Rainy Lake Medical Center

International Falls, Minnesota

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution December 22, 2022

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

Dear Community Member:

At Rainy Lake Medical Center, we have spent more than 70 years providing high-quality compassionate healthcare to the greater Koochiching community. The “2022 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how Rainy Lake Medical Center (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,

Robert Pastor
Chief Executive Officer
Rainy Lake Medical Center

TABLE OF CONTENTS

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.

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

The 2022 Significant Health Needs identified for Koochiching County are:

1. Mental Health/Suicide (2019 & 2016 Significant Need)
2. Alzheimer's Disease
3. Cancer Prevention
4. Chronic Disease Management
5. Obesity (2019 Significant Need)
6. Palliative Care
7. Emergency Room Services (2019 & 2016 Significant Need)
8. Healthcare Communication

The Hospital has developed implementation strategies for three of the eight needs (Cancer Prevention, Chronic Disease Management, and Healthcare Communication) including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

APPROACH

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

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designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent Schedule H (Form 990) filings made by the hospital.

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

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

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

Project Objectives

- Complete a CHNA report, compliant with Treasury – IRS
- Compile information required to complete the IRS – Schedule H (Form 990)
- Issue an assessment of community health needs and document an intended response

Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided to those who did not have the 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
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders

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

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

- 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.[4]

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 the health needs of the community;*
>
> *(2) members of medically underserved, low-income, and minority populations in the*

[4] Section 6652

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.[5]

…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 conducting the CHNA.

Additionally, all CHNAs developed after the very first CHNA must consider written commentary on the prior Assessment and Implementation Strategy efforts. The Hospital followed the Federal requirements in the solicitation of written

[5] 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

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."*[6]

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

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

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

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

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

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

(6) Other (please specify)

The methodology also takes a comprehensive approach to assess community health needs, perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[7] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis. Local expert area residents were asked to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.[8]

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

Data sources include:[9]

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

[7] "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

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

[9] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Koochiching County compared to all Minnesota counties	August, 2022	2015-2021
Internal patient admissions data.	Assess characteristics of the hospital's primary service area, at a zip code level.	August, 2022	2021
http://svi.cdc.gov	To identify the Social Vulnerability Index value	August, 2022	2012-2016
U.S. Census Data, 2021 Population Estimates	Demographic and population characteristics, population distribution, education level, race/ethnicity,	August, 2022	2021
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	August, 2022	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	August, 2022	2021
Bridge to Health Survey: Koochiching County Regional MN & Northwestern WI Regional Adult Health Status Survey	Self-reported adult health behaviors	August, 2022	2020

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

- A CHNA "Round 1" survey was deployed to our Local Expert Advisors in the form of an internet-based survey, 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 24 Local Expert Advisors. Survey responses started July 5, 2022 and ended with the last response on July 18, 2022.
- 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,

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

- 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.[10]
- 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, the information and summary conclusions were put before our Local Expert Advisors[11] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[12] Consultation with 26 Local Experts occurred again via an internet-based survey (explained below) beginning August 25, 2022 and ending September 9, 2022.

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.[13]

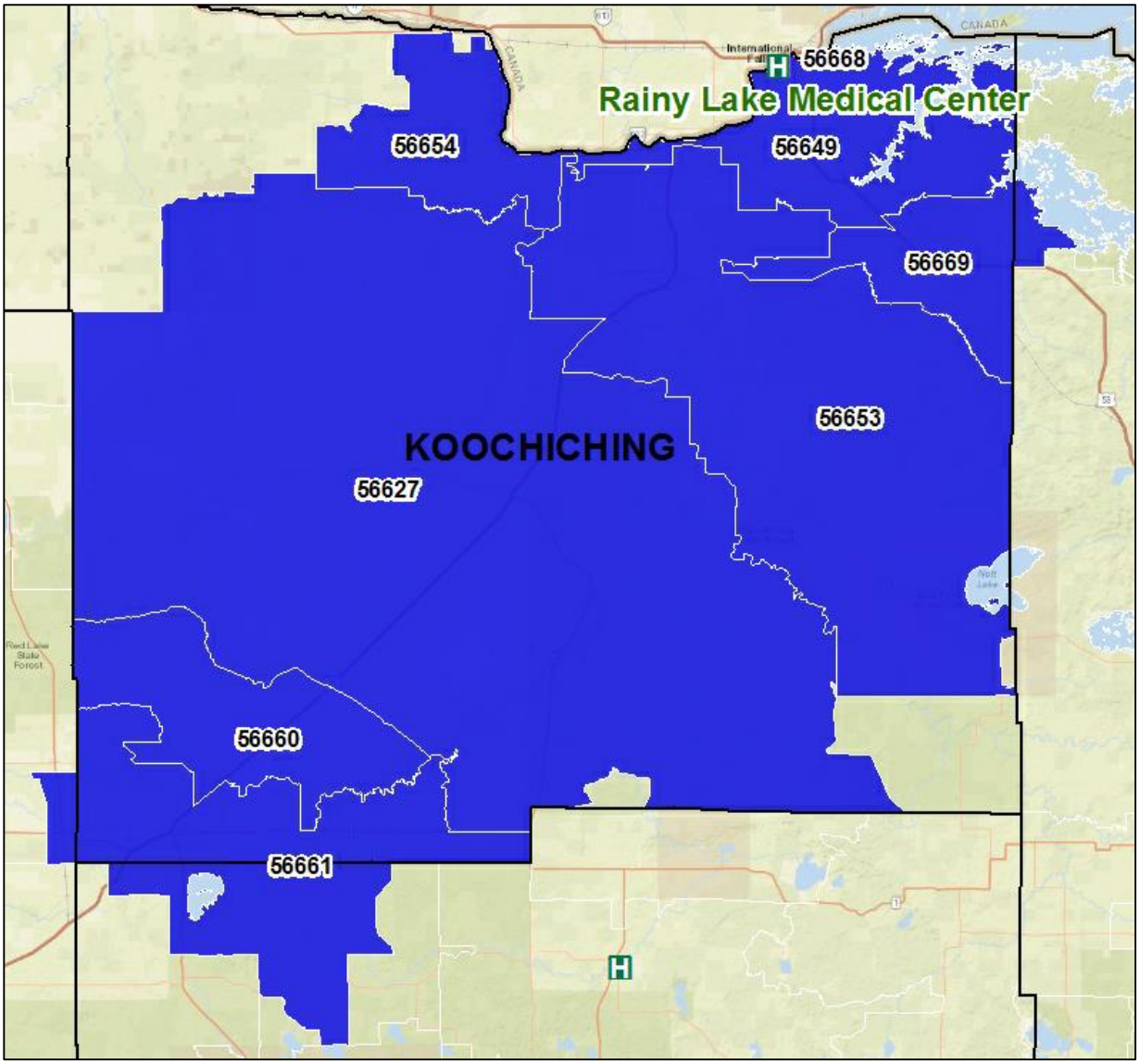
In the RLMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A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

The ranked needs were divided into two groups: "Significant" and "Other Identified Needs." The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least fifty percent (60%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable break point in rank order occurred.[14]

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[15]



For the purposes of this study, Rainy Lake Medical Center defines its service area as Koochiching County in Minnesota, which includes the following ZIP codes:[16]

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

During 2021, the Hospital received 89.0% of its Medicare inpatients from this area.[17]

[15] Responds to IRS Schedule H (Form 990) Part V B 3 a
[16] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[17] RLMC Patient Admissions Data ; Responds to IRS Schedule H (Form 990) Part V B 3 a

Demographics of the Community[18] [19]

VARIABLE (2020 Census)	KOOCHICHING COUNTY			MINNESOTA			UNITED STATES		
	2020	2021	%Change	2020	2021	%Change	2020	2021	%Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	12,062	11,941	-1.0%	5,706,494	5,707,390	z	331,449,281	331,893,745	0.1%
Total Male Population, percent	50%			49.8%			49.2%		
Total Female Population, percent	50%			50.2%			50.8%		
Median Household Income	$52,297			$73,382			$64,994		
POPULATION DISTRIBUTION									
Persons under 5 years, percent	4.2%			6.2%			6%		
Persons under 18 years, percent	17.7%			23.1%			22.3%		
Persons 65 years and over, percent	26.7%			16.3%			16.5%		
Persons over 50 years, percent	50%			35%			36%		
Median Age	50 yrs			38.1 yrs			38.2 yrs		
POPULATION CHARACTERISTICS									
Foreign Born Persons, Percent	5.1%			8.4%			13.5%		
With a Disability, Under 65 years, %	11.9%			7.4%			8.7%		
Persons Without Health Insurance, %	7.4%			5.8%			10.2%		
Persons in Poverty, Percent	11.6%			8.3%			11.4%		
EDUCATION LEVEL									
High school graduate, % persons ↑ 25	92.7%			93.4%			88.5%		
Bachelor's degree or ↑, % persons ↑ 25	15.1%			36.8%			32.9%		
RACE/ETHNICITY									
White, percent	93.2%			79.1%			60.1%		
Black/African American, percent	0.7%			7.0%			13.4%		
American Indian/Alaska Native, %	2.5%			1.4%			1.3%		
Asian, percent	0.6%			5.2%			5.9%		
Hispanic or Latino	1.3%			5.6%			18.5%		
Other	1.7%			1.7%			0.8%		

[18] Responds to IRS Schedule H (Form 990) Part V B 3 b
[19] 2020 US Census, 2021 US Census Population Estimates

Consumer Health Service Behavior [20] [21] [22]

Key health services topics for the service area population are presented in the table below. Where Koochiching County varies significantly above or below the Minnesota average, it is considered noteworthy. Items in the table with **red text** are viewed as **adverse** findings. Items with **blue text** are viewed as **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding. In terms of health outcomes and health factors, Koochiching County is ranked among the least healthy counties in Minnesota (81 out of 87, with 87 being the worst).

Health Outcomes	Koochiching County	Error Margin	Top U.S. Performers	Minnesota
HEALTH OUTCOMES				
Life expectancy	78.7	77.1-80.4	80.6	80.4
Premature age-adjusted mortality	340	280-400	290	280
Diabetes prevalence	9%	8-10%	8%	8%
HEALTH FACTORS				
Adult smoking	20%	18-23%	15%	15%
Adult obesity	35%	33-37%	30%	30%
Physical inactivity	24%	21-27%	23%	20%
Excessive drinking	24%	23-25%	15%	23%
Sexually transmitted infections	90		161.8	433.9
Food insecurity	13%		9%	8%
Limited access to healthy food	14%		2%	6%
Motor vehicle crash deaths	17	10-28	9	8
CLINICAL CARE				
Patients per Primary care physicians	3,060:1		1,010:1	1,100:1
Patients per Mental health providers	600:1		250:1	340:1
Patients per Dentists	2410:1			1320:1
Preventable hospital stays	6,144		2,233	3,073
Mammography screening	44%		52%	52%
Flu Vaccinations	25%		55%	55%
SOCIAL AND ECONOMIC FACTORS				
Unemployment	7.4%		4.0%	6.2%
Children in poverty	15%	9-22%	9%	10%
Injury deaths	100	77-128	61	69
Median household income	$56,900	$47,900-65,900	$75,100	$75,500
PHYSICAL ENVIRONMENT				
Air pollution – particulate matter	6.3			435
Severe housing problems	10%	7-12%	9%	13%
Broadband access	80%	76-83%	88%	87%

[20] https://datausa.io/profile/geo/koochiching-county-mn
[21] 2020 Bridge to Health Survey Koochiching County
[22] www.countyhealthrankings.org/app/minnesota/2022/county/snapshots

Conclusions from Demographic Analysis Compared to National Averages

The following areas were identified from a comparison of Koochiching County to national averages. **Adverse** metrics significantly different from the national average include:

- Lower life expectancy and higher premature age-adjusted mortality
- More likely to smoke, less likely to exercise, obesity more common
- More likely to have limited access to food and experience food insecurity
- More likely to have healthcare and mental health treatment accessibility issues
- More likely to have a preventable hospital stay
- Less likely to have a mammogram or flu vaccine
- More likely to die secondary to injury or motor vehicle crash
- Household incomes are lower and children are more likely to live in poverty

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

- Less likely to have a sexually transmitted infection
- Less likely to suffer from conditions secondary to air pollution
- More likely to have broadband access
- Less likely to suffer from severe housing problems

Koochiching County Leading Causes of Death[23]

Koochiching County's top five age-adjusted, cause specific death rates are listed in the table below. Koochiching County was compared to all other Minnesota counties, Minnesota state average, the U.S. average and whether the death rate was higher, lower or as expected compared to the U.S. average.

Cause of Death	Ranking Against Other MN Counties (with 1/87 the worst)	Koochiching Rate	MN Rate	U.S. Rate	Observation (Koochiching County compared to U.S.)
Cancer	5th out of 87	182.81	138.72	144.13	Higher than expected
Heart Disease	17th out of 87	168.92	118.12	168.19	As expected
Stroke	8th out of 87	48.46	32.05	38.84	Higher than expected
Influenza/Pneumonia	16th out of 87	16.62	7.86	13.05	Higher than expected
Nephritis/Kidney Disease	6th out of 87	16.39	7.26	12.71	Higher than expected

[23] 2018 MN County Health Tables

Koochiching County Rates for all Cancer Sites[24]

	Koochiching County	Minnesota	Observation (Koochiching County compared to MN)
Incidence Rate	470.3	456.5	Higher than expected
Mortality Rate	173.7	157.6	Higher than expected

New Koochiching County Cancer Cases Diagnosed Each Year[25]

The average number of most common new cancer cases diagnosed each year in Koochiching County.

All Sites	Colon & Rectum	Female Breast	Prostate	Lung & Bronchus	Leukemia	Melanoma	Non-Hodgkin Lymphoma	Bladder
92	14	12	12	11	5	4	4	4

[24] Cancer in Minnesota 1988-2014
[25] Minnesota Cancer Facts & Figures 2015

Ischemic Heart Disease[26]

The rate per 100,000 population (age-standardized) of ischemic heart disease in Koochiching County compared to Minnesota and the U.S.

SEX	KOOCHICHING COUNTY	MINNESOTA	U.S.	OBSERVATION
FEMALE	91.2	75.5	124.9	Higher than state
MALE	158.0	130.7	191.5	Higher than state

Cerebrovascular Disease (Stroke)[27]

The rate per 100,000 population (age-standardized) of cerebrovascular disease (stroke) in Koochiching County compared to Minnesota and the U.S.

SEX	KOOCHICHING COUNTY	MINNESOTA	U.S.	OBSERVATION
FEMALE	45.1	43.2	47.4	Higher than state
MALE	50.5	44.8	48.8	Higher than MN & U.S.

[26] http://www.healthdata.org, County Profile: Koochiching County
[27] http://www.healthdata.org County Profile: Koochiching County

Priority Populations[28]

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

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

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[29]

- The top three priority populations identified by the local experts are residents of rural areas, older adults and low-income groups
- There should be a focus on providing affordable and accessible healthcare to the community

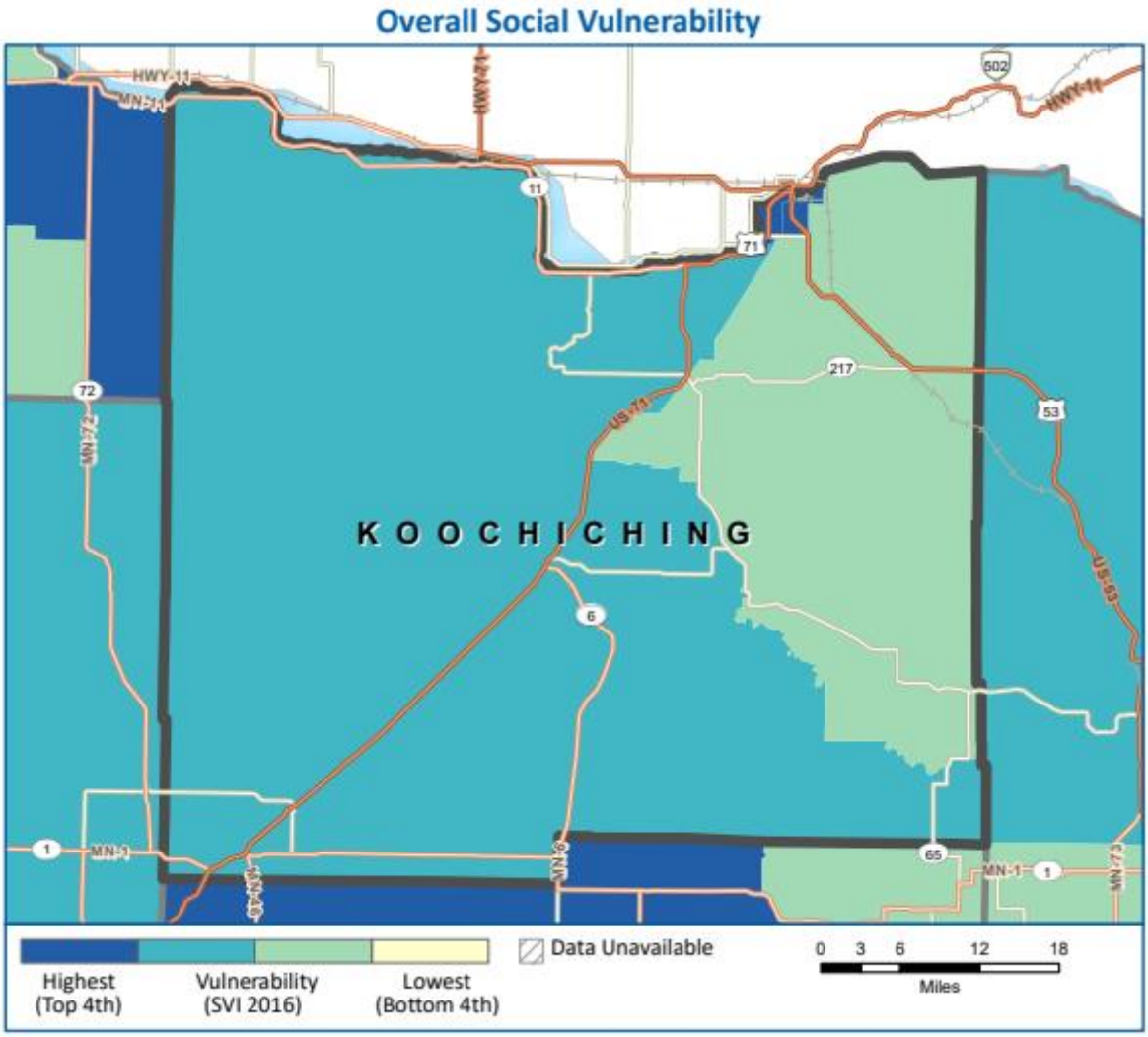
[28] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i
[29] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability[30]

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. Reducing social vulnerability can decrease both human suffering and economic loss. The Social Vulnerability Index uses U.S. census variables at tract level to help local officials identify communities that may need support in preparing for hazards, or recovering from disaster.

Social Vulnerability ranks an area's ability to prepare for and respond to disasters. Measures of socioeconomic status, household composition, race/ethnicity/language, and housing/transportation are layered to determine an area's overall vulnerability.

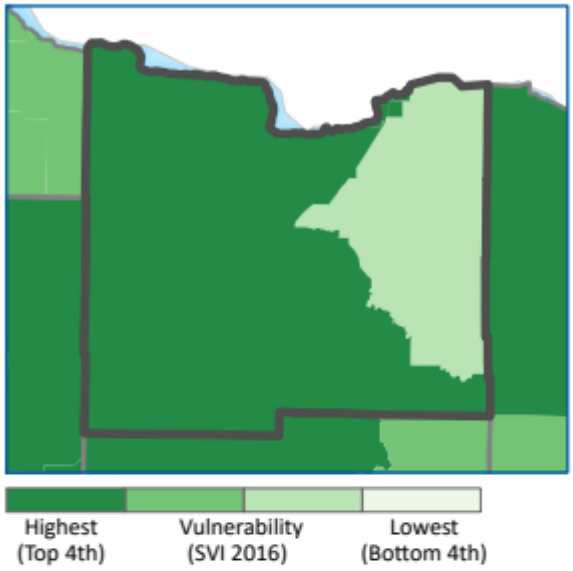
Based on the overall social vulnerability, Koochiching County falls into the second (light green) and third quartiles (light blue). The lower the vulnerability the better.



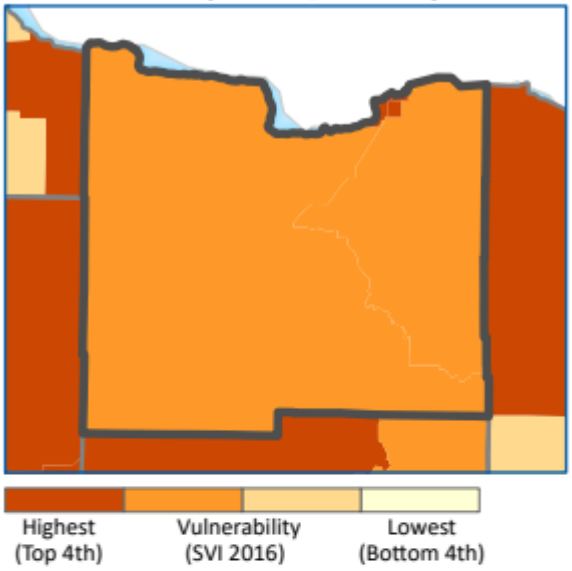
[30] http://svi.cdc.gov

SVI Themes

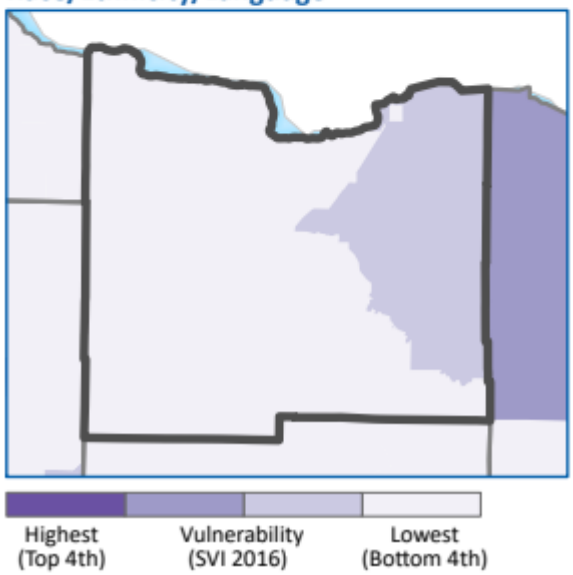
Socioeconomic Status



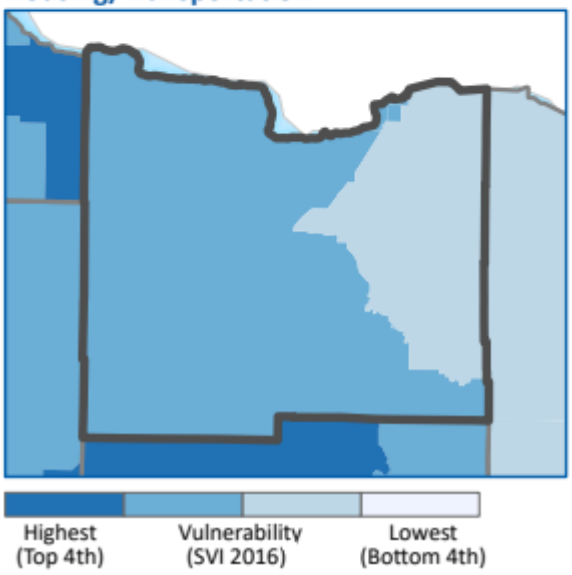
Household Composition/Disability



Race/Ethnicity/Language



Housing/Transportation



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 valued at $1,002,234 and reported by the Hospital in its implementation efforts and/or its prior year tax reporting (FY2021) included:

- RRCC Healthcare Partnership Contribution;
- A number of disaster readiness activities;
- Environmental activities related to community infectious and hazardous waste management;
- Community education and classes, examples include childbirth, infection control, arthritis management, injury prevention, flu shots, etc.;
- A number of financial and in-kind contributions to various community service clubs.
- Community involvement in many service and community based groups, sponsoring the community Christmas parade, planning assistance with the fourth of July parade;

IMPLEMENTATION STRATEGY

Significant Health Needs

The methodology used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by RLMC.[31] The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies 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, RLMC is the major 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:

- CHI Lakewood Health Center, Baudette, MN; 68 miles (72 minutes)
- Cook Hospital, Cook, MN; 73 miles (80 minutes)
- Bigfork Valley Hospital, Bigfork, MN; 78 miles (83 minutes)
- Essentia 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)
- LifeCare Medical Center, Roseau, MN; 126 miles (134 minutes)
- Essentia Health, Duluth, MN; 164 miles (173 minutes)
- St. Luke's Hospital, Duluth, MN; 165 miles (175 minutes)

All statistics analyzed to determine significant needs are "Lagging Indicators," measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the 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 QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

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

1. **MENTAL HEALTH/SUICIDE – Local expert concern; Koochiching County's number of poor mental health days is worse than the state average; Koochiching County's population to mental health provider ratio is worse than the state average; Suicide is the #10 leading cause of death in Koochiching County; Koochiching County's self-harm and interpersonal violence related deaths and mental and substance use related deaths increased from 1980-2014**

Public comments received on previously adopted implementation strategy:

This was not an RLMC significant health need in 2016 or 2019, so no comments were solicited.

RLMC services, programs, and resources available to respond to this need include:[32]

- Policies and procedures in place to work with Mobile Mental Health Crisis Team (Northland Counseling) to bring in team for assessments in the ER
- Provided staff training on de-escalation for patients presenting with mental health issues.
- Provide telehealth services in ER to perform mental health assessments with a counselor for placement purposes
- Provide telehealth visits with a mental health professional in the Rural Health Clinic
- Continuing to advocate for additional mental health beds in Northern Minnesota
- Participate in a quarterly mental health forum with local mental health crisis team
- Conduct PHQ9 depression screenings in family practice clinics at annual visits and physicals
- Conduct suicide risk assessments in the emergency department when patients present with mental health issues
- Using a ligature risk assessment to ensure patients in need are provided a safe area until they can be transferred to appropriate mental health services

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

- With the expansion of local community mental health services, RLMC will develop a collaboration plan to help ease the length of stay for acute ED mental health visits related to lack of referral options.

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

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

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

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 Health Crisis Team)	Dr. Allison O'Hara, PsyD	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:[33]

Organization	Contact Name	Contact Information
Essentia Health – International Falls Clinic	Rob Davenport, Administrator	2501 Keenan Dr International Falls, MN 56649 (218) 283-9431 www.essentiahealth.org

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

Organization	Contact Name	Contact Information
Hardwig House		803 9th St, International Falls, MN 56649 (218) 283-5571

2. ALZHEIMER'S – Local expert concern

Public comments received on previously adopted implementation strategy:

This was not a Significant Need identified in 2019 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
- 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:[34]

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

Organization	Contact Name	Contact Information
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		

3. **CANCER PREVENTION – Local expert concern;** L**eading cause of death in Koochiching; Both the incidence and mortality rates of cancer exceeds that of the State; Koochiching cancer death rate ranks 5th out of 87 counties; Most common new cancer cases diagnosed each year are in descending order: colon & rectum, female breast, prostate, lung & bronchus; Mammography screening rates are lower than the state and US, especially in females over 65; Adult smoking rates are higher than the state and U.S.; Women are less likely to receive Cervical Cancer Screening every 2 years.**

Public comments received on previously adopted implementation strategy:

- *This was not an RLMC significant health need in 2016 or 2019, so no comments were solicited.*

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

- RLMC general surgeon 6 days per month as well as a local Family Practice physician who both perform colonoscopies
- Providers and staff speak at annual health fair, local organization meetings and schools to provide health and wellness education
- Provide chemotherapy and infusion therapy services on site
- CT scanner, nuclear medicine, MRI, and PET CT available on-site
- Mammography and tomography on site
- Support SAGE Screening Program to provide mammography and pap testing for low income women
- Rural Health Clinic operates on a sliding fee scale, and offers morning hours for additional appointment slots
- New electronic medical record with patient portal to promote increased knowledge and decision-making in healthcare needs

- Provide space and facilitate luncheon to raise money for gas cards to assist with transportation, especially for Cancer treatment

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

- Promote provider referral for Mammography, especially in the over 65 age group. Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women and a provider's recommendation or referral is a major factor facilitating breast cancer screening.
- Promote annual colorectal screenings provided (cologuard + colonoscopies).
- Provide community education regarding prevention of colorectal and breast cancer (dietary, physical activity, weight control, etc).

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 provider referrals for annual mammography screening.
- Increase # of annual colorectal screenings provided (cologuard + colonoscopies) to more than 250.
    - 2020-250
    - 2021-231

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

- Percentage of female Medicare enrollees ages 65-74 in Koochiching County who receive an annual mammography screening.

- 2019 44%

- Cancer death rate, Koochiching County, age adjusted per 100,000 population
  - 2019 – 187.18
  - 2020 – 182.81

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

Organization	Contact Name	Contact Information
Sandford 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
Essentia Health – International Falls Clinic	Rob Davenport, Administrator	2501 Keenan Dr International Falls, MN 56649 (218) 283-9431 www.essentiahealth.org
Good Samaritan Society – International Falls	Zachary Schmitz, Administrator	2201 Keenan Dr, International Falls, MN 56649 (218) 283-8313 https://www.good-sam.com/locations/international-falls

4. **CHRONIC DISEASE MANAGEMENT – Koochiching County's population to primary care provider ratio is worse than the state average and U.S. median; preventable hospital stays is worse than the state average and U.S. median; Population to dentist or mental health provider ratios are worse than the state average; Uninsured rate is worse than the state average; Rates of smoking, obesity and physical inactivity are higher than the state and U.S.; Ischemic heart disease rates for females and males are higher than the state; CVA (Stroke) rates for females is higher than the state and higher than the state and U.S. for males; Heart disease and stroke are the second and third leading causes of death; Koochiching is ranked 8th out of 87 counties for age-adjusted stroke death rate per 100,000 population, Koochiching County is less likely to receive Routine Cholesterol Screenings**.

Public comments received on previously adopted implementation strategy:

- *This was not an RLMC significant health need in 2016 or 2019, so no comments were solicited.*

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

- Specialty services offered through specialty clinic: rheumatology, surgery, orthopedics, OB/GYN; lease space for ophthalmology, optometry, retail optical shop, audiology, oncology, cardiology, sleep studies, podiatry, and dermatology.
- Offer interventional radiology
- RLMC operates 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
- 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
- Provide health education, and free screenings for blood pressure and blood glucose
- Discounted flu shot clinics set up around the community
- Providers and staff speak at annual health fair, local organization meetings and schools to provide health and wellness education
- Provide chemotherapy and infusion therapy services on site
- CT scanner, nuclear medicine, tomography, MRI, and PET CT available on-site
- Support SAGE Screening Program to provide mammography and pap testing for low income women
- Rural Health Clinic operates on a sliding fee scale, and offers morning hours for additional appointment slots
- New electronic medical record with patient portal to promote increased knowledge and decision-making in

healthcare needs

- Make donations to the food shelf
- RLMC is actively recruited a medical school student in residency who will start 2024.
- Two orthopedic surgeons are available to provide weekly surgical services, including total knee and shoulder replacements. Hoping to have total hips available by early 2023. RLMC's orthopedic PA follows the joint replacement patients after their surgery. This ortho PA also assists in the Emergency Department with fractures, dislocations etc.

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

- Offer community education on the prevention of heart disease.
- Offer diabetes education free of charge
- Enhance RLMC's ability to meet quality measures for a Stroke Ready Hospital.

Anticipated results from RLMC Implementation Strategy

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

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

- Stroke symptom door to imaging performed = 60%
  - 2018 - 62.5%
- Stroke symptom door to needle
  - 2018 - 0%
- Enrollees in the chronic care management program

- 2021 - 44

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

- Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.
  - 2019: 6,144 hospital stays per 100,000 people enrolled in Medicare
- Diabetes death rate, Koochiching County age adjusted per 100,000 population
  - 2020 – 25.42
- Koochiching age adjusted stroke death rate per 100,000 population
  - 2021 – 48.46

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

Organization	Contact Name	Contact Information
Sandford 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

Organization	Contact Name	Contact Information
Essentia Health – International Falls Clinic	Rob Davenport, Administrator	2501 Keenan Dr International Falls, MN 56649 (218) 283-9431 www.essentiahealth.org
Good Samaritan Society – International Falls	Zachary Schmitz, 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:[35]

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

5. OBESITY/OVERWEIGHT – Local expert concern; Koochiching County's adult obesity rate is worse than the state average; Koochiching County's physical inactivity rate is worse than the U.S. median; Koochiching County's access to exercise opportunities is worse than the state average; Diabetes is the #7 leading cause of death in Koochiching County

Public comments received on previously adopted implementation strategy:

This was not an RLMC significant health need in 2019, so no comments were solicited.

[35] 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

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

- Actively monitor patients BMIs
- Offer diabetes education
- Offer community wide arthritis exercise program on an ongoing basis
- Weight management clinics.

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

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

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

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

Organization	Contact Name	Contact Information
Local public health department		

6. PALLIATIVE CARE - Local expert concern

Public comments received on previously adopted implementation strategy:

This was not a significant health need in 2019, so no comments were solicited.

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

- Case management services
- Swing bed services

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

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

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

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

Organization	Contact Name	Contact Information
Local public health department		
Local nursing home offers swing bed services.		

7. **EMERGENCY ROOM SERVICES – 2016 and 2019 Significant Need**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- Telehealth services available in ER for consultations
- Rural Health Clinic operates on a sliding fee scale, and offers morning hours for additional appointment slots
- Throughput assessment performed that resulted in Leaner, customer-friendly processes
- Patient Satisfaction survey results are closely monitored
- Enhanced patient and family-centered care model to increase customer satisfaction
- Enhanced customer feedback process and response
- Recently renovated emergency department, offering state of the art equipment and facilities
- PFAC developed a community based brochure on what to expect when coming to the emergency department and given at each admit
- Upgraded portal X-ray equipment
- RLMC is a level 4 trauma center

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

- Developed a Nurse Practitioner Hospitalist program thus relieving ER physicians of the dual role and improving RLMC's admit vs transfer rate.
- Renegotiated physician staffing agreement to improve quality and provider communication as well as provide for potential staffing of local providers
- Worked with ED staffing company to achieve a desirable roster of dedicated physicians.
- ED staffing company provided customer satisfaction training for each providers
- Secured a new ED Medical Director who assumes a majority of the monthly shifts
- ED department closely monitors ED patient satisfaction scores and compares individual provider scores
- PFAC closely monitors community satisfaction or dissatisfaction with emergency room services
- Monitoring Stroke Ready quality measures to improve stroke response times

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

Due to the number of improvements made in response to the 2016 and 2019 implementation plan, including recent improvements, the consistent improvement in ED patient satisfaction scores, resource constraints and priority of other significant needs, RLMC is choosing not to develop an implementation strategy for this need at this time. RLMC can have a greater impact by putting attention and resources toward other significant needs that RLMC views as higher priorities at this time.

Federal classification of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need	
11. Resource Constraints	**X**
12. Relative lack of expertise or competency to effectively address the need	
13. A relatively low priority assigned to the need	**X**
14. A lack of identified effective interventions to address the need	**X**

Other local resources identified during the CHNA process that are believed available to assist with this 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	Rob Davenport, Administrator	2501 Keenan Dr International Falls, MN 56649 (218) 283-9431 www.essentiahealth.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
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

Organization	Contact Name	Contact Information
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	Dr. Allison O'Hara, PsyD	900 5th St #305, International Falls, MN 56649 (218) 283-3406 www.northlandcounselingifalls.org

8. HEALTHCARE COMMUNICATION – Local expert concern; 3131 unique patients enrolled in patient portal; ED nurses' responses to questions/concerns at the 73rd percentile rank (lowest ranking on ED survey); Clinic provider efforts to include in decisions at the 24th percentile rank (second lowest ranking on Clinic survey);

Public comments received on previously adopted implementation strategy:

This was not a significant health need in 2019, so no comments were solicited.

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

- Press Ganey patient satisfaction surveys monitor the quality of services (including various monitors of healthcare communication) provided in the following areas: Emergency Department; Clinic; Inpatient; and Surgery.
- Patient portal;
- Patient concern/grievance process;
- Active self-governing Patient and Family Advisory Council to act as a conduit to and from the community.

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

- Promote patient enrollment and use of the patient portal.
- Undertake an improvement initiative to address Emergency Department nurses' responses to questions/concerns.
- Undertake an improvement initiative to address Clinic provider efforts to include the patient in decision-making (shared decision-making).

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
15. Available to public and serves low income consumers	X	
16. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
17. Addresses disparities in health status among different populations	X	
18. Enhances public health activities	X	
19. Improves ability to withstand public health emergency	X	
20. Otherwise would become responsibility of government or another tax-exempt organization	X	
21. 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 unique patients enrolled in patient portal since go-live/the number of unique patients seen
  - Current: 3131/4707 = 66%%
- Improve ranking of ED nurses' responses to questions/concerns
  - Current: 73rd percentile rank

9. Improve ranking of Clinic provider efforts to include patients in decision-making (shared decision-making)
  a. Current: 24th percentile rank

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

- Unable to develop an appropriate lagging indicator.

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

Organization	Contact Name	Contact Information
Avera Health	John Porter, President/CEO	3900 West Avera Drive, Sioux Falls, SD 57108 www.avera.org

Organization	Contact Name	Contact Information
Essentia Health – International Falls Clinic	Rob Davenport, Administrator	2501 Keenan Dr International Falls, MN 56649 (218) 283-9431 www.essentiahealth.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
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
Acute Care physician services (locum ER coverage)	Mark Menadue, President/CEO	P.O. Box 3288, Des Moines, IA 50316
Northland Counseling Center	Dr. Allison O'Hara, PsyD	900 5th St #305, International Falls, MN 56649 (218) 283-3406 www.northlandcounselingifalls.org

Other Needs Identified During CHNA Process

10. Healthcare Accessibility/Affordability – 2019 Significant Need

a. Despite the interruption of Covid, 62 monitored hypertensive patients with continuously high B/P were loaned a cuff for one or more weeks with B/P results evaluated by the Population Health Nurse q 2 weeks with final results provided to the PCP.

b. Despite the interruption of Covid, diabetic patients were provided education regarding diabetes management, oversite of blood sugar results, A1C goals, dietary education and management of food diaries. The PCP received a report of patient progress. Number of patients:

i. 2019 – 38

ii. 2020 – 43

iii. 2021 - 29

11. Physician Access

12. Physical Activity

13. Diabetes

14. Stroke

15. Heart Disease/Hypertension

16. Education/Prevention - 2019 Significant Need

a. A 2019 quality initiative improved EMR tracking of colonoscopy due dates and ensured staff were knowledgeable in the use of cologuard tests for those patients who were suitable.

b. A community health fair was held in 2022 in conjunction with multiple community agencies with an overwhelming community response.

c. Since December 2019 four "formal" OB related training opportunities were offered in a variety of different formats. Service was suspended in the spring of 2020. Subsequently, standard operating procedures and policies were created related to managing obstetrical patients in the ED as well as an OB rapid triage assessment form.

d. A sharps disposal program was developed and introduced to the community, free of charge for the residential public.

17. Women's Health

18. Maternal/Infant Measures

19. Substance Abuse – 2016 & 2019 Significant Need

a. RLMC did not develop an implementation strategy for this Significant Need.

20. **Kidney Disease**
21. **Smoking**
22. **Dental**
23. **Physical Environment**
24. **Accidents**
25. **Flu/Pneumonia**
26. **Lung Disease**
27. **Life Expectancy**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[36]

1. Cancer Prevention
2. Chronic Disease Management
3. Healthcare Communication

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

1. Mental Health/Suicide
2. Alzheimer's Disease
3. Obesity *2019 Significant Need
4. Emergency Room Services – 2016 & 2019 Significant Need

Other needs where hospital developed implementation strategy

1. N/A

Other needs where hospital did not develop implementation strategy

1. N/A

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

APPENDIX

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

Hospital solicited written comments about its 2019 CHNA.[38] 22 to 25 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

	Yes (Applies to Me)	Percentage of Respondents	Response Count
1) **Public Health Expertise**	5	22.73%	
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	5	22.73%	
3) **Priority Populations**	13	59.09%	
4) Representative/Member of **Chronic Disease Group** or Organization	0	0%	
5) Represents the **Broad Interest of the Community**	14	63.64%	
Other			
Answered Question			22
Skipped Question			2

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?

- *Housing access and food security are needed*
- *Low income individuals unable to access healthcare*
- *Priority populations need to feel safe working with medical staff (different cultural needs, understanding LGBT*

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

specific concerns, etc.), transportation barriers, homelessness, the need for more labor and delivery options, dialysis needs, mental health concerns, shortage of nurses for home care or hospice services

- *Educational needs of priority populations*
- *Older adults have unique needs such as comprehensive in-home supports to allow for aging in place, access to services, community based education related to dementia, best health practices, preventative care, disease management*
- *Several priority populations exist in our community including women and children but primarily older adults and rural residents. End of life care may need to be reassessed for its ability to meet current and projected needs*
- *Older adults and low income groups lack access to healthcare services*
- *Koochiching county has over "13,000" (sic) widows who are lonely, grieving and trying to live on one income. Lack of housing for this group. Rural community with no competition for prices, such as groceries, lack of affordable Home Care for special needs population and end of life care*
- *LGBT and individuals with major comorbidities have unique needs.*
- *Limited travel options*
- *Particularly interested in older adult population that is becoming an increasingly larger segment of the population with its unique needs for support and caregiving*
- *Distance is a barrier more than anything else, especially now with soaring gas prices*
- *We have an older population*
- *While we have all of these priority populations living here, low-income, women, children, elderly, rural residents, special needs, and LGBTQ individuals are especially in need of care in this area. Women and children are struggling with access to pediatric and OB/GYN care. The hospital needs to do a better job in educating low-income families or people without health insurance regarding their options for payment plans and access to healthcare. Elderly individuals, especially those who live at home, would benefit from some type of home visit nursing system. Therapies for special needs individuals are improving steadily. Communication and specific care needs of the LGBTQ+ community should be addressed.*

In the 2019 CHNA, there were three health needs identified as "significant" or most important:

1. **Healthcare Accessibility/Affordability**
2. **Education/Preventative Care**
3. **Emergency Room Services**

3. Should the hospital continue to consider and allocate resources to help improve the needs identified in the 2019 CHNA?

	Yes	% of Responses	Response Count
Accessibility/Affordability	21	87.5%	24
Pre-existing Conditions	20	83.33%	24
Emergency Room Services	22	91.67%	24

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

Comments:

- Add improving the Emergency Mental Health response to the list of priorities. Too many people are experiencing Mental Health emergencies and are either being sent away, put back on the street, or even put in jail. The hospital needs to be better equipped to handle these patients.
- Services that address geriatrics and dementia are needs that should be considered.
- Continue doing an excellent job of recruiting specialists and updating equipment.
- A mobile unit to serve our aging population as well as a large number of individuals who have transportation barriers. A mobile unit could either go to the patients for certain things, or events set up at locations where priority populations might gather (such as Backus/the Forestland building, the library, Kootasca, etc.). It seems mental health and substance abuse (self-medicating) issues get worse every year, throw a pandemic on top of it all - things are just very difficult.
- How Covid will play into the long term plan as the community is still dealing with this and possible new issues that come forth from it.
- Continued expansion of specialty care to improve access to services, Home Care services, consideration of a community liaison staff person to coordinate & refer clinic patients to community based services such as transportation, food, education, etc. (there are models of other rural health care providers providing this service that have led to improved health outcomes for patients).
- Continue to address preventive care and programs as well as end of life services.
- Urgent care hours available during the week. Even if someone has health insurance, a visit coded as ER is significantly higher priced than one coded as urgent care.
- Dermatology and Audiology
- Radiation Treatment/Dialysis Treatment. Both are likely not high enough needs in a small community but perhaps transportation to receive treatment could be improved.
- Ability to get virtual care at the hospital. Could meet with a doctor remotely, but don't have machines or Internet access at home.
- Dementia care; caregiver support, including respite; consideration of transportation hurdles in seeking health providers located outside the community
- Improve the ER service and public relations outreach
- Emergency Mental Health services. It is extremely difficult to find Mental Health stabilization beds. Many times people with mental health difficulties are released and there is no follow through with continued or ongoing care.
- Holistic medicine and naturopathy and functional medicine would be good additions since more people are aware of and interested in these methods.

- The extended services that have been offered have been great!
- Geriatric services. We have a huge population and few providers specific to aging.
- It would be incredible to see an elderly outreach program if possible. Even if just phone calls to individuals who have (or have had) health issues in the past to check on them periodically. A permanent pediatrician with knowledge of special needs children (autism and other speech/learning disorders) would be ideal.
- Preventative care and education is a huge void around the county. Falls Hunger is taking steps to fill this void as well.

5. **Please share comments or observations about the actions RLMC has taken to address <u>ACCESSIBILITY/AFFORDABILITY.</u>**

- It seems, anecdotally I admit, that the hospital doesn't try very hard to have insurance pay for services and turns to the patient far too quickly. The hospital billing department should be advocates for the patient.
- Grateful for financial assistance available for those who need it.
- Having MNsure Navigators at RLMC has been very helpful. Cancer patients are very appreciative of the gas cards to help them get to treatments. The clinic has helped a lot, hopefully there has been a reduction in ER visits as a result. Hopeful that the new pharmacy will be helpful to our community and wonder if they can partner with an agency to help patients sign up for programs when they can't afford prescriptions.
- Like how RLMC continues to be proactive in adding services that are high quality and therefore outweigh the affordability piece as long as RLMC can sustain with what insurance pays for low income groups. New pharmacy is a great addition.
- RLMC does work with people to help with bills.
- RLMC has done a great job of bringing primary and specialty services to the community, greatly increasing the access to care and reducing the need to travel outside of the community.
- The clinic is open later hours for accessibility. Not sure anything has been done to address affordability.
- I love the new improvements to the building that allows accessibility. It is also great that RLMC is working with all levels of income and helping people with financial concerns.
- RLMC recruited doctors to come to our Community on a regular basis. They hired 3 hospitalists to take turns in serving the hospital.
- Not having to leave town increases accessibility and affordability.
- Not aware.
- Don't know of any.
- I believe that RLMC has taken great effort in accessibility/affordability for the people of our community.
- Expanded hours for urgent care and open appointments for people who need to see a doctor but it's not an emergency.

- I was a recipient of the low-income grant a few years ago and would not have known about it without community word of mouth. Giving a gentle nudge to those in need is imperative to the success of this program and I believe that the hospital is doing a better job of this now than when I was receiving the assistance.
- I am not aware of any actions taken by RLMC that address accessibility and/or affordability.
- I'm not aware of any.

6. **Please share comments or observations about the actions RLMC has taken to address <u>EDUCATION/PREVENTATIVE CARE</u>.**
   - Unknown.
   - I am unsure.
   - I don't know.
   - The Population Health Nurse seems very helpful to our community.
   - Not sure.
   - Unsure what this question is asking exactly. However, have noticed that PCPs have been encouraged to increase patient visit volumes, often times requiring them to address only the main visit purpose which creates a concern that pre-existing or other important factors may not have time to be addressed in such a way that could positively impact patient holistic patient outcomes.
   - Specialists available for appointments at the clinic.
   - The nursing staff appears to be well trained in working with people with pre-existing conditions. I know the population does not warrant a dietitian, but perhaps group training in buying good nutritional food and more teaching on the food groups...perhaps even weight loss programs for overweight people.
   - Aware of senior annual health review, have seen information from RLMC about the importance of regular check-ups.
   - Not aware of actions taken.
   - Not aware of any.
   - I am not sure.
   - I'm not aware of any.
   - I feel like making known the services offered has been a huge improvement.
   - I'm not sure of any actions taken for this topic.
   - Not aware of any.
   - I'm not aware of any.

7. Please share comments or observations about the actions RLMC has taken to address <u>EMERGENCY ROOM SERVICES</u>.

- From an outsider's view, it seems there are some micro-cultures within RLMC: Clinic (which are great!) Hospitalists (which need some work) and the ER (which are great).
- Hiring ER doctors and staff. New ER wing. Portable equipment. Tele access to specialists.
- I've been hearing good things from patients who need to be seen in the ER - it seems they are happy with the level of care received and the doctors/nurses they are working with.
- Based on community feedback, emergency room services seem to be much improved.
- Do a good job.
- RLMC has given much attention to the ER Services and the community has noticed. Education to visitors about what to expect was an important first step, followed up by close attention to providers staffed as well as feedback from patients and families.
- Advertising has been beneficial.
- Not sure.
- I love how Dr Olsen has organized the ER and trained staff to know how to handle stroke and heart patients, so everyone knows their duty...
- Hired doctors to serve the ER.
- We still have one!
- Not aware of actions taken.
- Everything is shipped out so people are afraid to go there. I had a stroke and was never given any medications in the ER; after being there for 4 hours they sent me home with an appointment to see my doctor the next day at the clinic.
- The wait times are far too long.
- Much improved - ER physicians are much better and the news has gotten out.
- The new ER Doctor is AMAZING!
- Access to the emergency room has GREATLY improved over the last year. Demeanor and care has improved with the addition of staff and my interactions with care at the ER has been wonderful lately.
- Not aware of any.
- I have had to take my children there and it seems as if the facility is much cleaner and more efficient.

8. 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 our county?

- Keep on working toward culture improvements and community growth and partnerships! They are really working to improve the public perception of RLMC. I think the one black eye you get now stems from some of the out-of-town Docs that fly in with attitude and leave without remorse.
- I am grateful for the specialty services that can help fill the community's needs without traveling elsewhere.
- More publicity about the good work you do. I appreciate the hospital's engagement with the community.
- I think you're doing a fantastic job at building up staff at RLMC, creating a workplace that shows appreciation and showing that it's an enjoyable environment. Also adding providers -kudos to you! It feels like you're building that same sense of appreciation and pride is within our community, and I would just encourage you to keep going and keep pushing for ways to build relationships, trust, and services.
- Workforce, can RLMC keep all of the services going based on workforce shortage?
- We know that we have an aging population in this community, along with a lot of cancers and comorbid health conditions. I am not entirely informed about what end of life services are available in the community but it seems like what I often hear is that we don't have it or patients can't access it. It seems this could be an area of improvement and discussion, however RLMC can contribute.
- I feel like accessibility, services, education is already addressed. The most important in our community is affordability.
- This survey indicates RLMC is focused on assessing the health care needs of our county.
- I would really like to see more teaching on exercises that the elderly could utilize, perhaps even using some of the space downstairs for a walking program since we no longer have a mall to walk in.
- RLMC added many services to alleviate the need to go out of town.
- Economic inequities in the community affect access, knowledge of services, acute care crises and opportunities for prevention and management; education and accessibility are needed to work on solutions.
- The county is more than International Falls.
- Emergency Mental Health care and stabilization is a huge concern. I feel the ER staff need to have more education and training to better serve the people that come in for stabilization.
- We need to keep up with other facilities that are offering things like acupuncture, massage, and other innovative techniques and treatments. Even Mayo offers Healing Touch!

- If I were to name anything - would be nice to offer labor/delivery again, although I understand the difficulty of having a provider on call all the time.
- I think the hospital is moving in the right direction and trying to improve its care with regard to our special populations. The compassion and courtesy shown whenever I get care at the hospital or clinic is always above that of care I have received elsewhere. I believe putting our community first is something RLMC does well.
- Our county is predominately low-income individuals and families that have transportation issues. If you could help provide transportation to your facilities, I think that could be life changing for many.

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

Need Topic	Total Votes	# of Local Experts Voting for Need	Percent of Votes	Cumulative Votes	Need Determination
Mental Health/Suicide**	265	14	14.1%	14.1%	Significant Needs
Alzheimer's Disease	240	12	12.7%	26.8%	
Cancer Prevention	140	9	7.4%	34.2%	
Chronic Disease Management	130	10	6.9%	41.1%	
Obesity*	105	8	5.6%	46.7%	
Palliative Care	103	6	5.5%	52.1%	
Emergency Room Services**	95	6	5.0%	57.8	
Healthcare Communication	85	8	4.5%	61.7%	
Healthcare Accessibility/Affordability**	80	4	4.2%	65.9%	Other Identified Needs
Physician Access	75	7	4.0%	69.9%	
Physical Activity	70	6	3.7%	73.6%	
Diabetes	70	6	3.7%	77.3%	
Stroke	70	6	3.7%	81.1%	
Heart Disease/Hypertension	65	6	3.4%	84.5%	
Education/Prevention*	58	5	3.0%	87.6%	
Women's Health	57	3	3.0%	90.6%	
Maternal/Infant Measures	55	4	2.9%	93.5%	
Substance Abuse**	45	5	2.4%	95.9%	
Kidney Disease	40	4	2.1%	98.0%	
Smoking	20	3	1.1%	99.0%	
Dental	12	2	0.6%	99.7%	
Physical Environment	5	1	0.3%	100.0%	
Accidents	0	0	0.0%	100.0%	
Flu/Pneumonia	0	0	0.0%	100.0%	
Lung Disease	0	0	0.0%	100.0%	
Life Expectancy	0	0	0.0%	100.0%	
Write In:	0	0	0.0%	100.0%	

**- 2019 Significant Need*

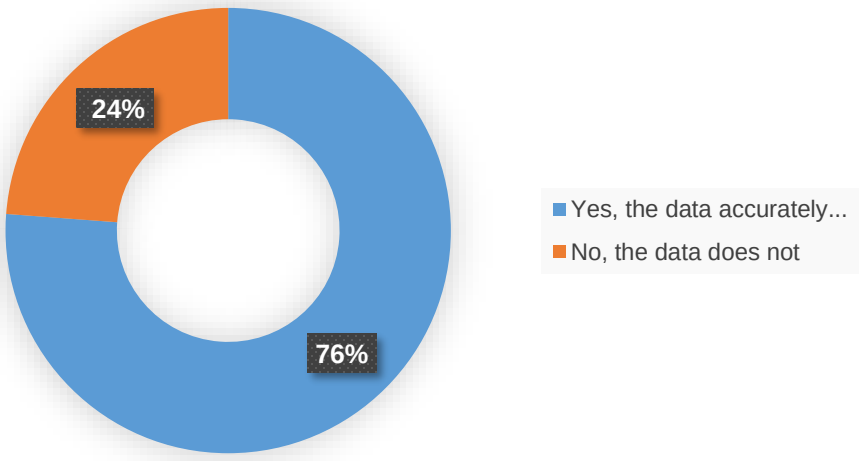
***- 2019 & 2016 Significant Need*

Individuals Participating as Local Expert Advisors[39]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	5	17	22
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	9	15	24
3) **Priority Populations**	19	4	23
4) Representative/Member of **Chronic Disease Group** or Organization	0	21	21
5) Represents the **Broad Interest of the Community**	22	3	25
Other			0
Answered Question			26
Skipped Question			0

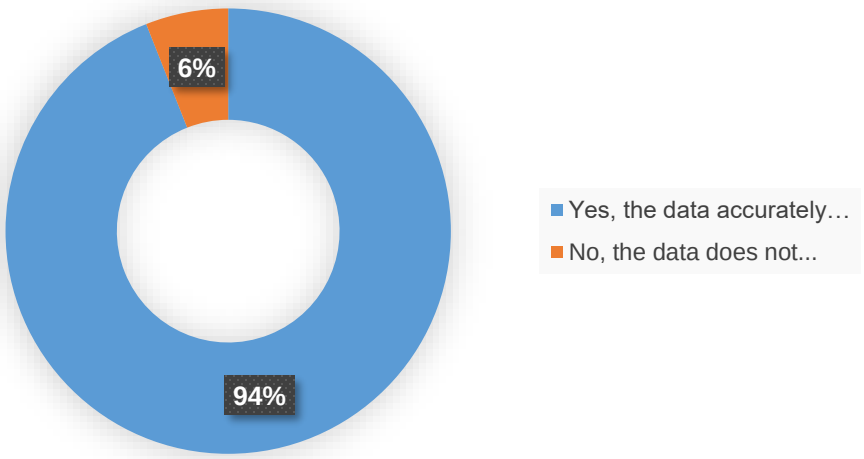
Advice Received from Local Expert Advisors

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

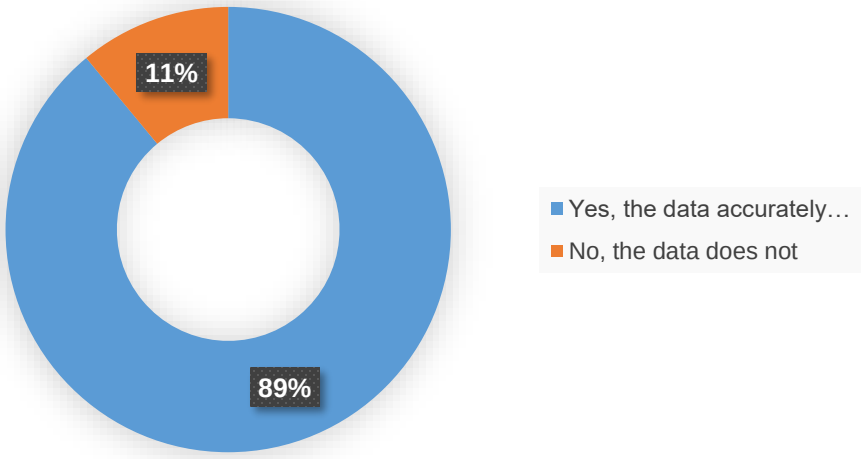


[39] Responds to IRS Schedule H (Form 990) Part V B 3 g

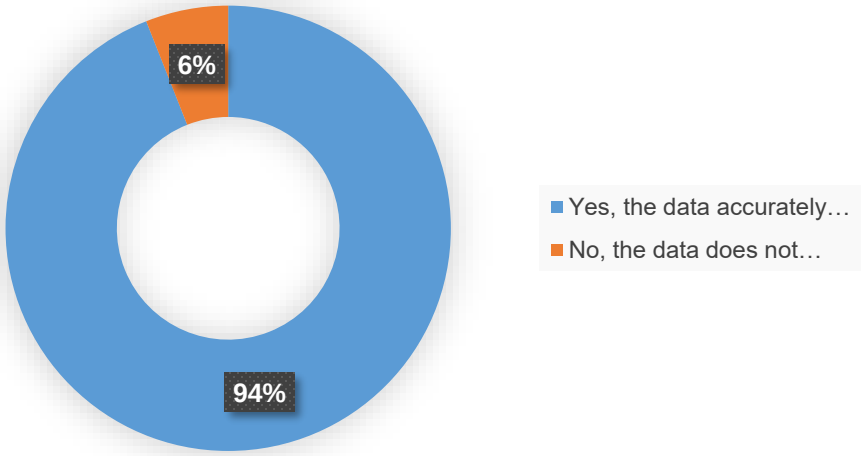
Question: Do you agree with the demographics and common health behaviors of Koochiching County?



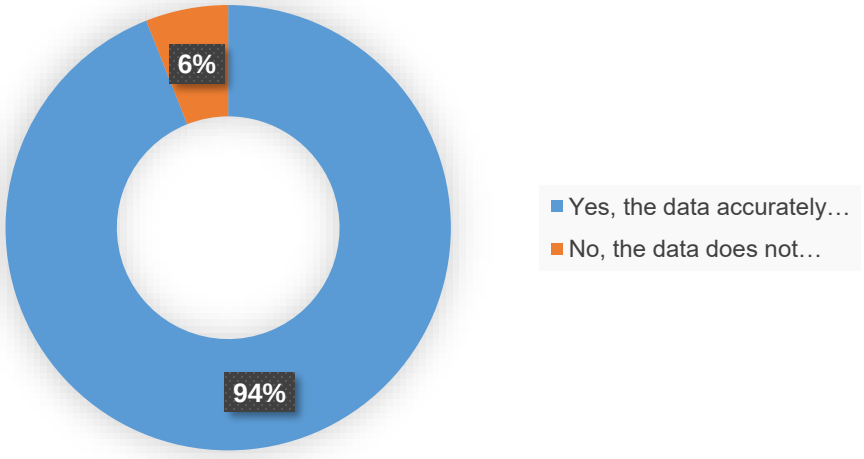
Question: Do you agree with the overall social vulnerability index for Koochiching County?



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



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



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

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

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

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

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

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

Key Findings

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

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

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

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

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

Trends

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

Looking Forward

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

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

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

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

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

Link to the full report:

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

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

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

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnote 16 on page 11

   b. **Demographics of the community**

      See footnote 19 on page 12

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

      See footnote 33 on page 26, footnote 34 on page 27 and footnote 35 on page 34

   d. **How data was obtained**

      See footnote 11 on page 9

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

      See footnote 31 on page 24

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

      See footnote 10 on page 9

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

      See footnote 14 on page 9

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

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

See footnotes 13 on page 9

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

See footnote 10 on page 9, footnotes 14 on page 9, and footnote 28 on page 18

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

N/A

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

2019

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

Yes, see footnote 14 on page 9 and footnote 39 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

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

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

Yes

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

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

https://www.rainylakemedical.com/

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

No other website

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

Yes

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

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

Yes

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

2019

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

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

b. https://rainylakemedical.com/RLMC-2019-CHNA.pdf

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

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

See footnote 32 on page 25

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

None incurred

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

Nothing to report

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

Nothing to report