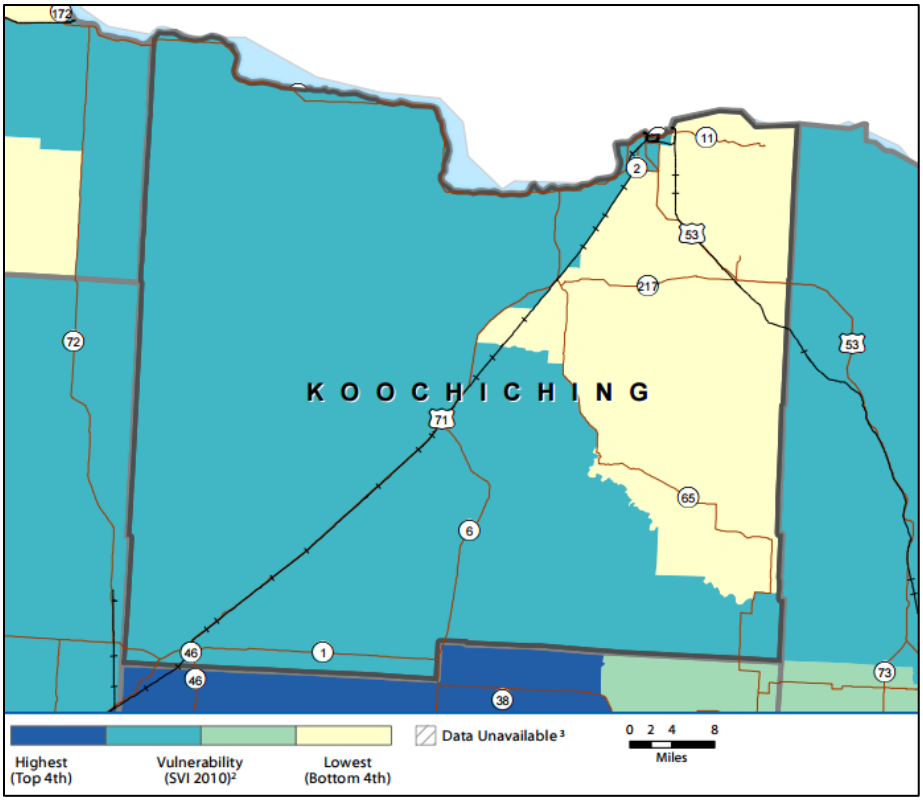
- Low-income groups are prevalent in the community
- Accessibility and transportation are issues given the rural nature of the area
- Koochiching County has a growing number of older adults with comorbidities

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

Social Vulnerability

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

- Koochiching County zip codes fall primarily into the *second highest quartile* of social vulnerability
- Northeastern Koochiching County is in the *lowest quartile* of vulnerability



Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 32 individuals provided feedback on the 2013 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	11	21	32
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	17	12	29
3) Priority Populations	16	13	29
4) Representative/Member of Chronic Disease Group or Organization	3	26	29
5) Represents the Broad Interest of the Community	21	8	29
Other			
Answered Question			32
Skipped Question			0

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

- Accessibility/Affordability
- Pre-Existing Conditions
- Mental Health/Suicide

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

	Yes	No	No Opinion
Accessibility/Affordability	28	0	0
Pre-Existing Conditions	25	2	1
Mental Health/Suicide	28	0	0

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

	Yes	No	No Opinion
Accessibility/Affordability	26	1	1
Pre-Existing Conditions	24	3	1
Mental Health/Suicide	28	0	0

Comparison to Other State Counties

To better understand the community, Koochiching County has been compared to all 87 counties in the state of Minnesota across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

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

	Koochiching	Minnesota	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	79/87		
Premature Death (deaths prior to age 75)*	7,400	5,100	5,200
Health Behaviors			
Overall Rank *(best being #1)*	51/87		
Adult Smoking	17%	16%	14%
Physical Inactivity	27%	20%	20%
Access to Exercise Opportunities	44%	84%	91%
Teen Births (per 1,000)	27	22	19
Clinical Care			
Overall Rank *(best being #1)*	80/87		
Uninsured	12%	9%	11%
Population to Primary Care Physicians^	2,640:1	1,100:1	1,040:1
Population to Dentists	2,570:1	1,500:1	1,340:1
Population to Mental Health Providers	920:1	490:1	370:1
Preventable Hospital Stays (per 1,000)	57	41	38
Mammography Screening	60%	65%	71%
Social & Economic Factors			
Overall Rank *(best being #1)*	84/87		
Some College	66%	74%	72%
Unemployment	8.4%	4.1%	3.5%

Children in Poverty	23%	15%	13%
Injury Deaths*	86	57	51
Physical Environment			
Overall Rank *(best being #1)*	21/87		

**Per 100,000*

^The data for this ratio was last gathered in 2012. Rainy Lake Medical Center, as well as other facilities, has focused on recruiting providers to the area, so this ratio should be more favorable today.

Comparison to Peer Counties

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

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

	Koochiching	Peer Ranking	U.S. Average
Mortality			
Better			
Chronic Lower Respiratory Disease Deaths*	37.8	6/50	49.6
Coronary Heart Disease Deaths*	90.1	4/50	126.7
Female Life Expectancy	81.5	5/50	79.8
Male Life Expectancy	76.4	7/50	75.0
Worse			
Nothing	--	--	--
Morbidity			
Better			
Adult Obesity	20.1%	4/42	30.4%
Adult Overall Health Status	12.4%	6/42	16.5%
Alzheimer's Diseases/Dementia	6.0%	2/50	10.3%
Gonorrhea	0.0%	7/50	30.5%
Older Adult Asthma	2.2%	3/49	3.6%
Older Adult Depression	9.8%	3/50	12.4%
Preterm Births	10.3%	10/50	12.1%
Syphilis	0.0%	16/50	0.0%
Worse			
Nothing	--	--	--
Healthcare Access & Quality			
Better			
Older Adult Preventable Hospitalizations (per 1,000)	52.4	2/50	71.3

	Koochiching	Peer Ranking	U.S. Average
Uninsured	12.3%	9/50	17.7%
Worse			
Nothing	--	--	--
Health Behaviors			
Better			
Adult Physical Inactivity	13.0%	2/46	25.9%
Adult Smoking	16.8%	3/38	21.7%
Teen Births (per 1,000)	25.9	2/50	42.1
Worse			
Adult Female Routine Pap Tests	59.5%	26/27	77.3%
Social Factors			
Better			
Children in Single-Parent Households	21.5%	5/50	30.8%
Inadequate Social Support	14.6%	6/28	19.6%
Poverty	12.9%	7/50	16.3%
Worse			
High Housing Costs	26.3%	46/50	27.3%
Physical Environment			
Better			
Air Quality	7.2	1/50	10.7
Worse			
Access to Parks	8.0%	38/50	14.0%
Housing Stress	26.5%	44/50	28.1%
Limited Access to Healthy Food	16.7%	47/50	6.2%
Living Near Highways	5.8%	50/50	1.5%

**Per 100,000*

Conclusions from Demographic Analysis Compared to National Averages

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

- Vigorous Exercise = 7.6% below avg., 52.4%
- Cervical Cancer Screening in Past Two Years = 12.7% below avg., 52.4%
- OB/Gyn Visit = 20.4% below avg., 36.8%

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

- Ate Breakfast Yesterday = 5.4% above avg., 71.0%
- Consumed Alcohol in the Past 30 Days = 16.3% below avg., 45.6%
- Mammography in Past Year = 6.6% above avg., 48.6%
- Used Midlevel in Last 6 Months = 6.9% above avg., 44.3%

Conclusions from Other Statistical Data

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

	Current Date of Data	Statistic	Percent Change	Last Date of Data
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change				
Female Heavy Drinking	2012	7.9%	2.1% pts	2005
Male Heavy Drinking	2012	13.5%	2.3% pts	2005
Female Binge Drinking	2012	18.4%	1.8% pts	2002
Male Obesity	2011	36.5%	7.5% pts	2001
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **FAVORABLE** change				
Male Binge Drinking	2012	35.1%	-0.2% pts	2002
Female Life Expectancy	2013	80.9 years	2.2 years	1985
Female Smoking	2012	24.3%	-0.3% pts	1996
Male Smoking	2012	27.6%	-1.2% pts	1996
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **UNFAVORABLE** change				
Female Obesity	2011	35.5%	6.7% pts	2001
Male Physical Activity	2011	59.2%	-0.2% pts	1996
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **FAVORABLE** change				
Male Life Expectancy	2013	76.5 years	4.8 years	1985
Female Physical Activity	2011	53.8%	1.6% pts	2001

Community Benefit

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

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

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

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

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

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

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

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

- Financial Assistance at Cost = $75,000
- Medicaid = $1,241,093
- Community Health Improvement Services & Community Benefit Operations = $9,766
- Health Professions Education = $40,481
- Subsidized Health Services = $6,839,820

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 RLMC.[25] The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies RLMC current efforts responding to the need including any written comments received regarding prior RLMC implementation actions
- Establishes the Implementation Strategy programs and resources RLMC will devote to attempt to achieve improvements
- Documents the Leading Indicators RLMC will use to measure progress
- Presents the Lagging Indicators RLMC 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, Rainy Lake Medical Center is the only hospital in the service area. RLMC is a 25-bed, critical access hospital located in International Falls, Minnesota. The next closest facilities are outside the service area and include:

- Essential Health, Virginia, MN, 100 miles (100 minutes)
- Fairview Range Medical Center, Hibbing, MN, 104 miles (119 minutes)
- Sanford Health, Bemidji, MN, 110 miles (110 minutes)
- Essentia Health, Duluth, MN, 164 miles (173 minutes)
- St. Luke's Hospital, Duluth, MN, 165 miles (175 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 RLMC 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 Quorum application, Leading Indicators also must be within the ability of the hospital to influence and measure.

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

1. **MENTAL HEALTH/SUICIDE** – 2013 Significant Need; population to mental health provider ratio worse than MN and US; suicide #10 leading cause of death

Public comments received on previously adopted implementation strategy:

- *RLMC has worked with local law enforcement to help the community in meeting the needs of those with such issues.*
- *I'm not familiar with what RLMC is doing in the mental health realm.*
- *Not sure*
- *More professionals available*
- *I am not aware of these*
- *I am unable to address this issue.*
- *Mental Health seems like it has taken a back seat to physical health but sometimes ignoring or not treating mental health issues leads to physical problems. I wish there were more help available for long term mental health.*
- *I'm not sure what the hospital has done, not aware if protocol.*
- *I do not know what those actions are.*
- *Responsive to implementing system for notifying guardians of adults when entering the hospital.*
- *From what I have witnessed the RLMC is struggling with the implementation actions. RLMC needs to be more consistent in the emergency services of Mental Health. This is difficult with the doctors that come in and out of the hospital that do not live locally. Possibly this consistency could be accomplished with the local nursing staff or coordinator services of the emergency department.*
- *glad we have an additional mental health professional in the community, could use one or two more*
- *Unaware of actions.*

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

We will work toward addressing this need through the following actions:

- Developing policies and procedures to work with Mobile Mental Health Crisis Team (Northland Counseling) to bring in team for assessments in the ER
- Looking into providing updated staff training on de-escalation for patients presenting with mental health issues, and making sure new staff are trained as they come on board
- Providing telehealth services in ER to perform mental health assessments with a counselor for placement purposes
- Continuing to advocate for additional mental health beds in Northern Minnesota

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

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

Organization	Contact Name	Contact Information
Northland Counseling Center (Mobile Mental Health Crisis Team)	Willard Johnson, PhD	900 5th St #305, International Falls, MN 56649 (218) 283-3406 www.northlandcounselingifalls.org

Other local resources identified during the CHNA process that are believed available to respond to this need:[26]

Organization	Contact Name	Contact Information
Essentia Health – International Falls Clinic	Robyn Pelowski, Administrator	2501 Keenan Dr International Falls, MN 56649 (218) 283-9431 www.essentiahealth.org
Hardwig House		803 9th St, International Falls, MN 56649 (218) 283-5571

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

2. **SUBSTANCE ABUSE** – Male and female heavy drinking worse than US average; male and female binge drinking worse than US average

Public comments received on previously adopted implementation strategy:

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

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

We will work toward addressing this need through the following actions:

- Spearheading new chronic pain management group in collaboration with other local groups to look into alternative pain management options
- Providers require narcotics contracts with patients to manage opioid prescription use/abuse
- Working with Wilderness Coalition Quality Committee to share information on management of opioid use and addiction
- Looking into additional training/CME for providers

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

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

Organization	Contact Name	Contact Information
Pineview Recovery Center		912 Main St, Littlefork, MN 56653 (218) 278-4607 http://dev.littleforkmedicalcenter.com/pineview-recovery/

Organization	Contact Name	Contact Information
Burntside Consultants (suboxone clinic)		911 3rd Ave, International Falls, MN 56649 (218) 283-2010
Koochiching County Public Health	Derek Foss	1000 5th St, International Falls, MN 56649 (218) 283-7070 http://www.co.koochiching.mn.us/163/Public-Health
Wilderness Coalition Quality Committee	Cassandra Beardsley, Executive Director	http://wildernesshealthmn.org/about/quality-committee/

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

Organization	Contact Name	Contact Information
Local NA Groups		http://www.naminnesota.org/index.php/meeting-list-pdf/localnacommunities/voyageurs-area
Local AA Groups		http://www.area35.org/
Borderland Alano Club		410 5th Ave, International Falls, MN 56649 (218) 283-2537
Rational Alternatives/Rainy River Recovery		900 5th St #301, International Falls, MN 56649 (218) 285-7029

3. ACCESSIBILITY/AFFORDABILITY – 2013 Significant Need; uninsured rate above MN and US average

Public comments received on previously adopted implementation strategy:

- *Employed more providers for better access by the community.*
- *RLMC seems to be working very hard at getting medical professionals up here, there have been quite a few additions in the last few years.*
- *I'm not sure*
- *Too much duplication of services*
- *I am unable to address this issue.*
- *Happy with the expanded services and accessibility.*
- *I am not sure what those implementation actions are.*
- *More services and specialists have been helpful.*
- *These categories, health behaviors include smoking rates among teens, overuse of alcohol, drug abuse, lack of physical activity, nutrition, number of obese and overweight residents, low disease screening rates and impact of geographic isolation on mental health and the desire to be healthy are all of the issues that need education and resources. As mentioned in the previous category there needs to be outreach to the rural parts of the county. The schools would be a prefect location for these areas. The L-BF and Indus schools are the center of these two communities.*
- *Do not know of any*
- *see articles, other indications that specialists are available both in person and electronically for consultation, increasing access locally*
- *Improvements to facility and increase in care options seem to be positive actions.*

RLMC services, programs, and resources available to respond to this need include: [27]

- Opened specialty services clinic to increase availability of services: rheumatology, surgery, orthopedics, OB/GYN; lease space for ophthalmology, optometry, retail optical shop, audiology, oncology, nephrology, cardiology, pediatrics, sleep studies
- Expanded services of interventional radiologist
- RLMC took on operation of Littlefork Rural Health clinic services
- Provide free baseline concussion screenings for local student athletes
- RLMC has financial assistance policy including self-insured discount
- Telehealth services available in ER to provide consultations
- Provide space and facilitate luncheon to raise money for gas cards to assist with transportation

[27] 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

- Free labor and delivery classes provided in conjunction with Koochiching County Health
- Partner with Koochiching County Health to put on annual Community Baby Shower to collect needed supplies distributed to all babies born in the county
- Hospital employs two MNCAA-certified (Minnesota Community Application Agent) counselors to help people sign up for Minnesota Care and health insurance exchange
- Financial counselors on staff to help people understand their bills and manage payment plans/options
- Sponsor two annual health fairs and invite other health organizations in the community; provide health education, discounted flu shots, and free screenings for blood pressure, blood glucose, and hemoglobin
- Discounted flu shot clinics set up around the community
- Providers and staff speak at local organization meetings and schools to provide health and wellness education
- Summer intern program for local students who are interested in pursuing a career in healthcare
- Working with Rainy River Community College to promote careers in healthcare
- Provide generous tuition reimbursement program to staff and providers to further healthcare education
- Provide chemotherapy and infusion therapy services on site
- CT scanner, nuclear medicine available on site
- Support SAGE Screening Program to provide mammography and pap testing for low income women

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

- Actively recruiting for family practice, internal medicine, neurology, and dermatology
- Expanding infusion therapy services through renovation of current space
- Look into expanding telemedicine services
- Analyzing feasibility of adding PET/CT
- Looking into further expanding orthopedics services
- Implementing new EMR system
- Bringing in C-ARM machine
- Exploring feasibility of becoming a stroke-ready hospital

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

- Renovated building and opened Rural Health Clinic that operates on a sliding fee scale, and expanded morning hours to add appointments
- Added tomography
- Added on-site MRI and expanded hours; EMG services available
- Expanded general surgery and orthopedics services
- Expanded therapy services (PT, OT, Speech) and outreach to treat inpatients as well as provide services in

schools and nursing homes across the region

- Outreach medical and therapy services to Koochiching Health Services
- Added two family practice providers and four mid-levels (RHC)
- Obtained National Health Service Corp designation to assist with recruitment of nurses and doctors
- Extensive building renovations to enhance patient-centered care with up-to-date, comfortable, and private spaces
    - Newly renovated medical/surgical facility with birthing suite
    - Expanded therapy and wellness space
    - Newly renovated emergency room
    - Renovated and expanded surgical suite
    - Upgraded lab facilities and technology
- Decreased average age of plant by replacing emergency generators and heating/cooling system
- Upgraded IT systems, infrastructure, and security

Anticipated results from RLMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency	X	
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

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

- Number of people seen by financial counselors = 258 (2015)
- Number of people signed up on Minnesota Care or healthcare exchange = 89 (2015)

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

- Uninsured Rate = 12%[28] (MN = 9%, U.S. Best = 11%)

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

Organization	Contact Name	Contact Information
Sanford Health – Bemidji	Sally Corser, Director of Outreach Services	1233 34th St NW, Bemidji, MN 56601 (218) 333-5000 www.sanfordhealth.org/locations/sanford-bemidji-main-clinic
Renaissance Hearing	Nathan Voss, President	1400 US-71, International Falls, MN 56649 (218) 444-4444 www.renaissancehearingcenters.com
Orthopedic Associates – Duluth	Dr. Joel Zamzow, MD	1000 E 1st St #404, Duluth, MN 55805 (218) 722-5513 www.oaduluth.com
Other healthcare providers		
Koochiching County Health	Derek Foss	1000 5th St, International Falls, MN 56649 (218) 283-7070 www.co.koochiching.mn.us/163/Public-Health
Rainy River Community College		1501 US-71, International Falls, MN 56649 (218) 285-7722 www.rrcc.mnscu.edu
Essentia Health – International Falls Clinic	Robyn Pelowski, Administrator	2501 Keenan Dr International Falls, MN 56649 (218) 283-9431 www.essentiahealth.org
Local school districts		
Wilderness Health		wildernesshealthmn.org

[28] County Health Rankings. Percentage of population under age 65 without health insurance. 2013.

Organization	Contact Name	Contact Information
Good Samaritan Society – International Falls	Adam Coe, Administrator	2201 Keenan Dr, International Falls, MN 56649 (218) 283-8313 https://www.good-sam.com/locations/international-falls

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

Organization	Contact Name	Contact Information
Arrowhead Transit		1200 Riverside Dr, International Falls, MN 56649 (800) 862-0175 arrowheadtransit.com/services/koochiching-county

4. ALZHEIMER'S – #6 leading cause of death

Public comments received on previously adopted implementation strategy:

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

Due to a relative lack of expertise or competency to effectively address the need and a relatively low priority assigned to this need, we are choosing not to develop an implementation strategy for this need at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

We will work toward addressing this need through the following actions:

- Looking into adding geriatric services via telemedicine
- Recruiting for a neurologist
- Providing standard treatment and medication management for patients diagnosed with Alzheimer's

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

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

Organization	Contact Name	Contact Information
Koochiching Aging Options – Memory Cafe		1000 5th St, International Falls, MN 56649 (218) 283-7030 www.koochichingagingoptions.org
ACT on Alzheimer's	Douglas Skrief Douglas.Skrief@co.koochiching.mn.us	www.actonalz.org/international-falls
Local nursing homes		
Local assisted living facilities		

5. **PRE-EXISTING CONDITIONS** – 2013 Significant Need; Local Expert concern; includes smoking, alcohol, substance abuse, nutrition, obesity, screenings, and mental health

Public comments received on previously adopted implementation strategy:

- *RLMC continues to recruit providers for addressing the those with Pre-existing conditions.*
- *I believe that RLMC is working on a diabetes prevention program.*
- *Not sure*
- *Better support for diabetes, encouraging exercise, and smoking cessation.*
- *I am not aware of these*
- *I am unable to address this issue.*
- *Communication between EOR and all medical clinics important. People end up in EOR and follow through not always adequate.*
- *Again, I am not sure what they are.*
- *The emergency room doctors, nurses, EMT/ambulance and LE personal need to receive more education in working with and identifying mental health situations. Identifying issues in children, teens, adults and elderly.*
- *don't know*
- *Unaware of actions.*

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

- Sponsor of local run/walks and golf event to help promote physical activity
- Sponsor two annual health fairs and invite other health organizations in the community; provide health education, discounted flu shots, and free screenings for blood pressure, blood glucose, and hemoglobin
- Discounted flu shot clinics set up around the community
- Providers and staff speak at local organization meetings and schools to provide health and wellness education
- Brochures, quarterly newsletters (Health Beat), and materials created and distributed to promote healthy behaviors and preventive care
- Promote Breast Cancer Awareness month – Rockin' for a Reason fundraiser to raise awareness and promote getting mammograms
- Free flu shots provided to staff and family members
- Employee and family wellness program that includes discounts to local fitness centers
- Smoking cessation education materials provided to all inpatients and available to ER patients

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

- Working on grant to create a healthy lifestyles program in the community that will encourage nutrition and healthy eating and will target preventing/decreasing obesity

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

- Nephrologist available
- Diabetes Education Program – RN patient educator who works with new and pre-diabetics or patients having trouble managing their condition
- Participating in community wellness grant to provide screenings to community to help identify pre-diabetics; RLMC staff have participated in motivational interviewing training to help encourage healthy lifestyle change

Anticipated results from RLMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

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

- Number of patients seen in Diabetes Education Program = 43 visits per year, 16 patients (2015)

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

- Diabetes Rate = 8.3%[29] (U.S. Median = 8.1%)

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

Organization	Contact Name	Contact Information
Charter Media (Rockin' for a Reason)	Suzie Best	1215 3rd Ave., International Falls, MN 56649 (855)522-4965

[29] CHSI. The percent of adults age 20+ living with diagnosed diabetes. 2005-2011.

Organization	Contact Name	Contact Information
Community Health Board – Aitkin-Itasca-Koochiching Community Health Board		Itasca County Health and Human Services 1209 SE 2nd Ave., Grand Rapids, MN 55744 (218) 327-2941
Falls Hunger Coalition	Sue Hamly, Chairperson	1000 5th St, International Falls, MN 56649 (218) 283-8020 www.fallshunger.org
Backus Community Center	Ward Merrill, Executive Director	900 5th St, International Falls, MN 56649 (218) 285-7225 www.backusab.org
Backus Community Center Café	Ward Merrill, Executive Director	900 5th St, International Falls, MN 56649 (218) 285-7225 www.backusab.org

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

Organization	Contact Name	Contact Information
Essentia Health – International Falls Clinic	Robyn Pelowski, Administrator	2501 Keenan Dr International Falls, MN 56649 (218) 283-9431 www.essentiahealth.org
Local fitness groups/gyms		

6. EMERGENCY ROOM SERVICES – Local Expert concern

Public comments received on previously adopted implementation strategy:

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

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

- RLMC took on operation of Littlefork Rural Health clinic services
- Telehealth services available in ER for consultations
- Renovated building and opened Rural Health Clinic that operates on a sliding fee scale, and expanded morning hours to add appointments
- Extensive building renovations to enhance patient-centered care with up-to-date, comfortable, and private spaces
    - Newly renovated emergency room with private rooms, and structured as a contained unit for increased security
- Throughput assessment performed that resulted in more Lean, customer-friendly processes
- Established Patient Satisfaction Committee to review survey results and take action as necessary
- Enhancing patient and family-centered care model to increase customer satisfaction
- Enhanced customer feedback process and response
- Added shift in the ER to provide increased staffing during busier times
- Local RLMC provider takes shifts in ER
- CNA rounds in ER, in addition to inpatients
- Day-long leadership training session to increase focus on patient and family-centered care

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

- Exploring feasibility of becoming a stroke-ready hospital
- Enhancing nurse education
- Working with Essentia Health to allow cross-viewing of patient records to increase patient satisfaction

Anticipated results from RLMC Implementation Strategy

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

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

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

- Percentage of people who leave ER after triage but before being seen by a physician = 1.8% (2015), 1.4% (1/1-9/30/ 2016)

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

- The Emergency Department rating compared to the NRC Average = 49.3%[30]

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

Organization	Contact Name	Contact Information
Avera Health	John Porter, President/CEO	3900 West Avera Drive, Sioux Falls, SD 57108 www.avera.org
Essentia Health – International Falls Clinic	Robyn Pelowski, Administrator	2501 Keenan Dr International Falls, MN 56649 (218) 283-9431 www.essentiahealth.org
Helmsley Family Trust		www.helmsleytrust.org
International Falls Ambulance Service	Adam Mannausau, EMS Director	600 4th St, International Falls, MN 56649 (218) 283-0706 http://www.ci.international-falls.mn.us/index.aspx?NID=120

[30] Catalyst Emergency Stoplight Report. Qtr 2 2016. Discharge Dates from Apr 1, 2016 to Dec 31, 2016. November 8, 2016.

Organization	Contact Name	Contact Information
Littlefork Ambulance Service	Chief Tom Donahou	901 Main St, Littlefork, MN 56653 (218) 278-4870 http://www.cityoflittlefork.com/index.asp?Type=B_BASIC&SEC=%7B8881982B-06E1-4C8B-9D1D-DC9B372F403C%7D
Regional air ambulance services		
Acute Care physician services (locum ER coverage)	Mark Menadue, President/CEO	P.O. Box 3288, Des Moines, IA 50316
Northland Counseling Center	Willard Johnson, PhD	900 5th St #305, International Falls, MN 56649 (218) 283-3406 www.northlandcounselingifalls.org

Other Needs Identified During CHNA Process

7. **COMMUNICATION**
8. **CANCER**
9. **PHYSICAL INACTIVITY**
10. **DIABETES**
11. **PHYSICIAN**
12. **OBESITY**
13. **SOCIAL FACTORS**
14. **PALLIATIVE CARE**
15. **KIDNEY DISEASE**
16. **MATERNAL/INFANT MEASURES**
17. **HEART DISEASE**
18. **SMOKING**
19. **DENTAL**
20. **ACCIDENTS**
21. **FLU/PNEUMONIA**
22. **LUNG DISEASE**
23. **LIFE EXPECTANCY**
24. **PHYSICAL ENVIRONMENT**
25. **STROKE**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[31]

3. Accessibility/Affordability
5. Pre-Existing Conditions
6. Emergency Room Services

Significant needs where hospital did not develop implementation strategy[32]

1. Mental Health/Suicide
2. Substance Abuse
4. Alzheimer's

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

7. Communication
8. Cancer
9. Physical Inactivity
10. Diabetes
11. Physician
12. Obesity
13. Social Factors
14. Palliative Care
15. Kidney Disease
16. Maternal/Infant Measures
17. Heart Disease
18. Smoking

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

19. Dental
20. Accidents
21. Flu/Pneumonia
22. Lung Disease
23. Life Expectancy
24. Physical Environment
25. Stroke

APPENDIX

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

Hospital solicited written comments about its 2013 CHNA.[33] 32 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	11	21	32
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	17	12	29
3) Priority Populations	16	13	29
4) Representative/Member of Chronic Disease Group or Organization	3	26	29
5) Represents the Broad Interest of the Community	21	8	29
Other			
Answered Question			32
Skipped Question			0

Congress defines "Priority Populations" to include:

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

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

- *Yes, such priority populations exist in our community.*
- *All of these populations exist in our community, and would have their own set of unique needs.*
- *All of the above exist in our community and their needs should be addressed.*

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

- *All of the above. Transportation, lack of providers in rural areas especially and lack of providers that can longer hours etc... Many older adults have no family to assist them.*
- *Tendency to use ER more often for medical needs*
- *All of the above*
- *women, low income groups*
- *yes. their needs include mental health services, easy, quick access to health care (they often cannot afford to miss work for routine or non-emergent care).*
- *We have individuals from each of the categories living in our community. Many people reside in more than two areas - for example a single Mom. There are some common needs among them like affordable housing and transportation. I don't know this for sure but I suspect that obesity is also an issue for people in several of these categories.*
- *Yes. Unique needs are due to living in rural area and having limited access to healthcare. Also have low income groups, and women. I'm sure there are other priority populations but none that utilize our services as much as women and low income groups.*
- *yes*
- *Many exist... I work with low income. older adults, disability and those with chronic health conditions. There is need for medical specialties, transportation to out of town medical specialties, assist in coordinating medical care. May older folks no longer have family in the area to assist them and many are on the fringe of any type of assist financially.*
- *They all exist in the community. Transportation both locally and to other towns/cities is a huge problem. Also, there is only minimal home care available in other areas of the county.*
- *Older Adults People with major comorbidity (people with chronic medical conditions requiring specialty care)*
- *Residents of rural areas; low- income groups , older adults - more resources medically in all areas*
- *Low-income groups are prevalent in our community and county as a whole. Access to the healthcare they need is difficult in our large, rural county. Many low-income and often elderly community members are isolated a large distance from the hospital or clinic.*
- *Yes to both.*
- *Yes, we have a population that includes all of the "priority populations" in our area. Yes, every individual in our area have unique and individual needs. Some are able to meet their needs on their own and others need help.*
- *Yes*
- *Low income, older adults, and rural. Distances, lack of access to specialists although it is getting better, lack of transportation, unwillingness on part of providers to travel or "make" their employees travel. Don't get me started....*
- *I believe all priority populations live in our area. some of the above named such as LGBT have not publicly*

disclosed due to possible bias that is prevalent in our community. Education- knowledge is what is needed so people are not threatened

- *yes, drug and alcohol abuse, remaining independent, receiving specialized care while remaining close to home*
- *In observing your care of those in need of end-of-life care, you serve well. Our area does have a growing number of older adults who may need more in home health care. The not so obvious low-income groups is becoming more apparent and may find it easier to approach health care professionals at site other then the clinic or ER.*
- *We serve older adults, often lower income, all rural, some with special needs, including dementia. Out-of-town medical transportation especially for dialysis and chemo is an issue. Need for respite care is a common concern. Home health care in greater Koochiching County is a need as is more chore service countywide.*
- *As part of our agencies federal reporting obligations we recorded the following health related statistics: Percent of low-income households who reported an item as a "serious problem" or "somewhat of a problem" for their household. Dealing with other emotional or mental health problems 58% Having trouble doing things that you normally enjoy or feeling sad, empty, and blue 51% Dealing with a physical health problem 49% Enough money to pay for eye care or repair of glasses 29% Dental insurance coverage 28% A dentist you can go to 22% Enough money to pay for prescription drugs 21% Enough money to pay for prescription drugs 21% Health insurance coverage 18% Help filling out insurance forms for billing and payments 17% Help paying for mental health services 15% Getting information on how to stay healthy 12% Assistance taking care of an elderly or disabled person 5%*
- *Low income groups - Some members in this group find it very difficult to plan, as they are often addressing crises in (sometimes multiple) areas of their lives. We hear from a lot of families who utilize urgent/emergency care rather than making regular appointments or having regular exams. Planning can be incredibly difficult for low income families due to the lack of supports that exist in their lives. There's also mental health and chemical dependency issues that can come into play. Children - Why does it seem like if a child gets sick, it's going to be at 2 am on a Saturday? Extended clinic hours (weekends or evenings) could help alleviate the use of urgent care and emergency room visits. There also seems to be a high need for pediatric services and additional children's mental health services.*
- *It is my understanding that all of these populations exist in our community.*
- *Older adults*

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

1. **Affordability/Accessibility**
2. **Pre-Existing Conditions**
3. **Mental Health/Suicide**

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

	Yes	No	No Opinion
Accessibility/Affordability	28	0	0
Pre-Existing Conditions	25	2	1
Mental Health/Suicide	28	0	0

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

	Yes	No	No Opinion
Accessibility/Affordability	26	1	1
Pre-Existing Conditions	24	3	1
Mental Health/Suicide	28	0	0

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

- *The hospital needs to continue working with the community and region on mental health care and other issues.*
- *Dialysis Adult and youth Dietician (in person)*
- *RLMC and Essentia need to co-operate in the available services. That a small community like us has duplication of services is ridiculous.*
- *I see a lot of drug/alcohol addiction in my position. This isn't a new problem and I don't know the roll that the hospital should or could play in reducing this issue. We have a SANE nurse which is great for our community but it would be nice if we could have at least one more if not two more. Sexual assault is a horrific crime and going through a sexual assault exam isn't easy and it can take hours to complete. Just imagine if it was your daughter, granddaughter or grand child.*
- *There needs to be an understanding of services available in the community, which are minimal. Often folks are referred for medical assist and waiver services but these take time to set up and there are many stipulations, criteria that need to be met. Better communication between the hospital and care coordinators or case managers at the county.*
- *In working with my clients there has been deep concern as to how individuals brought to the emergency room are treated. Some have been sent home only to return with the same conditions. Information on vulnerable adults, dementia and mental health seems to be lacking.*
- *The over use and abuse of prescription drugs.*
- *It was a while ago when I was extremely disappointed with the emergency doctors that were on 72 hour service. I haven't used this service for quite some time, so not sure if that has been changed.*
- *Emergency room services and staffing continue to be a big concern.....people must wait in an emergency*

room for far to long due to the number of patients, and the wait becomes longer when an ambulance comes in etc. Need two emergency room physicians on all hours

- *Increasing older adult population is going to result in increased incidence of dementia and the need for early screening, early diagnosis and best practices. This can be implemented in yearly wellness exams and routine cognitive screening added to other screening protocols.*

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

- *Comment Items 1, 2, 3 should all remain as priority health needs. To some degree the hospital has assisted in making the level of care better since 2013 because of the employing of more providers.*
- *Access to Care: It should remain a priority health need because it has been so difficult to get medical practitioners to our community, and because we are obviously still struggling with those socio-economic issues. Socio-Economic - I'm noticing that even though we have employment openings in our area, they're having a difficult time filling them due to potential applicants lacking in education, lack of childcare that would allow them to work, lack of reliable transportation (which is getting better as people us the Rural Rides program), or because potential applicants have a criminal record that could prevent them from obtaining employment. Also, as low income families are often in crisis mode, it makes it difficult for them to think of things such as preventative care. Family supports are being maxed out.*
- *All of the above.*
- *Sharing services and reducing duplication so we can have a broader variety offered should be a priority for both Essentia and RLMC.*
- *Continue to make coming in to the clinic a safe and pleasant experience*
- *Health care is expensive and we have a high rate of unemployment and/or underemployment. I don't know how to solve that problem. It makes the cost and effort to provide things like prevention and preventative care seem more affordable.*
- *I think it's great to have choice but this can also be confusing for some populations. If services can be provided locally that is great. I have difficulty when people are referred out of town, family needs to know the options...ie end of life, prognosis. Not sure who is responsible for this but it is sad when senior is referred out of town and there is little that can be done for them. They are often alone, family unable to be there. etc...*
- *The biggest obstacle as I see it is transportation. I have also been informed from many individuals that they are not being given choices when it comes to seeing specialists. If there is no one to advocate for them they are sent to Sanford, even if they have had medical care in Duluth in the past. In addition, getting medical records transferred to other locations is an issue. In working with the community I am being told that the competition between Essentia and Sanford is causing hardships for those needing care.*
- *we need to get more physicians to the area to serve the population*
- *I believe that RLMC has done a very good job in the past three years to provide health education information*

and public awareness to the community. There still seems to be a large population of residents that are under served. More health education opportunities outside the city of International Falls would help, such as opportunities in Indus/Loman/ Birchdale areas. The residents from the south end of the county get medical treatment from Big Fork/Scenic Rivers or Bemidji.

- *Koochiching County is the second largest county in the state with many very isolated areas. This makes it difficult for residents to reach the care that they need, simply due to the distance.*
- *Rural areas have been left out and continue to face many barriers to care.*
- *progress has been made, but unless it remains a priority we'll slide back*
- *Connecting with the community using off-site clinics and having information booths at the various community events.*
- *Socio-economic factors speak for themselves and are not likely to see sudden improvement. Access by a locally-based provider seems prudent and appropriate.*
- *Has been hard to have elderly with mental health issues to find care.*

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

- *Employed more providers for better access by the community.*
- *RLMC seems to be working very hard at getting medical professionals up here, there have been quite a few additions in the last few years.*
- *I'm not sure*
- *Too much duplication of services*
- *I am unable to address this issue.*
- *Happy with the expanded services and accessibility.*
- *I am not sure what those implementation actions are.*
- *More services and specialists have been helpful.*
- *These categories, health behaviors include smoking rates among teens, overuse of alcohol, drug abuse, lack of physical activity, nutrition, number of obese and overweight residents, low disease screening rates and impact of geographic isolation on mental health and the desire to be healthy are all of the issues that need education and resources. As mentioned in the previous category there needs to be outreach to the rural parts of the county. The schools would be a prefect location for these areas. The L-BF and Indus schools are the center of these two communities.*
- *Do not know of any*
- *see articles, other indications that specialists are available both in person and electronically for consultation, increasing access locally*

- *Improvements to facility and increase in care options seem to be positive actions.*

8. Please share comments or observations about keeping <u>Pre-Existing Conditions</u> among the most significant needs for the Hospital to address.

- *The community is underserved and given our geographic location more assistance is needed.*
- *It should remain a priority health need because those behaviors are incredibly difficult to improve upon, and it takes a lot of time to make those lifestyle changes. Using alcohol seems to be the norm here, starting in high school (or even earlier). We see a lot of families who have mental health and chemical dependency issues, they start young and have difficulty getting away from the people in their lives who use MAC. Seeking help for mental health is difficult, I know that there's a high demand put on our mental health practitioners and it's hard for people to admit that they might need some help for their mental health. People use alcohol and drugs as a reason to socialize, a coping mechanism, to self-medicate (can be cheaper, faster, and easier to access than going through a medical professional). For obesity/overweight issues, it can be difficult to get (and stay) with healthy habits - our social interactions often revolve around food, fresh produce is expensive and not always in the best shape, and it's hard to get out and be active in the winter when it's so cold. Plus those mental health issues such as depression and anxiety come into play. Low disease screening rates - I definitely see the families we work with using a head in the sand approach for those bigger disease concepts. They seem equipped only to deal with what is going on at that moment, and they don't want to think about anything else that might come down the road. If they don't get screened, they won't have to deal with the potential outcome.*
- *This does need to be addressed.*
- *We need to encourage healthy behaviors in our community.*
- *I am not aware of these*
- *I am unable to address this issue.*
- *Preventive care is a challenge for all agencies, chronic medical issues should be managed locally ie. Diabetes, CHF, etc... not sure what the answer to this issue is as not always enough time, resources.*
- *This is very significant. One comment that I have heard from many sources is that the elderly are not always treated with respect. If the same health problem existed in a 21 year old would the treatment be the same?*
- *More prevention and coordination with all other providers would be helpful in treating the whole person. Perhaps having a social worker to specifically coordinate with other providers and help with discharge planning and follow through on recommendations.*
- *Mental health services are extremely underserved in the whole county. International Falls tends to be more served but education and out reach should be a big priority. Also education for the emergency providers could be better. The emergency room doctors, nurses, EMT/ambulance and LE personal need to receive more education in working with and identifying mental health situations.*
- *continue to see huge need for drug/alcohol intervention, look at court records education/motivation to improve healthy lifestyle is needed*

- *Your activity is not known to me. Are you in the schools with education and long range plans for improving conditions*
- *Low rankings in health behaviors suggest need for ongoing education, outreach and collaboration by the Hospital with the broader community.*

9. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Pre-Existing Conditions</u>.**
    - *RLMC continues to recruit providers for addressing the those with Pre-existing conditions.*
    - *I believe that RLMC is working on a diabetes prevention program.*
    - *Not sure*
    - *Better support for diabetes, encouraging exercise, and smoking cessation.*
    - *I am not aware of these*
    - *I am unable to address this issue.*
    - *Communication between EOR and all medical clinics important. People end up in EOR and follow through not always adequate.*
    - *Again, I am not sure what they are.*
    - *The emergency room doctors, nurses, EMT/ambulance and LE personal need to receive more education in working with and identifying mental health situations. Identifying issues in children, teens, adults and elderly.*
    - *don't know*
    - *Unaware of actions.*

10. **Please share comments or observations about keeping <u>Mental Health/Suicide</u> among the most significant needs for the Hospital to address.**
    - *This area of health care continues to be in need of assistance.*
    - *Mental Health: It should remain a priority because so much of a person's general health and well-being starts with their mental and emotional health.*
    - *Not sure*
    - *Better access for children who are having problems. We need more access to professions for the children in our area.*
    - *don't know*
    - *I am unable to address this issue.*
    - *Big issues r/t mental health remain and the hospital is often the place people turn to for help. This is a system issue which isn't going to go away. Many seniors have unidentified depression issues, mental health*

problems are evident in a lot of "criminal" population, drug seeking etc... ????

- *This is a major issue. Psychiatric care is at a minimum. I also believe that there is a lack of knowledge of dementia and dementia care.*
- *Better coordination (or any communication at all) with mental health providers. Perhaps some training or inservice on treating MH patients.*
- *As stated above, identifying mental health issues and accessing or referring to the proper resources. Many times medical issues/emergencies are a result of underlying mental health issues. Medication seeking and overdose are often a result of unmet mental health needs.*
- *There is a shortage of mental health practitioners/beds throughout the state. Any increase in professionals who can serve this population in our area would be a great improvement.*
- *see people needing help on a regular basis*
- *It is easy to say but difficult to practice how we doing with support groups for those who have lost family to death and those who are dealing with crises such as abuse?*
- *Negative health behaviors over all ages tied to challenging socio-economic factors argue for a continued increase in Mental Health challenges that will have to be met and may appropriately be addressed as a priority by the Hospital.*
- *We have seen this consistently reported by low-income community members as the most significant barrier to success with 58% of all households we serve reporting mental health challenges as a serious or somewhat serious problem in their households.*

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

- *RLMC has worked with local law enforcement to help the community in meeting the needs of those with such issues.*
- *I'm not familiar with what RLMC is doing in the mental health realm.*
- *Not sure*
- *More professionals available*
- *I am not aware of these*
- *I am unable to address this issue.*
- *Mental Health seems like it has taken a back seat to physical health but sometimes ignoring or not treating mental health issues leads to physical problems. I wish there were more help available for long term mental health.*
- *I'm not sure what the hospital has done, not aware if protocol.*
- *I do not know what those actions are.*

- *Responsive to implementing system for notifying guardians of adults when entering the hospital.*
- *From what I have witnessed the RLMC is struggling with the implementation actions. RLMC needs to be more consistent in the emergency services of Mental Health. This is difficult with the doctors that come in and out of the hospital that do not live locally. Possibly this consistency could be accomplished with the local nursing staff or coordinator services of the emergency department.*
- *glad we have an additional mental health professional in the community, could use one or two more*
- *Unaware of actions.*

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

- *Very well covered. Thanks you*
- *I would rather doctor locally so any improvements would be good.*
- *The community is adamant about co-operation between the existing entities and being able to choose the hospital of there choice when they need to be transported by ambulance. They feel they are being pushed to go to Sanford when they would prefer to go to Duluth. There are lots of stories circulation in the community about not having a choice.*
- *n/a*
- *Obesity seems to be an issue in our community. I suffer from it myself. If you can find ways to reduce obesity in our citizens - it will improve our overall health and well being. It doesn't solve all problems but many of them would fall to the wayside if the issue of obesity was resolved.*
- *You are on the right track and there must be some solutions to a wide variety of issues. Thanks for continuing to address these and keep up the good work!*
- *I believe that all agencies need to work together cooperatively. This would make it easier for individuals to access the services they need without frustration and delays.*
- *Better coordination.*
- *The over use and abuse of prescription drugs.*
- *I feel that access to care is the most important feature for our county. RLMC has done a great job in bringing in specialists and providing services in our community that have not been here in the past.*
- *Elderly cost ratio Rural lack of access Lack of CONSISTENT, On DEMAND transportation from rural areas*
- *I think a focus on prevention needs to be created. Not sure how to involve the hospital directly, but need to stop disabling actions before they get disabling.*
- *A mental health issue that is growing has to do with bullying in our schools. Is there any way you can connect with this?*
- *The "Age Wave" coming to Minnesota is already evident in the county and argues for putting in place more needed supports for older adults who will, in this rural area, face a shortage of family caregivers, means to*

afford preventative care, options for long term care - all while living longer and needing health provider support over a longer period. It will become a priority even without planning for it.

- *no*

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

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health/Suicide - 2013 Significant Need	249	12	16.61%	16.61%	Significant Needs
Substance Abuse	224	12	14.94%	31.55%	
Accessibility/Affordability - 2013 Significant Need	150	10	10.01%	41.56%	
Alzheimer's	93	6	6.20%	47.77%	
Pre-Existing Conditions - 2013 Significant Need	87	7	5.80%	53.57%	
Emergency Room Services	84	6	5.60%	59.17%	
Communication	70	4	4.67%	63.84%	Other Identified Needs
Cancer	67	5	4.47%	68.31%	
Physical Inactivity	67	5	4.47%	72.78%	
Diabetes	64	6	4.27%	77.05%	
Physician	58	5	3.87%	80.92%	
Obesity	52	4	3.47%	84.39%	
Social Factors	52	4	3.47%	87.86%	
Palliative Care	37	3	2.47%	90.33%	
Kidney Disease	35	4	2.33%	92.66%	
Maternal/Infant Measures	35	4	2.33%	95.00%	
Heart Disease	22	3	1.47%	96.46%	
Smoking	20	2	1.33%	97.80%	
Dental	13	2	0.87%	98.67%	
Accidents	8	2	0.53%	99.20%	
Flu/Pneumonia	3	1	0.20%	99.40%	
Lung Disease	3	1	0.20%	99.60%	
Life Expectancy	2	1	0.13%	99.73%	
Physical Environment	2	1	0.13%	99.87%	
Stroke	2	1	0.13%	100.00%	
Total	1499		100.00%		

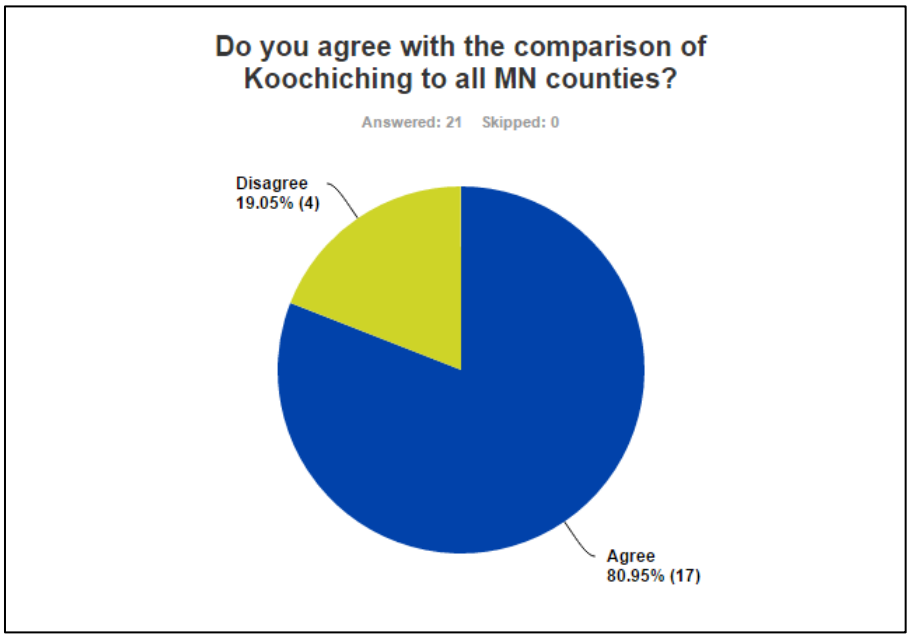
Individuals Participating as Local Expert Advisors[34]

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	6	9	15
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	13	5	18
3) Priority Populations	7	6	13
4) Representative/Member of Chronic Disease Group or Organization	1	12	13
5) Represents the Broad Interest of the Community	14	2	16
Other			
Answered Question			21
Skipped Question			0

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

Advice Received from Local Expert Advisors

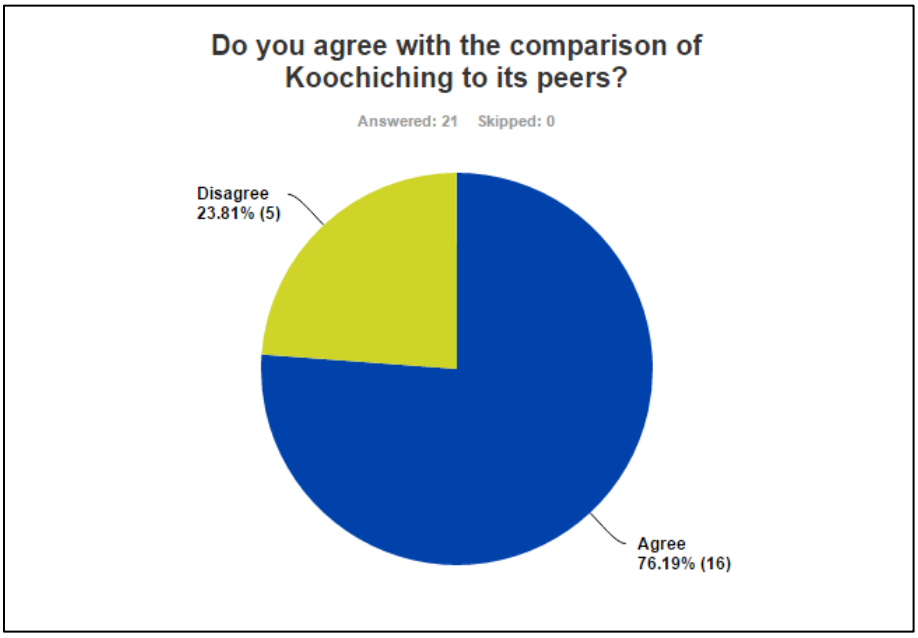
Question: Do you agree with the observations formed about the comparison of Koochiching County to all other Minnesota counties?



Comments:

- *The population I deal with live for today. It's a struggle just getting through the day let a lone take precaution measure for their health.*
- *I do not have enough knowledge or expertise to dispute any of the above data*
- *I can only comment on the Social and Economic Factors. As far as unemployment and children in poverty still exist but not as much as back in 2013. The clients and families we are dealing with suffer from MI issues and are stuck and that is reasons that the UI and poverty still continue to exist. Residents are given great opportunities to attend college especially those of lower income. There are a great many training opportunities to get you ready for college and support to stay in college. I also think that there are wrong reasons those of poverty may attend and it the grants or loans they can take out if their MFIP (cash assistance) limit is up.*
- *Much of the information is correct, however, I suspect that much of this information came from the County Health Rankings that came out earlier this year. This information is old, back to 2013 and pre-dates the Affordable Care Act. I believe that these numbers are very different (better) today than they appear in this document.*
- *I think that more individuals have some type of medical insurance. Also, in many of the categories transportation is an issue.*

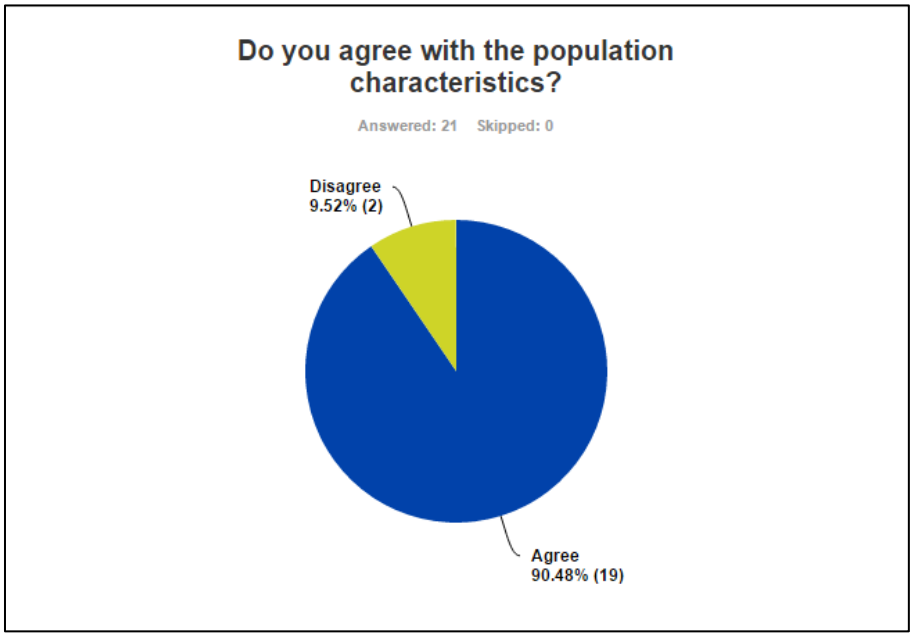
Question: Do you agree with the observations formed about the comparison of Koochiching County to its peer counties?



Comments:

- *I feel we have the physical environment but the population needs to take the time to use it. I also agree with the social factors with the inadequate social support. Without a partner their looking at other people with similarities that often have the same sticken thinken.*
- *We numerous community parks and Minnesota's only National Park is in our back yard. We have two state highways that intersect our town.*
- *Social factors for those in poverty keep to their own network. Live for today, don't think about the future or those who could be an influence on their families life. To many boyfriends using resources from the family well they sit and do nothing. Housing in Koochiching is terrible. The slumlords are renting to those who qualify for HUD (lower income) and getting market rent. This is not fair to those who live there with children and make it unsafe or impossible to get out of the situation there in.*
- *I believe that there is more access to health food as there are multiple programs available. With housing one of the issues on the increase is tenants behaving badly in rental facilities. Also, hoarding is an issue that prevents some landlords from renting.*
- *with literally dozens of State and County parks and the presence of Voyageurs National Park 8% seems awfully low*

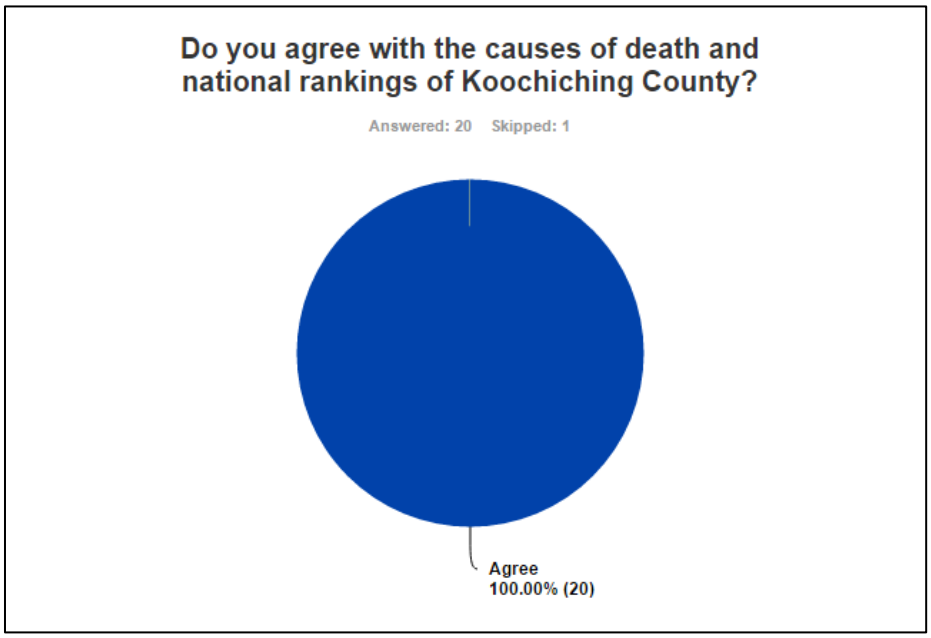
Question: Do you agree with the observations formed about the population characteristics of Koochiching County?



Comments:

- *Unsure*
- *The OB/Gyn visits may reflect on availability. Also, I believe that there are more exercise opportunities. The problem may be individuals not accessing them. There are reduced costs for some individuals through their health plans.*

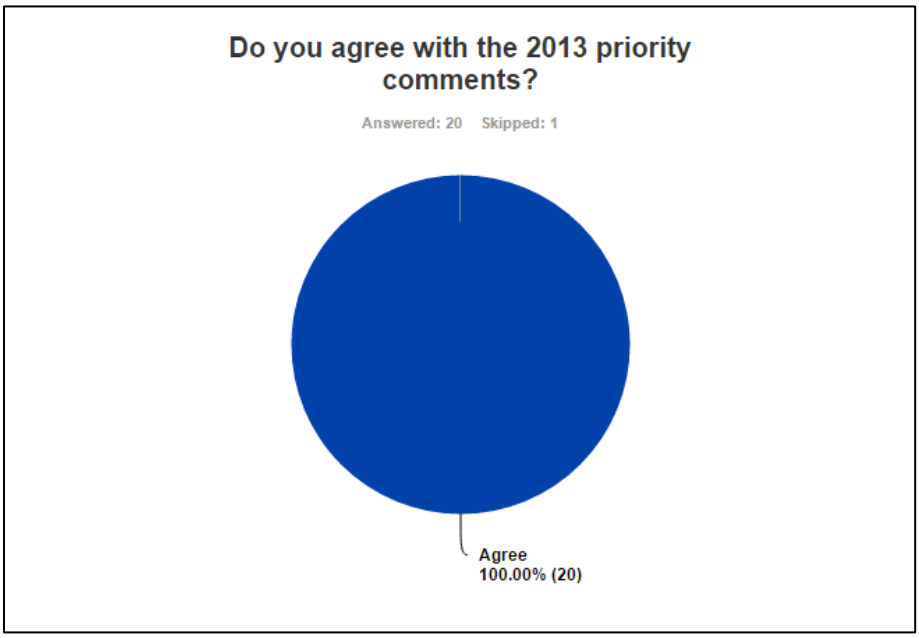
Question: Do you agree with the observations formed from the national rankings and leading causes of death?



Comments:

- *Unsure*
- *I am basing this one the clients I see. Drinking continues to be a huge problem in many age groups, including the elderly.*

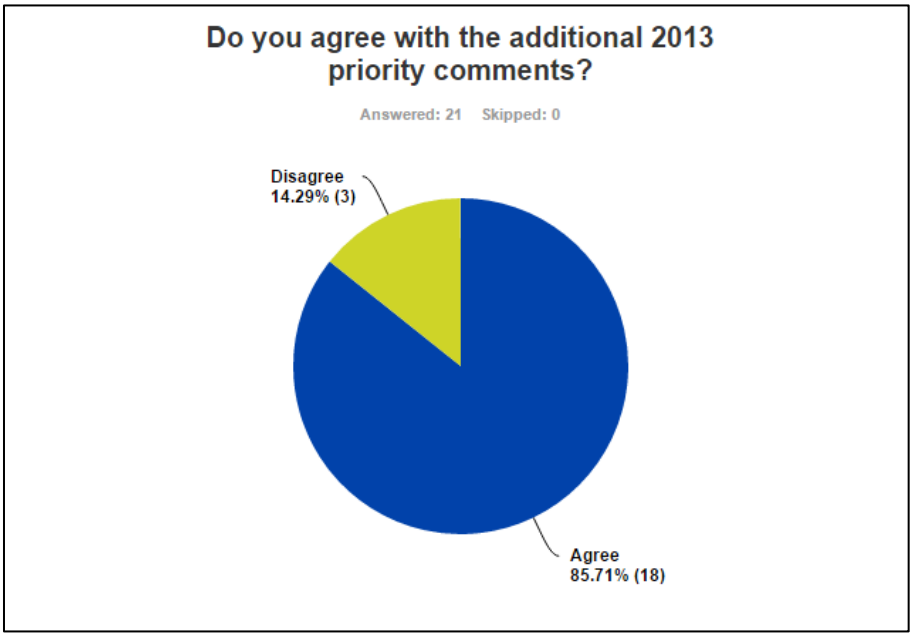
Question: Do you agree with the written comments received on the 2013 CHNA?



Comments:

- *I agree with the above.*
- *The issue of the need for dialysis treatment is continual.*
- *Cannot speak to some areas of concern such as Emergency Room. Mental health and drug related issues continue to be important, both prescription and non-Rx, from what I understand from others serving that population. Dementia will continue to increase as population ages.*
- *Many years of social work experience.*
- *don't know*

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



Comments:

- *This is very frustrating for those who are insured and will not seek medical for the cost factor. People who do not have healthcare have no excuse. there are agency willing to help enroll people without insurance. There the ones driving up the cost for those who have insurance. I do feel that Mental Health/Suicide is an alarming factor that needs to be addressed as a higher priority then the other two.*
- *The pre-existing conditions might include dementia not just unhealthy behaviors. From data provided, unhealthy behaviors to be addressed would include smoking and obesity and binge drinking. Mental health and accessibility may be increasing issues as demographics shift towards a lower income population.*
- *I think the addition of a gerontologist would be very beneficial and the hiring of a hospital social worker.*

Appendix C – National Healthcare Quality and Disparities Report[35]

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

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

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

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

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

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

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[36] consistent with these trends.

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

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

Trends

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

Disparities

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

Trends

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

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

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[37]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[38]

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

Disparities

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

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

[38] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

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

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

Disparity Trends

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

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

Trends

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

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

Trends

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

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

Achieved Success

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

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

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

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

Improving Quickly

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

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

time of surgery

Worsening

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

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

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

Disparities

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

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

Disparity Trends

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

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

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

Disparities Trends

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

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

Geographic Disparities

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

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

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

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[39]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

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

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

Trends

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

Disparities

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

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

Disparities Trends

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

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

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

Trends

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

Disparities

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

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

Trends

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

Disparities

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

Disparities Trends

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

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

Trends

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

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

Disparities

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

Disparities Trends

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

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

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

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[40]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

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

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

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

CONCLUSION

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

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

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

Illustrative IRS Schedule h Part V Section B (Form 990)[41]

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnotes 17 and 19 on page 12

   b. **Demographics of the community**

      See footnote 20 on page 13

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

      See footnote 26 on page 33 and footnote 27 on page 36

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 25 on page 31

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

      See footnote 12 on page 9

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

      See footnote 34 on page 64

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

      See footnotes 8 and 9 on page 7

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

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

See footnote 10 on page 8, footnote 13 on page 9, footnote 14 on page 10, and footnote 23 on page 19

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

N/A

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

2013

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

Yes; see footnote 15 on page 10 and footnote 33 on page 53

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

No

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

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

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

Yes

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

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

http://www.rainylakemedical.com/patient-resources/

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

No other website

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

Yes

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

No other effort

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

See footnotes 31 and 32 on page 50

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

   2013

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

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

       http://www.rainylakemedical.com/patient-resources/

    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 27 on page 36

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

    None incurred

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

    Nothing to report

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

    Nothing to report