# Neosho Memorial Regional Medical Center

*Chanute, Kansas*

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution October 20, 2016

Dear Community Member:

At Neosho Memorial Regional Medical Center (NMRMC), we have spent 65 years providing high-quality compassionate healthcare to the greater Chanute community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how NMRMC will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we are meeting our obligations to efficiently deliver medical services.

NMRMC plans to 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.

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,

Dennis Franks
Chief Executive Officer
Neosho Memorial Regional Medical Center

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# EXECUTIVE SUMMARY

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Neosho Memorial Regional Medical Center ("NMRMC" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community and develop an implementation plan to outline and organize how to meet those needs.

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

The Significant Health Needs for Neosho County are:

1. Obesity/Overweight
2. Alcohol/Substance Abuse
3. Affordability
4. Smoking/Tobacco Use
5. Physical Inactivity

The Hospital has developed implementation strategies for all five of the needs (Obesity/Overweight and Physical Inactivity will be addressed together) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

# APPROACH

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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 501(c)(3) hospitals as a condition of retaining tax-exempt status. ***While Neosho Memorial Regional Medical Center is not a 501(c)(3) hospital, this study is designed to comply with the same standards[2] and helps assure NMRMC identifies and responds to the primary health needs of its residents.***

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.

## Project Objectives

NMRMC partnered with Quorum Health Resources (Quorum) to:[3]

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

## Overview of Community Health Needs Assessment

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

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

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

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility must conduct a CHNA at least once every three taxable years, and adopt an implementation strategy to meet the community needs identified through the assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization, and may be conducted together with one or more other organizations, including related

[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] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

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 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*

[4] Section 6652

[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

*''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."*[6]

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

*"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the*

[6] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources.

*form of written comments."*[7]

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

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

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

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

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

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

**Other** (please specify)

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

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

[7] Federal Register Op. cit. P 78967

[8] "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.

Data sources include:[9]

| Website or Data Source | Data Element | Date Accessed | Data Date |
|---|---|---|---|
| www.countyhealthrankings.org | Assessment of health needs of Neosho County compared to all state counties | June 22, 2016 | 2012 |
| www.cdc.gov/communityhealth | Assessment of health needs of Neosho County compared to its national set of "peer counties" | June 22, 2016 | 2011 |
| Truven (formerly known as Thompson) Market Planner | Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics | June 22, 2016 | 2016 |
| www.capc.org and www.getpalliativecare.org | To identify the availability of Palliative Care programs and services in the area | June 22, 2016 | 2015 |
| www.caringinfo.org and iweb.nhpco.org | To identify the availability of hospice programs in the county | June 22, 2016 | 2015 |
| www.healthmetricsandevaluation.org | To examine the prevalence of diabetic conditions and change in life expectancy | June 22, 2016 | 2010 |
| www.cdc.gov | To examine area trends for heart disease and stroke | June 22, 2016 | 2010 |
| http://svi.cdc.gov | To identify the Social Vulnerability Index value | June 22, 2016 | 2010 |
| www.CHNA.org | To identify potential needs from a variety of resources and health need metrics | June 22, 2016 | 2015 |

[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 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

| Website or Data Source | Data Element | Date Accessed | Data Date |
|---|---|---|---|
| www.datawarehouse.hrsa.gov | To identify applicable manpower shortage designations | June 22, 2016 | 2015 |
| www.worldlifeexpectancy.com/usa-health-rankings | To determine relative importance among 15 top causes of death | June 22, 2016 | 2015 |

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

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 37 Local Expert Advisors. Survey responses started June 1, 2016 and ended with the last response on June 17, 2016.
- Information analysis augmented by local opinions showed how Neosho County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.
- 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
    - The low income, underinsured population is a major issue in the community
    - Obesity, diabetes, and poor nutrition need to be addressed through education and disease management
    - The elderly population has needs around transportation, care in the home, and medication compliance
    - There is a high incidence of drug abuse, particularly methamphetamine use, in the area

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors 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. Consultation with 21 Local Experts occurred again via an internet-based survey (explained below) beginning July 21, 2016 and ending August 5, 2016.

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

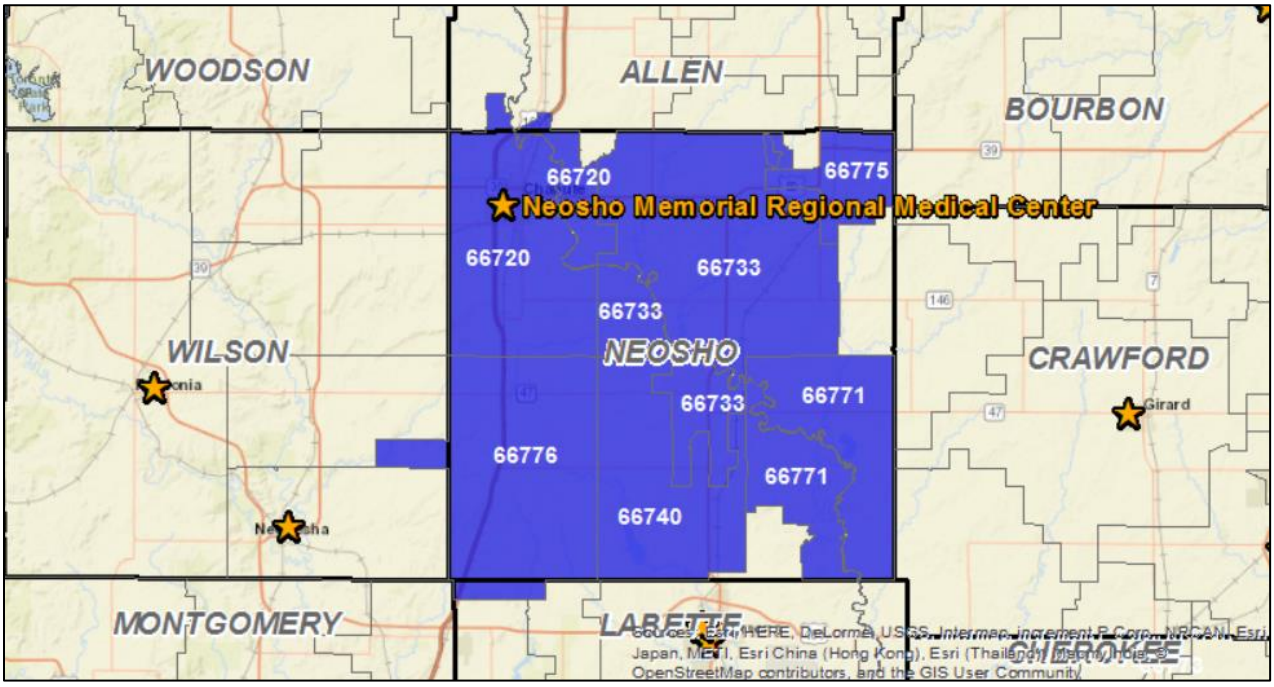
In the NMRMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings. We developed a summary of all needs identified by any of the analyzed data sets. The Local Experts then allocated 100 points among the potential

significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

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

# COMMUNITY CHARACTERISTICS

## Definition of Area Served by the Hospital




NMRMC, in conjunction with Quorum, defines its service area as Neosho County in Kansas, which includes the following ZIP codes:[10]

66720 – Chanute 66733 – Erie 66740 – Galesburg 66771 – Saint Paul 66775 – Stark
66776 – Thayer

In 2014, the Hospital received 71.3% of its patients from this area.[11]

[10] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[11] Truven MEDPAR patient origin data for the hospital

## Demographics of the Community[12]

| | County | State | U.S. |
|---|---|---|---|
| 2016 Population[13] | **16,427** | **2,919,379** | **322,431,073** |
| % Increase/Decline | **0.1%** | **2.0%** | **3.7%** |
| Estimated Population in 2021 | **16,438** | **2,979,068** | **334,341,965** |
| % White, non-Hispanic | **89.8%** | **76.1%** | **61.3%** |
| % Hispanic | **5.6%** | **11.8%** | **12.3%** |
| Median Age | **40.1** | **36.4** | **38.0** |
| Median Household Income | **$45,300** | **$53,878** | **$55,072** |
| Unemployment Rate | **6.4%** | **3.8%** | **5.0%** |
| % Population >65 | **19.1%** | **14.9%** | **15.1%** |
| % Women of Childbearing Age | **17.1%** | **19.2%** | **19.6%** |

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

**DEMOGRAPHIC CHARACTERISTICS**

| | Selected Area | USA |
|---|---|---|
| 2010 Total Population | 16,599 | 308,745,538 |
| 2016 Total Population | 16,427 | 322,431,073 |
| 2021 Total Population | 16,438 | 334,341,965 |
| % Change 2016 - 2021 | 0.1% | 3.7% |
| Average Household Income | $55,764 | $77,135 |

| | 2016 | 2021 | % Change |
|---|---|---|---|
| Total Male Population | 8,130 | 8,141 | 0.1% |
| Total Female Population | 8,297 | 8,297 | 0.0% |
| Females, Child Bearing Age (15-44) | 2,803 | 2,870 | 2.4% |

**POPULATION DISTRIBUTION**

| | Age Distribution | | | | |
|---|---|---|---|---|---|
| Age Group | 2016 | % of Total | 2021 | % of Total | USA 2016 % of Total |
| 0-14 | 3,353 | 20.4% | 3,311 | 20.1% | 19.0% |
| 15-17 | 697 | 4.2% | 717 | 4.4% | 4.0% |
| 18-24 | 1,523 | 9.3% | 1,632 | 9.9% | 9.8% |
| 25-34 | 1,748 | 10.6% | 1,766 | 10.7% | 13.3% |
| 35-54 | 3,717 | 22.6% | 3,432 | 20.9% | 26.0% |
| 55-64 | 2,249 | 13.7% | 2,132 | 13.0% | 12.8% |
| 65+ | 3,140 | 19.1% | 3,448 | 21.0% | 15.1% |
| Total | 16,427 | 100.0% | 16,438 | 100.0% | 100.0% |

**HOUSEHOLD INCOME DISTRIBUTION**

| | Income Distribution | | |
|---|---|---|---|
| 2016 Household Income | HH Count | % of Total | USA % of Total |
| <$15K | 931 | 14.0% | 12.3% |
| $15-25K | 989 | 14.9% | 10.4% |
| $25-50K | 1,765 | 26.5% | 23.4% |
| $50-75K | 1,223 | 18.4% | 17.6% |
| $75-100K | 842 | 12.7% | 12.0% |
| Over $100K | 903 | 13.6% | 24.3% |
| Total | 6,653 | 100.0% | 100.0% |

**EDUCATION LEVEL**

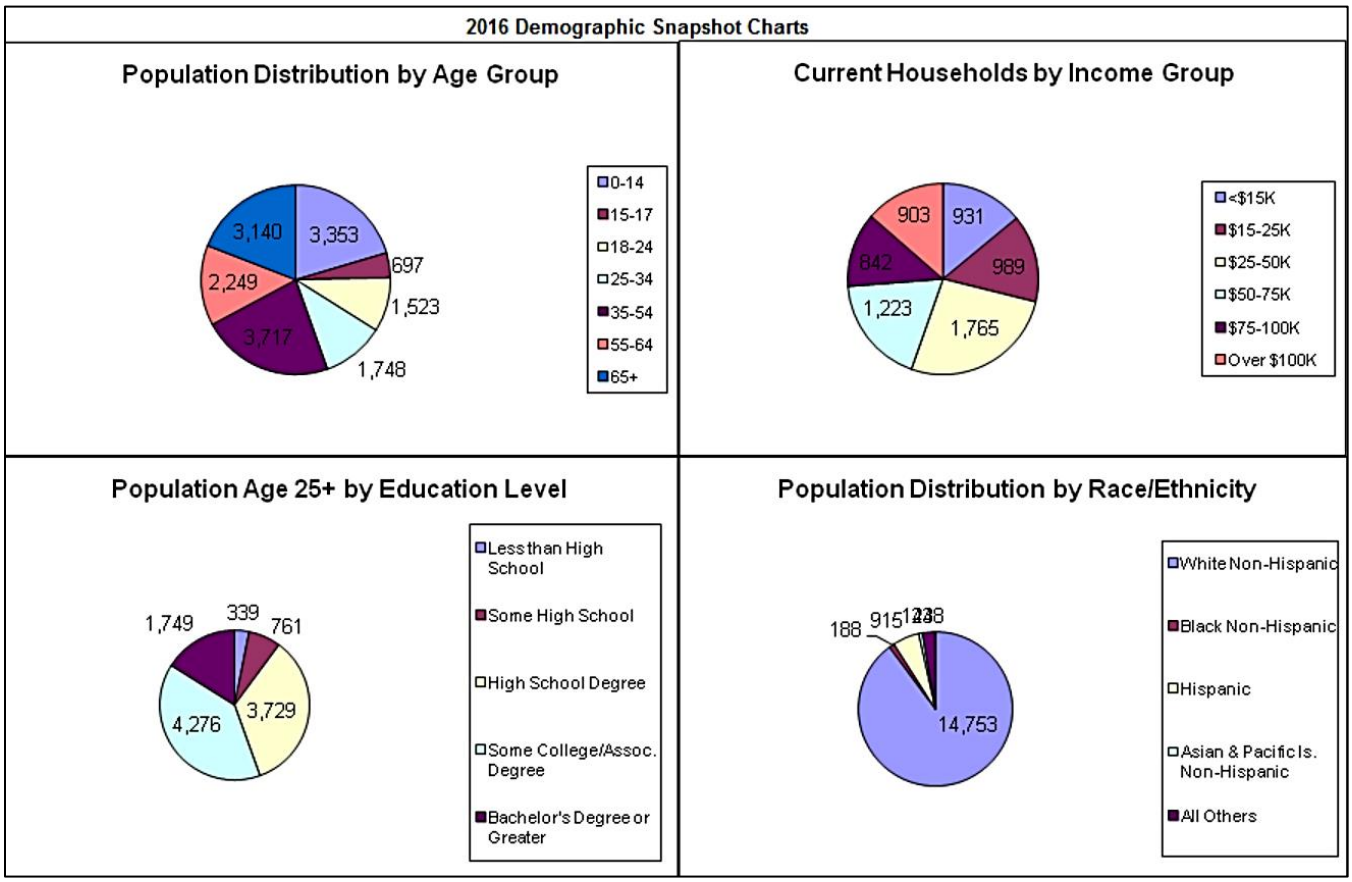
| | Education Level Distribution | | |
|---|---|---|---|
| 2016 Adult Education Level | Pop Age 25+ | % of Total | USA % of Total |
| Less than High School | 339 | 3.1% | 5.8% |
| Some High School | 761 | 7.0% | 7.8% |
| High School Degree | 3,729 | 34.4% | 27.9% |
| Some College/Assoc. Degree | 4,276 | 39.4% | 29.2% |
| Bachelor's Degree or Greater | 1,749 | 16.1% | 29.4% |
| Total | 10,854 | 100.0% | 100.0% |

**RACE/ETHNICITY**

| | Race/Ethnicity Distribution | | |
|---|---|---|---|
| Race/Ethnicity | 2016 Pop | % of Total | USA % of Total |
| White Non-Hispanic | 14,753 | 89.8% | 61.3% |
| Black Non-Hispanic | 188 | 1.1% | 12.3% |
| Hispanic | 915 | 5.6% | 17.8% |
| Asian & Pacific Is. Non-Hispanic | 123 | 0.7% | 5.4% |
| All Others | 448 | 2.7% | 3.1% |
| Total | 16,427 | 100.0% | 100.0% |



[12] The tables below were created by Truven Market Planner, a national marketing company
[13] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner




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

| Area | 2016-2021 % Population Change | Median Age | Population 65+ % of Total Population | Population 65+ % Change 2016-2021 | Females 15-44 % of Total Population | Females 15-44 % Change 2016-2021 | Median Household Income | Median Household Wealth | Median Home Value |
|---|---|---|---|---|---|---|---|---|---|
| USA | 3.7% | 38.0 | 15.1% | 17.6% | 19.6% | 1.5% | $55,072 | $54,224 | $192,364 |
| Kansas | 2.0% | 36.4 | 14.9% | 15.0% | 19.2% | 1.7% | $53,878 | $59,524 | $140,897 |
| Selected Area | 0.1% | 40.1 | 19.1% | 9.8% | 17.1% | 2.4% | $45,300 | $58,860 | $78,200 |

Demographics Expert 2.7
DEMO0003.SQP

## Customer Segmentation

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

| Claritas Prizm Segments | Characteristics |
|---|---|
| **Segment #1 (31%)** | With many of its residents over 65 years old, Segment #1 is mostly a retirement lifestyle: a neighborhood of lower-middle-class singles and couples living in modestly priced homes. Many are high school-educated seniors who held blue-collar jobs before their retirement. And a disproportionate number served in the military, so many residents are members of veterans clubs. |
| **Segment #2 (22%)** | With a population of white-collar couples and families, Segment #2 is a classic rural lifestyle. Residents are high school-educated, with downscale incomes and modest housing; one-fifth live in mobile homes. And there's an air of self-reliance in these households as Segment #2 helps put food on the table through fishing, gardening, and hunting. |
| **Segment #3 (11%)** | The residents of Segment #3 typically live in exurban towns rapidly morphing into bedroom suburbs. Their streets feature new fast-food restaurants, and locals have recently celebrated the arrival of chains like Walmart, Radio Shack, and Payless Shoes. Middle-aged or older, often with limited education and midscale incomes, these folks are transitioning from blue-collar jobs to the service industry. |

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

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

| Health Service Topic | Demand as % of National | % of Population Affected | Health Service Topic | Demand as % of National | % of Population Affected |
|---|---|---|---|---|---|
| **Weight / Lifestyle** | | | **Cancer** | | |
| BMI: Morbid/Obese | 107.8% | 31.9% | Mammography in Past Yr | 96.1% | 43.8% |
| Vigorous Exercise | 98.2% | 55.0% | Cancer Screen: Colorectal 2 yr | 96.5% | 24.6% |
| Chronic Diabetes | 113.3% | 13.5% | Cancer Screen: Pap/Cerv Test 2 yr | 88.2% | 53.0% |
| Healthy Eating Habits | 90.5% | 26.8% | Routine Screen: Prostate 2 yr | 99.6% | 32.0% |
| Ate Breakfast Yesterday | 110.2% | 61.2% | **Orthopedic** | | |
| Slept Less Than 6 Hours | 104.2% | 18.7% | Chronic Lower Back Pain | 110.7% | 25.8% |
| Consumed Alcohol in the Past 30 Days | 83.7% | 46.1% | Chronic Osteoporosis | 127.4% | 12.5% |
| Consumed 3+ Drinks Per Session | 105.7% | 27.8% | **Routine Services** | | |
| **Behavior** | | | FP/GP: 1+ Visit | 103.4% | 91.3% |
| I Will Travel to Obtain Medical Care | 94.7% | 22.9% | Used Midlevel in last 6 Months | 107.4% | 44.5% |
| I am Responsible for My Health | 93.1% | 60.8% | OB/Gyn 1+ Visit | 85.9% | 39.8% |
| I Follow Treatment Recommendations | 95.8% | 49.8% | Medication: Received Prescription | 100.9% | 52.3% |
| **Pulmonary** | | | **Internet Usage** | | |
| Chronic COPD | 130.3% | 5.2% | Use Internet to Talk to MD | 69.3% | 8.8% |
| Tobacco Use: Cigarettes | 112.4% | 28.7% | Facebook Opinions | 74.1% | 7.6% |
| **Heart** | | | Looked for Provider Rating | 87.6% | 12.6% |
| Chronic High Cholesterol | 114.5% | 25.2% | **Emergency Service** | | |
| Routine Cholesterol Screening | 93.9% | 47.7% | Emergency Room Use | 101.9% | 34.5% |
| Chronic Heart Failure | 136.1% | 6.7% | Urgent Care Use | 92.7% | 21.7% |

## Leading Causes of Death

| Cause of Death | | | Rank among all counties in KS (#1 rank = worst in state) | Rate of Death per 100,000 age adjusted | | Observation (Compared to U.S.) |
|---|---|---|---|---|---|---|
| Neosho Rank | KS Rank | Condition | | KS | Neosho | |
| **1** | 2 | Heart Disease | 18 of 105 | 157.4 | 220.0 | As expected |
| **2** | 1 | Cancer | 20 of 105 | 166.8 | 193.2 | As expected |
| **3** | 4 | Accidents | 55 of 105 | 44.1 | 56.2 | As expected |
| **4** | 3 | Lung | 39 of 105 | 49.2 | 52.8 | As expected |
| **5** | 5 | Stroke | 48 of 105 | 39.0 | 49.1 | As expected |
| **6** | 9 | Kidney | 7 of 105 | 16.6 | 26.1 | Higher than expected |
| **7** | 8 | Flu - Pneumonia | 36 of 105 | 18.2 | 24.5 | Higher than expected |
| **8** | 6 | Alzheimer's | 52 of 105 | 21.9 | 19.7 | As expected |
| **9** | 11 | Blood Poisoning | 1 of 105 | 10.3 | 19.0 | Higher than expected |
| **10** | 7 | Diabetes | 79 of 105 | 19.2 | 18.1 | Lower than expected |
| **11** | 10 | Suicide | 70 of 105 | 15.7 | 13.0 | As expected |
| **12** | 12 | Parkinson's | 64 of 105 | 9.4 | 6.4 | As expected |
| **13** | 13 | Liver | 88 of 105 | 8.9 | 4.4 | Lower than expected |
| **14** | 14 | Hypertension | 72 of 105 | 5.7 | 3.9 | Lower than expected |
| **15** | 15 | Homicide | 34 of 105 | 3.7 | 3.1 | As expected |

## Priority Populations[14]

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

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

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the report trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[15]

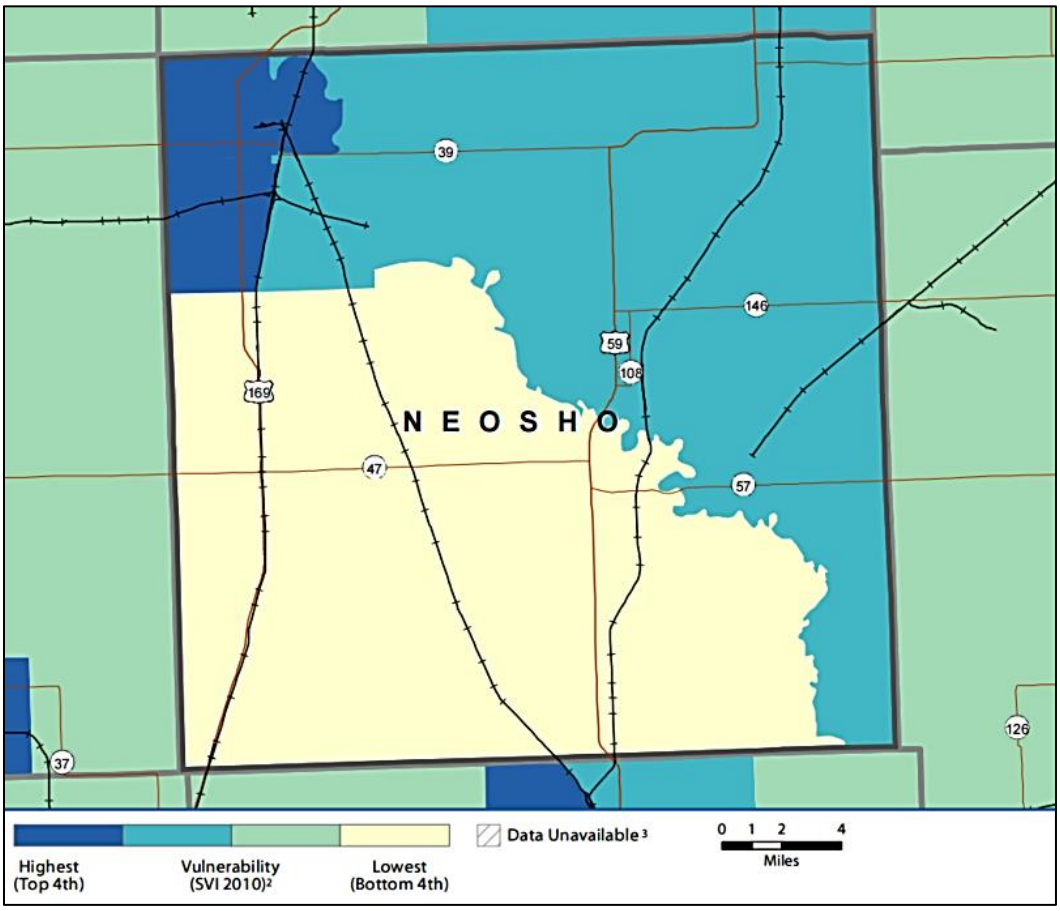
- The low income, underinsured population is a major issue in the community
- Obesity, diabetes, and poor nutrition need to be addressed through education and disease management
- The elderly population has needs around transportation, care in the home, and medication compliance
- There is a high incidence of drug abuse, particularly methamphetamine use, in the area

[14] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html
[15] All comments and the analytical framework behind developing this summary appear in Appendix A

## Social Vulnerability

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

Northeast Neosho County falls into the second highest quartile of social vulnerability, and southwest Neosho County is in the lowest quartile. Northwest Neosho County is noted as being in the highest quartile of vulnerability.



## Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 37 individuals provided feedback on the 2013 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

| Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy | Yes (Applies to Me) | No (Does Not Apply to Me) | Response Count |
|---|---|---|---|
| 1) Public Health Expertise | 4 | 27 | 31 |
| 2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital | 5 | 28 | 33 |
| 3) Priority Populations | 7 | 25 | 32 |
| 4) Representative/Member of Chronic Disease Group or Organization | 4 | 28 | 32 |
| 5) Represents the Broad Interest of the Community | 26 | 7 | 33 |
| Other | | | |
| Answered Question | | | 34 |
| Skipped Question | | | 3 |

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

- Obesity/Overweight
- Alcohol/Substance Abuse
- Smoking/Tobacco Use
- Affordability
- Compliance Behavior/Predisposing Conditions
- Coronary Heart Disease

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

| | Yes | No | No Opinion |
|---|---|---|---|
| Obesity/Overweight | 32 | 2 | 0 |
| Alcohol/Substance Abuse | 32 | 2 | 0 |
| Smoking/Tobacco Use | 32 | 2 | 0 |
| Affordability | 32 | 1 | 1 |
| Compliance Behavior/Predisposing Conditions | 30 | 3 | 1 |
| Heart Disease | 33 | 0 | 1 |

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

| | Yes | No | No Opinion |
|---|---|---|---|
| Obesity/Overweight | 30 | 3 | 0 |
| Alcohol/Substance Abuse | 30 | 3 | 0 |
| Smoking/Tobacco Use | 29 | 4 | 0 |
| Affordability | 29 | 2 | 2 |
| Compliance Behavior/Predisposing Conditions | 26 | 5 | 2 |
| Heart Disease | 32 | 0 | 1 |

## Comparison to Other State Counties

To better understand the community, Neosho County has been compared to all 101 counties in the state of Kansas across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

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

| | Neosho County | Kansas | U.S. Best |
|---|---|---|---|
| **Health Outcomes** | | | |
| Overall Rank *(best being #1)* | 55/101 | | |
| Premature Death (deaths prior to age 75) | 7,600 | 6,800 | 5,200 |
| **Health Behaviors** | | | |
| Overall Rank *(best being #1)* | 87/101 | | |
| Adult Obesity | 33% | 30% | 25% |
| Physical Inactivity | 29% | 25% | 20% |
| Adult Smoking | 19% | 18% | 14% |
| Alcohol Impaired Driving Deaths | 45% | 33% | 14% |
| Teen Births (per 1,000 female population ages 15-19) | 52 | 38 | 19 |
| Access to Exercise Opportunities | 23% | 76% | 91% |
| **Clinical Care** | | | |
| Overall Rank *(best being #1)* | 62/101 | | |
| Uninsured Rate | 15% | 14% | 11% |
| Preventable Hospital Stays | 86 | 55 | 38 |
| Mammography Screening | 53% | 63% | 71% |
| Population to Primary Care Physician | 1,830:1 | 1,330:1 | 1,040:1 |
| Population to Dentist | 3,280:1 | 1,840:1 | 1,340:1 |
| Population to Mental Health Provider | 970:1 | 550:1 | 370:1 |
| **Social & Economic Factors** | | | |
| Overall Rank *(best being #1)* | 97/101 | | |

| | Neosho County | Kansas | U.S. Best |
|---|---|---|---|
| Children in Poverty | 26% | 18% | 13% |
| Children in Single-Parent Households | 32% | 29% | 21% |
| Unemployment | 7.2% | 4.5% | 3.5% |
| Injury Deaths | 72 | 67 | 51 |
| Some College | 64% | 69% | 72% |
| **Physical Environment** | | | |
| Overall Rank *(best being #1)* | 14/101 | | |

## Comparison to Peer Counties

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

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

| | Neosho County | Peer Ranking (#1 is best) | U.S. Average |
|---|---|---|---|
| **Mortality** | | | |
| **Better** | | | |
| Cancer Deaths | 177.9 | 9/37 | 185.0 |
| Diabetes Deaths (per 100,000) | 13.9 | 2/28 | 24.7 |
| **Worse** | | | |
| Chronic Kidney Disease Deaths (per 100,000) | 30.2 | 23/27 | 17.5 |
| **Morbidity** | | | |
| **Better** | | | |
| Alzheimer's Diseases/Dementia | 8.8% | 6/36 | 10.3% |
| Older Adult Asthma | 2.1% | 4/36 | 3.6% |
| Syphilis (per 100,000) | 0.0% | 6/36 | 0.0% |
| **Worse** | | | |
| Adult Diabetes | 11.4% | 30/35 | 8.1% |
| Gonorrhea (per 100,000) | 60.8 | 36/37 | 30.5 |
| **Healthcare Access & Quality** | | | |
| **Better** | | | |
| None | -- | -- | -- |
| **Worse** | | | |
| None | -- | -- | -- |
| **Health Behaviors** | | | |
| **Better** | | | |
| Adult Smoking | 17.4% | 5/27 | 21.7% |
| **Worse** | | | |
| Teen Births (per 1,000 female population ages 15-19) | 55.0 | 30/37 | 42.1 |

| | Neosho County | Peer Ranking (#1 is best) | U.S. Average |
|---|---|---|---|
| **Social Factors** | | | |
| **Better** | | | |
| On Time High School Graduation | 93.1% | 4/33 | 83.8% |
| **Worse** | | | |
| High Housing Costs | 25.7% | 32/37 | 27.3% |
| **Physical Environment** | | | |
| **Better** | | | |
| Access to Parks | 42.0% | 2/37 | 14.0% |
| **Worse** | | | |
| Limited Access to Healthy Food | 8.8% | 9/37 | 6.2% |

## Conclusions from Demographic Analysis Compared to National Averages

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

- **BMI: Morbid/Obese** = 7.8% above average, 31.9%
- **I am Responsible for my Health** = 6.9% below average, 60.8%
- **Routine Cholesterol Screening** = 6.1% below average, 47.7%
- **Cervical Cancer Screening in past two years** = 11.8% below average, 53.0%
- **OB/GYN Visit** = 14.1% below average, 39.8%

The following are metrics impacting more than 30% of the population and that are statistically significantly **better** than the national average:

- **Ate Breakfast Yesterday** = 10.2% above average, 61.2%
- **Consumed Alcohol in the Past 30 Days** = 16.3% below average, 46.1%
- **Used Midlevel in Last 6 Months** = 7.4% above average, 44.5%

## Conclusions from Other Statistical Data

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

| | Current Date of Data | Statistic | Change | Last Date of Data |
|---|---|---|---|---|
| **UNFAVORABLE** COUNTY measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change | | | | |
| Male Heavy Drinking | 2012 | 10.3% | 2.4% pts | 2005 |
| Male Binge Drinking | 2012 | 24.6% | 1.7% pts | 2002 |
| Female Smoking | 2012 | 26.6% | 1.8% pts | 1996 |
| Female Obesity | 2011 | 39.1% | 9.4% pts | 2001 |
| Male Obesity | 2011 | 39.3% | 10.9% pts | 2001 |
| Male Physical Activity | 2011 | 47.7% | -6.9% pts | 2001 |
| **UNFAVORABLE** COUNTY measures that are **WORSE** than the U.S. average and had an **FAVORABLE** change | | | | |
| Female Life Expectancy | 2013 | 79.7 | 0.8 years | 1985 |
| Male Life Expectancy | 2013 | 74.1 | 0.9 years | 1985 |
| Male Smoking | 2012 | 27.0% | -1.6% pts | 1996 |
| Female Physical Activity | 2011 | 47.7% | 7.4% pts | 2001 |
| **DESIRABLE** COUNTY measures that are **BETTER** than the US average and had an **UNFAVORABLE** change | | | | |
| Female Heavy Drinking | 2012 | 4.7% | 1.1% pts | 2005 |
| Female Binge Drinking | 2012 | 10.9% | 0.4% pts | 2002 |
| **DESIRABLE** COUNTY measures that are **BETTER** than the US average and had an **FAVORABLE** change | | | | |
| None | -- | -- | -- | -- |

## Community Benefit

*"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.

# IMPLEMENTATION STRATEGY

## Significant Health Needs

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by NMRMC. 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 NMRMC current efforts responding to the need including any written comments received regarding prior NMRMC implementation actions
- Establishes the Implementation Strategy programs and resources NMRMC will devote to attempt to achieve improvements
- Documents the Leading Indicators NMRMC will use to measure progress
- Presents the Lagging Indicators NMRMC 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, Neosho Memorial Regional Medical Center is the major hospital in the service area. NMRMC is a 25-bed, critical access hospital located in Chanute, Kansas. The next closest facilities are outside the service area and include:

- Allen County Regional Hospital in Iola, KS, 22 miles (22 minutes)
- Wilson Medical Center in Neodesha, KS, 32 miles (35 minutes)
- Fredonia Regional Hospital in Fredonia, KS, 29 miles (31 minutes)
- Labette Health in Parsons, KS, 37 miles (42 minutes)

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

1. **OBESITY/OVERWEIGHT** – 2013 Significant Need; adult obesity worse than KS and US average; BMI: Morbid/Obese 7.8% above average; male and female obesity worse than US average

5. **PHYSICAL INACTIVITY** – physical inactivity worse than KS and US average; access to exercise opportunities below KS and US average; male and female physical activity worse than US average

**Public comments received on previously adopted implementation strategy for <u>Obesity/Overweight</u>:**

- *Need to continue to promote healthy diet, access to healthy food and physical activity.*
- *Diet exercise assembly at area schools*
- *I am not aware of what was implemented.*
- *Neosho County health Department spoke with farmers markets and was unsuccessful in the farmers market, agreeing to accept snap are WIC or even to contemplate the conversation. We have seen this be successful in other counties and know that are County could do this also. It would encourage families to come the farmers markets where recipes on cooking fresh and not processed could be passed out to families with a better understanding of the nutritional value.*
- *Maybe a weight loss support group and possibley a series of expert talks for the community on obesity.*
- *i dont know what can be done. councilling is not enough to change a lifestyle. even the limitation of toxic foods will not prevent them from importing them.*
- *N/a*
- *Focus on addition. In my layman's opinion food is an addition related to stress level and personal situation, much in the same way drug addition and smoking is. The difference, unlike smoking or drugs, is that we have to eat every six hours or so, it's legal, and we have a nearly unlimited supply of food at our fingertips. The cheaper the food the worse it is for you. So treat food addiction like drug or smoking addition. Of course treatment for drugs and smoking is not incredibly effective with lots of failure and backsliding along the way. It's an uphill battle. But as Walt Disney said, "It's kind of fun to do the impossible."*
- *Low cost or no cost options would be great.*
- *Free after school groups who do activities and learning experiences on good food vs bad food. What is a diet and why you should watch what and how much you eat. Weight control should also be addressed. Parents or care givers should also be included in this group. It needs to be open to the public. Exercise programs is another topic to discuss with the group. Some of the overweight people do not even know who to start or begin loosing weight. They think just eating one not 2 or 3 frozen burrito for supper is how to loose weight. They need to be educated on good food vs bad food.*
- *See comment #3 [Is there someway the community can partner with the REC commission or NCCC or USD413 to offer some type of cooking or nutrition classes? I believe there is grant money available at the state and national levels to do something like this.]*
- *see above [NMRMC has done a lot and continues to help in this area....affordability of the fitness center is one are that might be reviewed.]*

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

- NMRMC Rehabilitation and Fitness Center is open to the public and includes group fitness classes, therapy swimming pool, racquetball courts, free weights and machines; offers payment plans and employer-subsidized programs; access to personal trainer
- The Best Café (hospital cafeteria) is open to the public and includes program called Healthy Living that offers healthier food choices and healthier preparation of food; public education on making healthy food choices; calorie counts listed; Aramark foods synced with food trackers/apps
- Sponsor of local health events including Turkey Trot 5K run/walk, local sports teams and fitness/recreation programs, local park events, health fairs in several communities, and on-site health fairs at local employers
- Employee Wellness Program that includes comprehensive lab screens and program with point system and employee challenges to encourage physical activity and healthy living, which can lead to reduction in health insurance costs
- Quarterly community newsletter articles, daily social media posts/articles, and speaking engagements on a variety of health topics including nutrition and healthy living
- Registered dietician available to inpatients and public; starting new diabetes program with dietician and nurse to provide one-on-one and group sessions to teach nutrition and healthy living to better manage diabetes
- Reduced-cost screenings at health fairs including weight, blood pressure, BMI, lipid panel, and A1C
- Weekly free blood pressure and blood sugar screenings offered in a variety of locations throughout the community
- Home Health provides monthly education events including topics on obesity, nutrition

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

- Adding calorie counts on meals in The Best Café
- Adding Chronic Care Coordinator who is working with primary care providers to streamline and manage care and provide overall health coaching including diet and medication management
- Working toward Baby Friendly Hospital designation and encouraging breastfeeding and working with local lactation consultant to provide education and counseling
- Adding facility accommodations for overweight and obese patients through construction projects

**NMRMC evaluation of impact of actions taken since the immediately preceding CHNA:**

- Added primary care clinics (including expansion to higher-risk area) that include initial screenings for BMI during visits
- Added social media articles/posts on nutrition and healthy living
- Free blood sugar screenings added
- Improved vending machine offerings and encouraged water consumption over sweetened beverages

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

- Number of participants in the employee wellness program = 265 (2015)
- Number of members enrolled in fitness center = 409 (2015)

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

- Percentage of residents with BMI of 30 or greater[16] = 33%

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

| Organization | Contact Name | Contact Information |
|---|---|---|
| Rehabilitation and Fitness Association | Aaron Liudahl, Director | (620) 432.5379<br>www.nmrmc.com/services-fitness |
| Aramark | Troy Pervin, NMRMC Facilities Officer | www.aramark.com |
| Viverae (employee wellness portal) | | viverae.com |
| Health Department (lactation consultant) | Stephanie Henry, IBCLC, NCHD Lactation Consultant | 320 E Main St, Chanute, KS 66720<br>(620) 431-5770<br>www.neoshocountyks.org/health.asp |

[16] County Health Rankings. County Demographics. BMI>=30. 2011-2013.

| Organization | Contact Name | Contact Information |
|---|---|---|
| Kansas Heart and Stroke Collaborative (Chronic Care Coordinator) | Megan Jones, RN, Health Coach | khsc@kumc.edu<br>www.kumed.com/about-us/community-outreach/rural-health |
| Parks and Recreation Commissions (Erie & Chanute) | Steve Slane, Director (Chanute)<br>Denise Reissig, Coordinator (Erie) | www.chanuterecreation.com<br>(620) 431-4199<br>www.lovesmalltownamerica.com/eriks_com.php |

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

| Organization | Contact Name | Contact Information |
|---|---|---|
| Local fitness centers | | |
| Local school districts (St Paul, Erie, Chanute, Thayer) | | |
| Local fitness advocates (individuals) | | |
| Neosho County Community College | Dr. Brian Inbody, President | 800 W 14th St, Chanute, KS 66720<br>(620) 431-2820<br>www.neosho.edu |

2. **ALCOHOL/SUBSTANCE ABUSE** – 2013 Significant Need; Local Expert concern; alcohol-impaired driving deaths above KS and US average; male binge drinking and male heavy drinking worse than US average

   **More specifically: Alcohol Abuse/Methamphetamines/Opioid Abuse**

**Public comments received on previously adopted implementation strategy:**

- *There is a lack of resources at the state level that makes it difficult to treat these patients. The community mental health services need to be increased to address these patients.*
- *Put on an anti drug assembly at area schools*
- *Neosho County health Department would like to see a program like the fire escape for the youth in our community. We feel with supervised and structured activities possibly even an open gym with volunteers from the community or even paid mentors.*
- *Possibly a narcotics anonymous group and further education to the community about narcotic dependence.*
- *Mental health department would be a better avenue*
- *Personally, I'm not aware of the treatment services provided by the hospital. I'm sure you have them, I just never used them or know of folks who have.*
- *Education programs and or speakers*
- *This could be a joint effort with the Mental Health program here in town.*

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

- Quarterly community newsletter articles, daily social media posts/articles, and speaking engagements on a variety of health topics including alcohol and substance abuse
- Drug screening services provided at local employers
- Physical therapists available to help rehabilitate patients and expand pain management options
- Employee Assistance Program with resources for six free counseling sessions for any life challenges and online resources for education
- Social worker on staff to help with referrals and resources for substance abuse issues

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

- Evaluate potential for coordinating providers' approach to prescribing opioids and managing chronic pain
- Investigate ways to educate providers, staff, and overall community on resources available including local AA chapter, NA chapter, chiropractors, massage therapists, etc.
- Adding Chronic Care Coordinator who is working with primary care providers to streamline and manage care and provide overall health coaching including medication and pain management
- Investigate ways to work with local school departments and recreation commissions to increase education and awareness

- Potentially expand community involvement/education through Patient and Family Advisory Council

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

- Number of drug screens processed through the lab = 438 (2015)

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

- Number of drug overdose deaths (modeled)[17] = 12.0-14.0/100,000 population

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

| Organization | Contact Name | Contact Information |
|---|---|---|
| Kansas Heart & Stroke Collaborative (Chronic Care Coordinator) | Megan Jones, RN, Health Coach | khsc@kumc.edu<br>www.kumed.com/about-us/community-outreach/rural-health |
| Other local healthcare providers | | |
| Local school departments | | |

[17] County Health Rankings. Drug Overdose Deaths – modeled. Range of drug poisoning deaths per 100,000 population, 2014. Due to small population size, this is an estimate based on the overall Kansas statistics and similarly sized counties.

| Organization | Contact Name | Contact Information |
|---|---|---|
| Parks and Recreation Commissions (Erie & Chanute) | Steve Slane, Director (Chanute)<br>Denise Reissig, Coordinator (Erie) | www.chanuterecreation.com<br>(620) 431-4199<br>www.lovesmalltownamerica.com/eri eks_com.php |

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

| Organization | Contact Name | Contact Information |
|---|---|---|
| Public Health Department | Teresa Starr | 320 E Main St, Chanute, KS 66720<br>(620) 431-5770<br>www.neoshocountyks.org/health.asp |
| Southeast Kansas Mental Health Department | Doug Wright, Ph.D., Clinical Psychologist | 304 N Jefferson Ave, Iola, KS 66749<br>(620) 365-5717<br>www.cityofiola.com/healthcare.html |
| Local AA Chapter | | www.kansas-aa.org |
| Local NA Chapter | | 1609 West 1st Street, Chanute, KS 66720<br>www.naws.org/meetingsearch |
| FireEscape Coffee House (youth ministry) | Mark & Marilyn Harms, Executive Directors | 126 W Main St, Chanute, KS 66720<br>(620) 431-5815<br>www.fireescape.net |
| Cherry Street Youth Center | Jennifer Shields, Director | 710 N Forest Ave, Chanute, KS 66720<br>(620) 431-2161<br>www.cherrystreetyouthcenter.org |
| Local churches | | |

3. **AFFORDABILITY** – 2013 Significant Need; Local Expert concern; uninsured rate higher than KS and US average

**Public comments received on previously adopted implementation strategy:**

- *The hospital had programs for those who cannot afford care, but this needs to also be addressed at the community/state level.*
- *Monitor insurance frivolous reasons to come to ER should be denied and be paid for by the person that is abusing the medical card*
- *I think the hospital provides a great service in our patient assistance program. I would like to see, however some charge for all patients. I don't think medical care should ever be free. I see people abusing the patient assistance program. It should also be granted for shorter period of times.*
- *More programs to help those who need help need to be put in place.*
- *Not sure what you can do here. Free clinic for low income people?*
- *I do understand how smoking hurts not only the smoker but people around them but if you have to be admitted to the hospital for any reason the patient not being able to have a cigarette has stress them out and could cause more problems. I being an ex-smoker understand this.*
- *For example, when I saw dressings being changed there were numerous times when an excessive amount of pads, tape, etc., were brought into the room. The extra items remained in the room for days. New material came to the room with each caregiver. I just wonder if some cost could have been saved.*

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

- Funding a navigator program to help people enroll on the Healthcare Marketplace and help eligible people enroll in Medicaid
- Financial Assistance program with sliding discount available
- Partnership with local bank to help patients secure long-term payment plans; advertised quarterly and promoted through brochure
- Financial Assistance counselors available to discuss payment options and assist with applications
- ImPACT Program – Hospital Foundation funds free baseline concussion screenings offered at local school districts
- Discounted sports physicals offered through local clinics
- NMRMC Rehabilitation and Fitness Center is open to the public and includes group fitness classes, therapy swimming pool, racquetball courts, free weights and machines; offers payment plans and employer-subsidized programs; access to personal trainer
- The Best Café (hospital cafeteria) is open to the public and includes a program called Healthy Living that offers healthier food choices and healthier preparation of food; public education on making healthy food choices; calorie counts listed; Aramark foods synced with food trackers/apps
- Reduced-cost screenings at health fairs including weight, blood pressure, BMI, lipid panel, A1C, cholesterol, PSA, colorectal, mammograms, pulmonary function

- Weekly free blood pressure and blood sugar screenings and in-home safety assessments offered in a variety of locations throughout the community
- Contract with state and insurance companies to provide discounted services to patients
- Provide ambulance services at local events
- Providers and trainers volunteer at local football games for on-site evaluations and treatment of injuries
- Hospital provides transportation services to patients to receive hospital services
- Hospital leadership working with state legislators to review expanding Medicaid to help address 800 working-poor residents in community
- Hospital creates 450 jobs within the community and pays a base rate higher than the minimum wage to help boost economic development/viability
- Hospital coordinates payer contracts with local providers to help stabilize out-of-pocket costs for residents
- PHO Coordinators contact local employers to ensure coverage for services

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

- Evaluate potential for urgent care facility to remove burden on ER and provide lower-cost services for lower acuity patients
- Working on process to help babies born to Medicaid mothers get enrolled on Medicaid

**NMRMC evaluation of impact of actions taken since the immediately preceding CHNA:**

- Annual event to educate on open enrollment and assist residents in signing up for Medicaid/Medicare/disability

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

- Number of patients assisted by Navigator = 81 (2015)
- Number of free baseline concussion screenings provided through ImPACT Program = 400 (2015)

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

- Uninsured rate[18] = 15%

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

| Organization | Contact Name | Contact Information |
|---|---|---|
| Chanute Community Foundation (medication access) | Koralyn Barkman | (620) 212-2589<br>https://www.facebook.com/chanutecommunityfoundation |
| NMRMC Foundation | Anna Methvin, Director | (620) 432.5496<br>www.nmrmc.com/foundation |
| Tioga Healthcare Alliance (PHO) | Cherie McGuire, Executive Director | (620) 432.5444<br>www.nmrmc.com/patients-tioga |
| Local school districts | | |
| Kansas Hospital Association | Tom Bell, President and CEO | 215 SE 8th Ave, Topeka, KS 66603<br>(785) 233-7436<br>www.kha-net.org |
| Rehabilitation and Fitness Association | Aaron Liudahl, Director | (620) 432.5379<br>www.nmrmc.com/services-fitness |
| Aramark | Troy Pervin, NMRMC Facilities Officer | www.aramark.com |
| Home Savings Bank | Jonathon Johnson, President | 214 N Lincoln Ave, Chanute, KS 66720<br>(620) 431-1100<br>www.homesavingschanute.com |
| Chanute Regional Development Authority | Matthew Godinez, Executive Director | 410 S. Evergreen, Chanute, KS 66720<br>(620) 431-5222<br>www.chanute.org/473/Chanute-Regional-Development-Authority |

[18] County Health Rankings. County Demographics. Population Under 65. 2013.

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

| Organization | Contact Name | Contact Information |
|---|---|---|
| Public Health Department | Teresa Starr | 320 E Main St, Chanute, KS 66720<br>(620) 431-5770<br>www.neoshocountyks.org/health.asp |
| Circles Program | | hmorgan@twsproject17.org<br>www.twsproject17.org/circles-out-of-poverty |

4. **SMOKING/TOBACCO USE** – 2013 Significant Need; adult smoking worse than KS and US average; male and female smoking worse than US average

**Public comments received on previously adopted implementation strategy:**

- *The hospital can provide education, but this needs to be addressed at the primary care level.*
- *referral to appropriate avenue for help*
- *N/A*

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

- Respiratory therapist performs community outreach to educate on effects of tobacco
- Smoking cessation programs (employee and community) offered
- Approximately 13,000 patients screened each year for smoking/tobacco use and provided with cessation education if responding affirmatively
- Reduced-cost screening at health fairs for pulmonary function
- Hospital-wide smoking/tobacco ban
- Quarterly community newsletter articles, daily social media posts/articles, and speaking engagements on a variety of health topics including smoking and tobacco use

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

- Number of patients screened for tobacco use = start tracking in 2016

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

- Tobacco Use[19] = 19%

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

| Organization | Contact Name | Contact Information |
|---|---|---|
| Local school districts | | |
| Blue Cross Blue Shield of Kansas | | www.bcbsks.com |
| Local healthcare providers | | |

[19] County Health Rankings. County Demographics. Current Smokers. 2014.

## Other Community Health Programs, Services, Resources

- Kansas Heart & Stroke Collaborative
  - Stroke Education Program
  - Stop Sepsis
  - Heart Failure/MI
- Care transition plans for heart, stroke, and COPD
- Efforts within OB/Maternal education
  - A Period of Purple Crying to educate parents and prevent shaken baby syndrome
  - Safe Sleep education to reduce infant mortality (sleep sacks, co-sleeping, proper bedding, etc.)
  - Skin-to-skin
  - Child-birth education
  - Vaccinations
  - Lactation Consulting and Breastfeeding Education
  - Contraceptive Management
- Telemedicine services offered in ED to increase access to specialty services
- Increasing physician recruitment
- Implementing new EHR system to improve patient flow and coordinate care
- Lease space for targeted radiation treatments

## Other Needs Identified During CHNA Process

6. **COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS** – 2013 Significant Need
7. **CORONARY HEART DISEASE** – 2013 Significant Need
8. **DIABETES**
9. **CANCER**
10. **MENTAL HEALTH**
11. **DENTAL**
12. **SEXUALLY TRANSMITTED INFECTION**
13. **BLOOD POISONING**
14. **MATERNAL/INFANT MEASURES**
15. **FLU/PNEUMONIA**
16. **STROKE**
17. **ACCIDENTS**
18. **PALLIATIVE CARE**
19. **KIDNEY DISEASE**
20. **LIFE EXPECTANCY**
21. **LUNG DISEASE**
22. **PHYSICIAN**
23. **ALZHEIMER'S**

## Overall Community Need Statement and Priority Ranking Score

**Significant needs where hospital has implementation responsibility**

1. Obesity/Overweight
2. Alcohol/Substance Abuse
3. Affordability
4. Smoking/Tobacco Use
5. Physical Inactivity

**Significant needs where hospital did not develop implementation strategy**

None

**Other needs where hospital developed implementation strategy**

None

**Other needs where hospital did not develop implementation strategy**

6. Compliance Behavior/Predisposing Conditions
7. Coronary Heart Disease
8. Diabetes
9. Cancer
10. Mental Health
11. Dental
12. Sexually Transmitted Infection
13. Blood Poisoning
14. Maternal/Infant Measures
15. Flu/Pneumonia
16. Stroke
17. Accidents
18. Palliative Care

19. Kidney Disease
20. Life Expectancy
21. Lung Disease
22. Physician
23. Alzheimer's

# APPENDIX

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

Hospital solicited written comments about its 2013 CHNA. 37 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

| Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy | Yes (Applies to Me) | No (Does Not Apply to Me) | Response Count |
|---|---|---|---|
| 1) Public Health Expertise | 4 | 27 | 31 |
| 2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital | 5 | 28 | 33 |
| 3) Priority Populations | 7 | 25 | 32 |
| 4) Representative/Member of Chronic Disease Group or Organization | 4 | 28 | 32 |
| 5) Represents the Broad Interest of the Community | 26 | 7 | 33 |
| Other | | | |
| Answered Question | | | 34 |
| Skipped Question | | | 3 |

**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?**

- *Elderly*
- *The elderly population has needs around transportation, care in the home and medication compliance. Many have multiple conditions that are difficult to manage.*
- *Public education and awareness regarding all priority groups treatment and support needs will contribute to improve access and reduce negative stigma. All healthcare providers and human services organizations can better promote and respectfully support and advocate their needs.*
- *I see an increase in drug abuse by people in this area. I know this is common knowledge, but I wish there*

*were more anti-drug education in schools. Kids need to know what these drugs (particularly meth) do to your body and appearance.*

- *High incidence of Methamphetamine use with Medical complications*
- *Definitively an aging community. Diseases such associated with shin such as Alzheimer's dementia or other chronic conditions*
- *Transportation is a huge issue for a lot of the patients that we see. The care car is available during most hours, but it is those hours through the night and weekends when there is limited transportation.*
- *Low income obese diabetics need additional education and support for managing their health*
- *Obesity*
- *Neosho County priorities and population have unique health needs due to lack of education on good nutrition habits, obesity, smoking and binge drinking are two of the issues we see in our County. We also have the working poor that fall through the cracks and are truly the underserved in every County.*
- *The low income, under insured population is a big issue in our community. Likely would benefit from a community health center. Also a liason to other programs to help those populations. Expansion of Medicaid is paramount.*
- *large population of young families in poverty. also elderly residents with limited income and significant medical illness*
- *N/A*
- *I am worried about the high percentage of low income population and their access to health care - i.e. using the emergency room as their primary doctor. The lack of preventative medicine for them will cost the taxpayer a lot more in the long run. The income level and unemployment level of the county is at or near the worst in the state. That has to have long-term health impacts. Greater outreach to this group is needed, but I am unsure as to what that might look like.*
- *Diabetes seems to be an ongoing issue. Education for the individual and any support workers on how to manage the disease is needed. Everyone has a role. The person should seek out this information, hospital and medical staff should make sure it is readily available, insurance should have incentives and service providers should make sure staff have the training to support the person.*
- *Within our county we see individuals with chronic conditions in and out of the hospital. In an effort to help with these issues our agency addresses Fall Prevention and Diabetes Self Management Programs to maintain individuals in the community as long as possible.*
- *Obesity needs to be addressed in the community. Parents who have a history of being overweight tend to have children who are also overweight which leads to increased health problems. These problems can be from breathing to bad joints.*
- *I feel the community as a whole - including all populations - have no clue about nutrition, what to eat, how to fix it, etc. I have observed community members and students eating in a cafeteria for 10 years now and I'm blow away at their choices. I believe 1 out of 8 make healthy choices. Obesity and poor nutrition is the root*

*cause for a good deal of our health care woes.*

- *Large % of population are at or below federal poverty guidelines*
- *Poverty - many families live on government assistance or disability . Many adults cannot work due to ptsd.. From a traumas to life for inadequate coping skills Elderly - in rural communities there are not always affordable are options .. And many residents are not willing to move To a safer environment for fear of losing autonomy or due to cost*
- *Elderly and low-income*
- *Low income groups with drug and alcohol issues. Need programs to address these issues, there are none in the area.*
- *Since we have such a high population of low-income, unemployed and children with not health care, we need to have more information.*
- *HEALTH CARE ACCESS*
- *College students who do not know where to receive affordable and available care All types of health care for low income families*
- *Low income is a concern --- children not getting the nutrition needed and regular preventative care including dental needs attention*

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

1. **Obesity/Overweight**
2. **Alcohol/Substance Abuse**
3. **Smoking/Tobacco Use**
4. **Affordability**
5. **Compliance Behavior/Predisposing Conditions**
6. **Heart Disease**

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

| | Yes | No | No Opinion |
|---|---|---|---|
| Obesity/Overweight | 32 | 2 | 0 |
| Alcohol/Substance Abuse | 32 | 2 | 0 |
| Smoking/Tobacco Use | 32 | 2 | 0 |
| Affordability | 32 | 1 | 1 |
| Compliance Behavior/Predisposing Conditions | 30 | 3 | 1 |
| Heart Disease | 33 | 0 | 1 |

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

| | Yes | No | No Opinion |
|---|---|---|---|
| Obesity/Overweight | 30 | 3 | 0 |
| Alcohol/Substance Abuse | 30 | 3 | 0 |
| Smoking/Tobacco Use | 29 | 4 | 0 |
| Affordability | 29 | 2 | 2 |
| Compliance Behavior/Predisposing Conditions | 26 | 5 | 2 |
| Heart Disease | 32 | 0 | 1 |

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

- *Comment consider other housing options for the elderly who are not ready for assisted living but need both assistance and autonomy. it might make the transition easier later.*
- *n/a*
- *Take a more holistic approach to low income - not just from a health perspective. Form a team of local social services, education, job placement, and health care to provide a "one -contact" system for the low income persons. Studies show that there is a direct correlation between health outcomes and educational attainment and a correlation between job placement and educational attainment. All of it is interdependent. If you are sick then you are not looking to improve your education and thus get a job. If you don't have a job then no insurance/money to go to the doctor for preventative service. It's a vicious circle.*
- *If hospitals/doctors would consider contracting with the Southeast Kansas Area Agency on Aging to have our case managers provide oversight to individuals returning to the community after a hospital stay we could partner to reduce rehospitalization*
- *Not at this time.*
- *Please see my comment on #3*
- *No*
- *I am concerned about over use of narcotics...but realize we are treating or perceived pain...thus leading to disability and to addiction.. While pts with true operative pain have quite a gassed getting meda*

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

- *Not only a local problem but a nationwide issue*
- *This is still a significant need.*
- *Diet and exercise are important for kids to learn about at early ages and we try to help with this at ces*
- *It continues to be a significant problem*

- *Neosho County health Department would like to see more engagement with farmers markets to encourage fresh fruits and vegetables and the ability for farmers markets to accept snap in WIC*
- *More education or classes available to learn about exercise and diet. A county challenge? Some way for people to afford "eating" healthy. It is expensive to try and eat healthy and expensive for those that may need the exercise to have programs to attend.*
- *Obesity is a major risk factor for so many diseases that we need to focus on education and provide resources for weight loss.*
- *it is especially important to obstetrics. multiple problems are associated with maternal obesity including childhood obesity. unfortunately the range has gotten bigger.. obese is not 250. it is 350.*
- *true*
- *#1 is directly correlated with #6 and probably #5. You can solve #6 if you solve #1. #1,#2, #3 are very much personal choice items but matters of addiction as well. That's a hard nut to crack. So focus on addition and you can take care of #1, #2, #3 and improve #6. That's quite a few of your items affected by one effort.*
- *Obesity impacts costs of medical care and medications an individual takes.*
- *Free after school groups who do activities and learning experiences on good food vs bad food. What is a diet and why you should watch what and how much you eat. Weight control should also be addressed. Parents or care givers should also be included in this group. It needs to be open to the public. Exercise programs is another topic to discuss with the group. Some of the overweight people do not even know who to start or begin loosing weight. They think just eating one not 2 or 3 frozen burrito for supper is how to loose weight. They need to be educated on good food vs bad food.*
- *Once again see comment #3*
- *If all hospital employees were at normal weight, that could be a good role model.*
- *Coaching opportunities to inform population on the hazards/preventive needs for weight control and proper diet*
- *I believe this is still a big issue and I believe the hospital should offer, if it is already not doing so, weight loss programs at little or no cost.*
- *NMRMC has done a lot and continues to help in this area....affordability of the fitness center is one are that might be reviewed.*

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

- *Need to continue to promote healthy diet, access to healthy food and physical activity.*
- *Diet exercise assembly at area schools*
- *I am not aware of what was implemented.*
- *Neosho County health Department spoke with farmers markets and was unsuccessful in the farmers market,*

*agreeing to accept snap are WIC or even to contemplate the conversation. We have seen this be successful in other counties and know that are County could do this also. It would encourage families to come the farmers markets where recipes on cooking fresh and not processed could be passed out to families with a better understanding of the nutritional value.*

- *Maybe a weight loss support group and possibley a series of expert talks for the community on obesity.*
- *i dont know what can be done. councilling is not enough to change a lifestyle. even the limitation of toxic foods will not prevent them from importing them.*
- *N/a*
- *Focus on addition. In my layman's opinion food is an addition related to stress level and personal situation, much in the same way drug addition and smoking is. The difference, unlike smoking or drugs, is that we have to eat every six hours or so, it's legal, and we have a nearly unlimited supply of food at our fingertips. The cheaper the food the worse it is for you. So treat food addiction like drug or smoking addition. Of course treatment for drugs and smoking is not incredibly effective with lots of failure and backsliding along the way. It's an uphill battle. But as Walt Disney said, "It's kind of fun to do the impossible."*
- *Low cost or no cost options would be great.*
- *Free after school groups who do activities and learning experiences on good food vs bad food. What is a diet and why you should watch what and how much you eat. Weight control should also be addressed. Parents or care givers should also be included in this group. It needs to be open to the public. Exercise programs is another topic to discuss with the group. Some of the overweight people do not even know who to start or begin loosing weight. They think just eating one not 2 or 3 frozen burrito for supper is how to loose weight. They need to be educated on good food vs bad food.*
- *See comment #3*
- *see above*

**8. Please share comments or observations about keeping <u>Alcohol/Substance Abuse</u> among the most significant needs for the Hospital to address.**

- *Still a significant need, especially opioid addiction.*
- *The issue with substance abuse has a lot to do with lack of supervised activities for youth in our community*
- *There is not much available for groups support or counseling in Chanute. And the "small town" nature, people want confidentiality to attend support and programs and not a lot of ways to do so.*
- *Substance abuse is a huge problem. There are very few resources available to help.*
- *the population of meth and halluinatory drugs is so difficult to care for. They also have no insite into the danger they are in nor are they motivated to quit...how do we effect change in this population?*
- *Mental health department would be a better avenue*
- *It keeps people from getting more education and thereby, a good job which is correlated with poor health.*

*It's not as big a group as obesity but it's a significant number.*

- *The focus needs to start with young adults.*
- *In house treatment facility would be great. Family should also play a big part in getting help for the alcoholic and if there was a facility here this could happen more easily. I think the closest in house facility is Girard.*
- *Short term/long term affects of alcohol and substance abuse*
- *This is still a big issue and I am not for sure if there has been any progress in this area due to a lack of providers capable of providing this service.*
- *I see the impact of drugs and alcohol on the lives of children in the community, but I don't have any specific areas on which NMRMC can improve.*

**9. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Alcohol/Substance Abuse</u>.**

- *There is a lack of resources at the state level that makes it difficult to treat these patients. The community mental health services need to be increased to address these patients.*
- *Put on an anti drug assembly at area schools*
- *Neosho County health Department would like to see a program like the fire escape for the youth in our community. We feel with supervised and structured activities possibly even an open gym with volunteers from the community or even paid mentors.*
- *Possibly a narcotics anonymous group and further education to the community about narcotic dependence.*
- *Mental health department would be a better avenue*
- *Personally, I'm not aware of the treatment services provided by the hospital. I'm sure you have them, I just never used them or know of folks who have.*
- *Education programs and or speakers*
- *This could be a joint effort with the Mental Health program here in town.*

**10. Please share comments or observations about keeping <u>Smoking/Tobacco Use</u> among the most significant needs for the Hospital to address.**

- *Still a significant need.*
- *Same as above*
- *Expensive for people to try to get help with this addiction. Programs and groups have to be affordable and available. I hear ads on the radio for Allen County for programs to help stop smoking.*
- *we probably be more activ offering patches and meds for cetation*
- *referral to appropriate avenue for help*

- *I know you offer services here. We struggle with this issue at my place of work. Personal choice vs. healthy living expectations (and lowering health insurance costs). We are slowly working on it. But it's a thorny issue.*
- *I believe everyone is doing a good job at getting the word out about how harmful smoking is. As an X-smoker you will quit when you are ready.*
- *Long-term and short-term health affects.*
- *None*
- *I think improvements have been made in this area. The message seems to be getting to teenagers not to start smoking. No new observations for improvements*

**11. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Smoking/Tobacco Use</u>.**

- *The hospital can provide education, but this needs to be addressed at the primary care level.*
- *referral to appropriate avenue for help*
- *N/A*

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

- *Still a significant need-increasing as co-pays and deductibles increase. Also lack of Medicaid expansion in Kansas has increased this problem.*
- *Our biggest concern is we have the working poor, the falls between the cracks and offer them no insurance it is sad to see people try to get ahead and work and then taking away or denying them insurance because they are working. They lose benefits that are still needed*
- *Care is very expensive. We need to find a way to help people but still have some accountability for their care.*
- *i believe som tests and meds and supplies are far overpriced. i know a urine preg test costs $1.00. our test hast to cost more beause we read it and record it but it prob should not be 20X.....*
- *More programs to help those who need help need to be put in place.*
- *Here the State has really screwed you guys over, and thereby the public. The costs are getting out of hand. Health insurance at our place of business when up 9% last year and as much as 11% this year. Salaries went up only 1.5% which means that the employees had to eat that increase in their existing wages. This is not sustainable.*
- *The biggest issue that we run across in dealing with the elderly is how individuals afford health care especially if they are under 65 years of age.*
- *Affordability is the key here. Even though you can arrange payment plans some of the people can't even afford the high payment or are a 1 income single parent family and if they miss work something has to give*

*somewhere.*

- *This will continue to be an issue until we have Medicaid expansion.*
- *With wages being stagnant and more layoffs occurring in our community, this is a serious concern. Having spent several weeks in the hospital with a loved one, I did see a lot of waste that could be controlled to keep cost down.*

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

- *The hospital had programs for those who cannot afford care, but this needs to also be addressed at the community/state level.*
- *Monitor insurance frivolous reasons to come to ER should be denied and be paid for by the person that is abusing the medical card*
- *I think the hospital provides a great service in our patient assistance program. I would like to see, however some charge for all patients. I don't think medical care should ever be free. I see people abusing the patient assistance program. It should also be granted for shorter period of times.*
- *More programs to help those who need help need to be put in place.*
- *Not sure what you can do here. Free clinic for low income people?*
- *I do understand how smoking hurts not only the smoker but people around them but if you have to be admitted to the hospital for any reason the patient not being able to have a cigarette has stress them out and could cause more problems. I being an ex-smoker understand this.*
- *For example, when I saw dressings being changed there were numerous times when an excessive amount of pads, tape, etc., were brought into the room. The extra items remained in the room for days. New material came to the room with each caregiver. I just wonder if some cost could have been saved.*

**14. Please share comments or observations about keeping <u>Compliance Behavior/Predisposing Conditions</u> among the most significant needs for the Hospital to address.**

- *Still a significant need. This problem is exacerbated by substance abuse and affordability issues. Some patients cannot afford the medications or treatments that are recommended.*
- *No comment*
- *I think I talked about this enough. Low income is such a generational problem. We need a concentrated group effort to attempt to fix it. Even then, it's hard to change this situation. There are so many factors.*
- *N/A*
- *The comments on drug/alcohol may apply here, too.*

15. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Compliance Behavior/Predisposing Conditions</u>.**

- *no comment*
- *Be the core of a group of social service, education and job placement team.*
- *N/A*

16. **Please share comments or observations about keeping <u>Coronary Heart Disease</u> among the most significant needs for the Hospital to address.**

- *Still a significant issue-exacerbated by smoking and obesity.*
- *i believe the public has no usfullknowledge about heart dz. and they think if they have a stent is like a new hose for your washing machine.... and that you can just get a new one anytime and they always work perfectly. they really have no concept that there is still damage in the heart itself or in the electrical system ro that you dont really have replacemtnt parts. I dont know haow we can educate in away they become more knowlegable or invested in their health.*
- *Hospital needs to expand and offer more recourses. Most patients go out of town.*
- *Bigger push on screenings maybe? See earlier answers on #1*
- *N/A*
- *Life style, personal habits, over weight, cardio conditions, preventive matters and family history*

17. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Coronary Heart Disease</u>.**

- *work on prevention strategies??*
- *Hospital needs to expand and offer more recourses. Most patients go out of town.*
- *Provide options for individuals.*
- *N/A*

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

- *Access to primary care is crucial in addressing the needs of our patients.*
- *I think elementary school is when kids build beliefs and I think that can be a good place to start with education. It may seem that it would be over their heads, but we often don't give young kids enough credit for what they are capable of.*
- *Neosho Memorial regional medical center is an asset to our community and strives to maintain community*

*consistency and care to the population. Again, I will mention the working poor. We don't given the opportunity with no insurance to have their health needs met and know that that is a barrier to the working poor for County.*

- *Health education is low within the low income population. Gen health education would benefit*
- *Insurance is confusing. No one knows where to go to get help. So many cannot afford any type of health insurance. Help educate and have locations set up to help. Figuring out ways to communicate with the county is a challenge. So many means of communication. What gets it to them is important.*
- *we have lots of elderly and a baby boomer age the situation will escaltate. they have limited resources.. do not want to loose autonomy or loose their homes yet health is declining. They lack insite into their situation. can we create alternative avenues for them..... apartments....healthy food....safety....perhaps even a home assessment of needs and safety...so patients and family can plan. we/they are never prepared to age*
- *no*
- *Awards and expansion are fantastic. It shows we have a high quality hospital. What has happened in Independence has reminded us all about the need for a great regional hospital. But we need to be effective too. Unless we actually see movement on those items 1-6 and their statistics are we really effective?*
- *I think it would be helpful to know what options are available in the community before developing any new program.*
- *Not at this time*
- *I don't see a lot on your social media with regard to any of these topics - tips, advice, etc. Also, you had an intro thing for Dr. Alex Mih during the day - why wouldn't you have it at night so the working population has a chance to go. One blood pressure clinic during the week at G & W. Seems like you're missing opportunities to put yourself "out there".*
- *No*

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

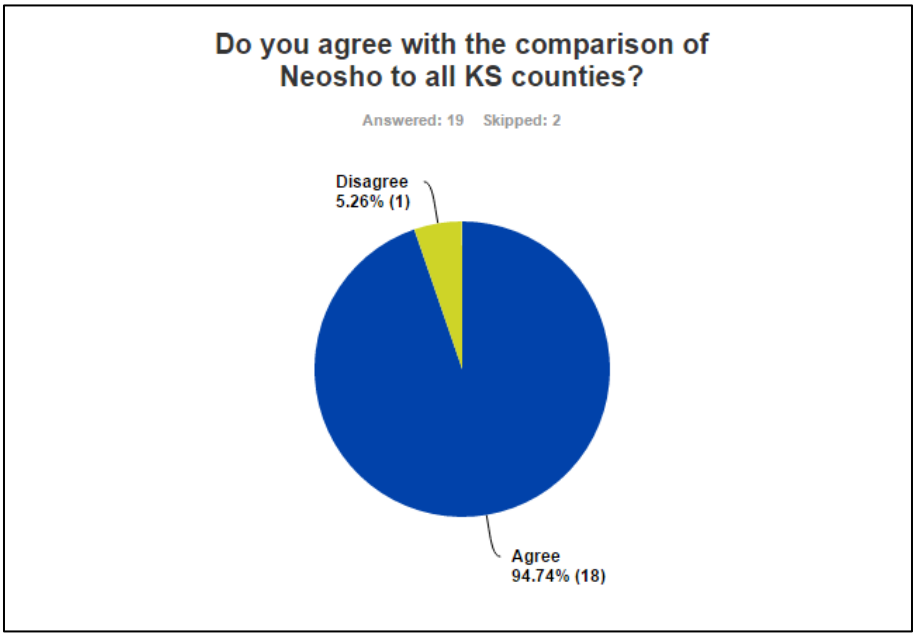
| Need Topic | Total Votes | Number of Local Experts Voting for Needs | Percent of Votes | Cumulative Votes | Need Determination |
|---|---|---|---|---|---|
| Obesity/Overweight - 2013 Significant Need | 378 | 15 | 20.87% | 20.87% | Significant Needs |
| Alcohol/Substance Abuse - 2013 Significant Need | 190 | 15 | 10.49% | 31.36% | |
| Affordability - 2013 Significant Need | 186 | 15 | 10.27% | 41.63% | |
| Smoking/Tobacco Use - 2013 Significant Need | 136 | 12 | 7.51% | 49.14% | |
| Physical Inactivity | 102 | 10 | 5.63% | 54.78% | |
| Compliance Behavior/Predisposing Conditions - 2013 Significant Need | 96 | 9 | 5.30% | 60.08% | Other Identified Needs |
| Coronary Heart Disease - 2013 Significant Need | 81 | 10 | 4.47% | 64.55% | |
| Diabetes | 75 | 10 | 4.14% | 68.69% | |
| Cancer | 63 | 9 | 3.48% | 72.17% | |
| Mental Health | 55 | 8 | 3.04% | 75.21% | |
| Dental | 53 | 7 | 2.93% | 78.13% | |
| Sexually Transmitted Infection | 50 | 7 | 2.76% | 80.89% | |
| Blood Poisoning | 46 | 7 | 2.54% | 83.43% | |
| Maternal/Infant Measures | 45 | 9 | 2.48% | 85.92% | |
| Flu/Pneumonia | 37 | 8 | 2.04% | 87.96% | |
| Stroke | 36 | 9 | 1.99% | 89.95% | |
| Accidents | 31 | 7 | 1.71% | 91.66% | |
| Palliative Care | 31 | 7 | 1.71% | 93.37% | |
| Kidney Disease | 27 | 6 | 1.49% | 94.86% | |
| Life Expectancy | 26 | 6 | 1.44% | 96.30% | |
| Lung Disease | 26 | 6 | 1.44% | 97.74% | |
| Physician | 20 | 6 | 1.10% | 98.84% | |
| Alzheimer's | 16 | 6 | 0.88% | 99.72% | |
| Unallocated Points | 5 | 1 | 0.28% | 100.00% | |
| Total | 1811 | | 100.00% | | |

**Individuals Participating as Local Expert Advisors**

| Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy | Yes (Applies to Me) | No (Does Not Apply to Me) | Response Count |
|---|---|---|---|
| 1) Public Health Expertise | 5 | 7 | 12 |
| 2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital | 3 | 10 | 13 |
| 3) Priority Populations | 3 | 9 | 12 |
| 4) Representative/Member of Chronic Disease Group or Organization | 2 | 9 | 11 |
| 5) Represents the Broad Interest of the Community | 18 | 0 | 18 |
| Other | | | |
| Answered Question | | | 21 |
| Skipped Question | | | 0 |

## Advice Received from Local Expert Advisors

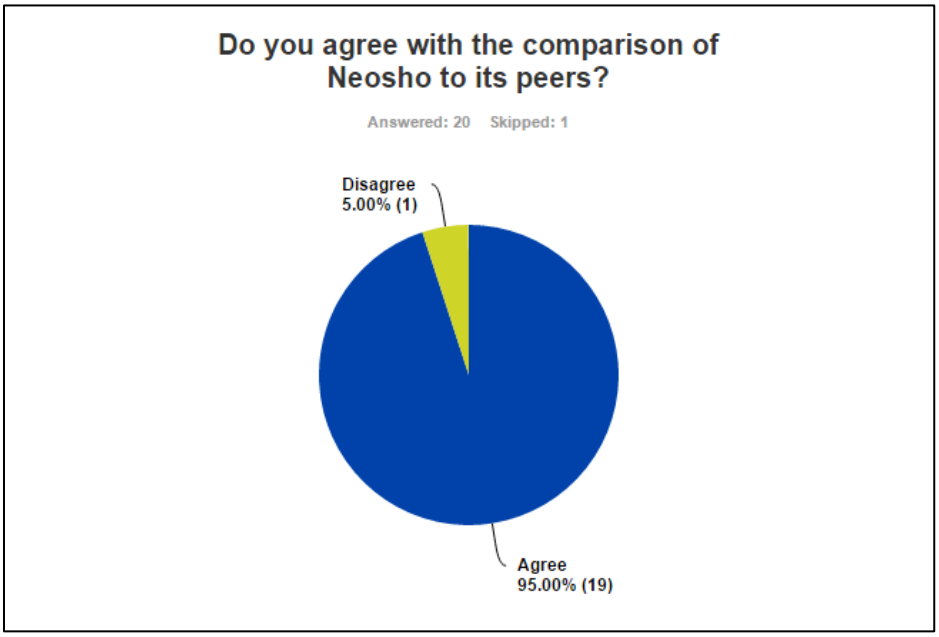
**Question: Do you agree with the observations formed about the comparison of Neosho to all other Kansas counties?**




Comments:

- *data places us at alarming risk. i dont have a reason to disagree but i dont think my experience would agree with some of the statements*
- *Poverty, unemployment, lower educational attainment - all contributing factors*
- *I guess I would agree with stats that are gathered as I would have no knowledge of this.*
- *When compared to some other counties. I believe the numbers can be skewed. I'm not sure we always compare apples to apples*
- *From time to time my volunteer work with the poverty population in Neosho and the surrounding counties. Food pantries are having trouble meeting their needs. When in the schools I see obese children in all the schools. At some point I would like to help get a team of professional to start a program to help these kids and parents learn more about healthy food and get them all on an exercise program to loose weight.*
- *High unemployment and drug use in SEK.*

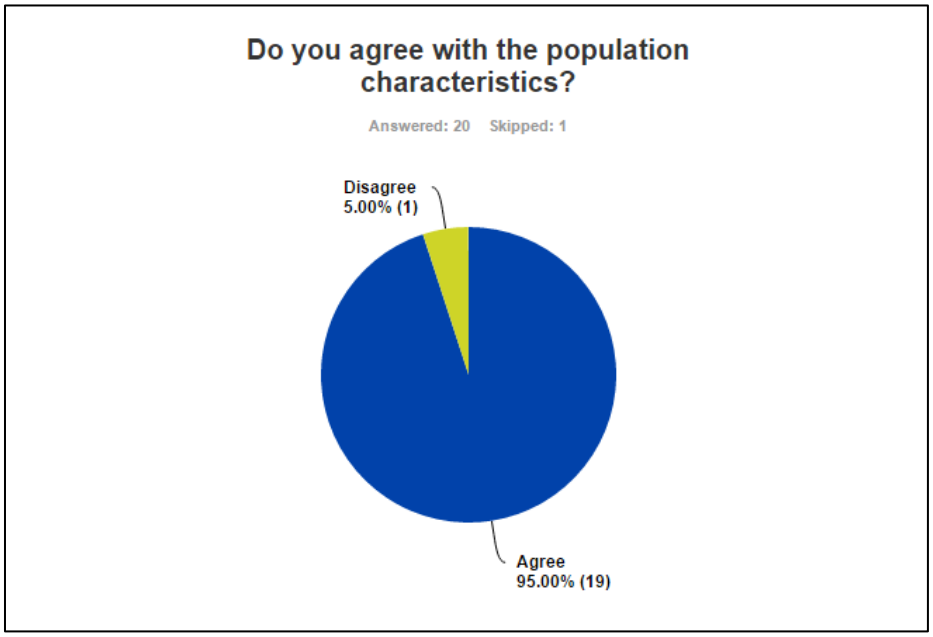
**Question: Do you agree with the observations formed about the comparison of Kansas to its peer counties?**




Comments:

- *i dont think our teen birth rate is high. do they consider giving birth at age 18 or 19 abnormal? no idea why our kidney deaths oud be higher..but we have a dialysis center. is it possible those pts with end stage renal disease cluster here for that service?*
- *We have one of the worst unemployment rates in the State so I believe it.*
- *again, taking this all in and would have to agree as I have no information that I would have on this.*
- *I know the understanding of healthy food is different to different people. Some think quick food is healthy.*

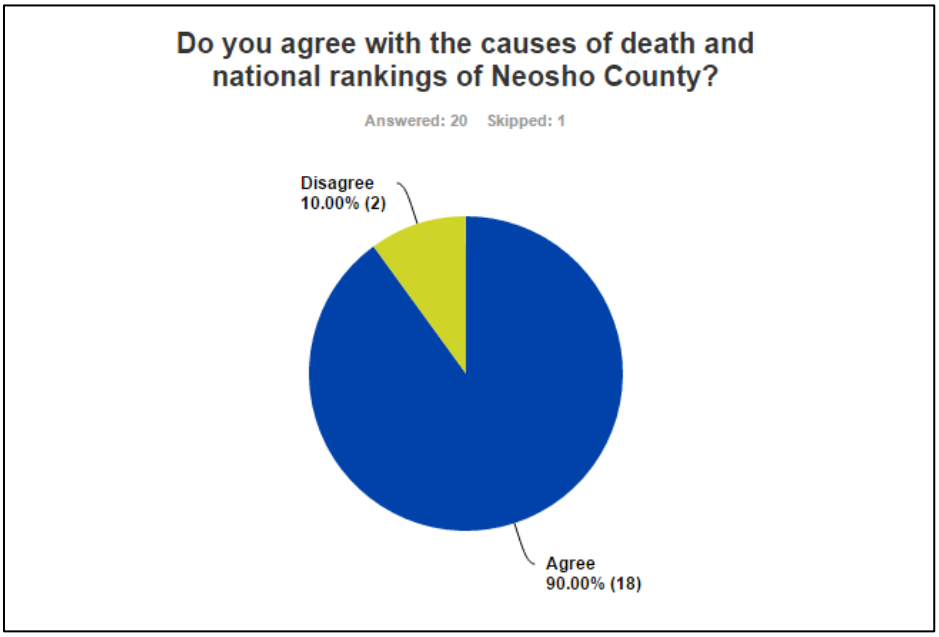
**Question: Do you agree with the observations formed about the population characteristics of Neosho County?**




Comments:

- *i don not see how eating breakfast . consuming or not consuming an alcoholic drink in the month , or seeing a midlevel (specifically) relates to any health*

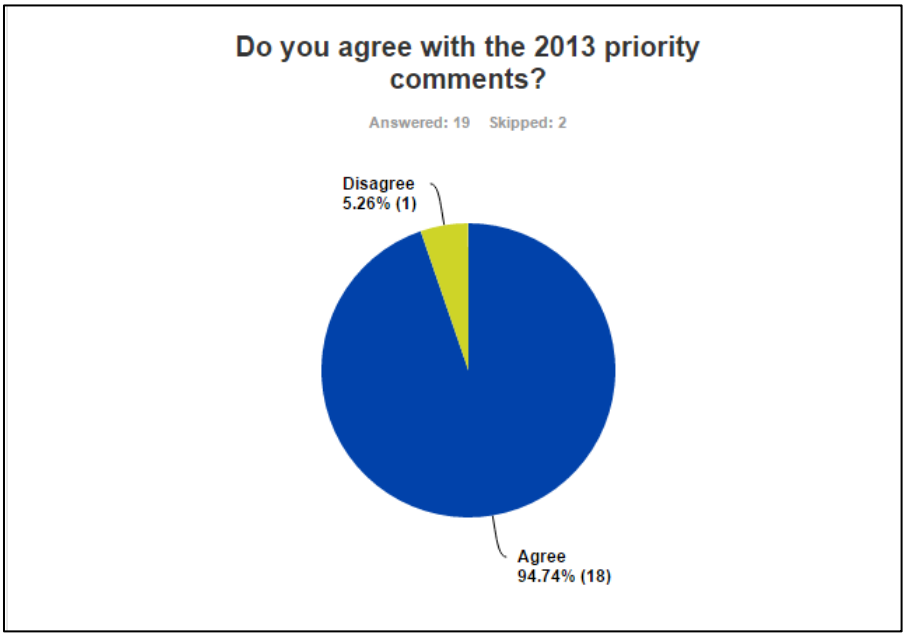
**Question: Do you agree with the observations formed from the national rankings and leading causes of death?**




Comments:

- *This data suggests that resources for healthy living such as exercise and lifestyle coaching are sorely ineffective and/ or absent in our area. Initiation of this type of service would impact wellness in all categories.*
- *The only thing I would question is associated with blood poisoning. What does that entail?*
- *Blood poisoning?!? what's going on there?*

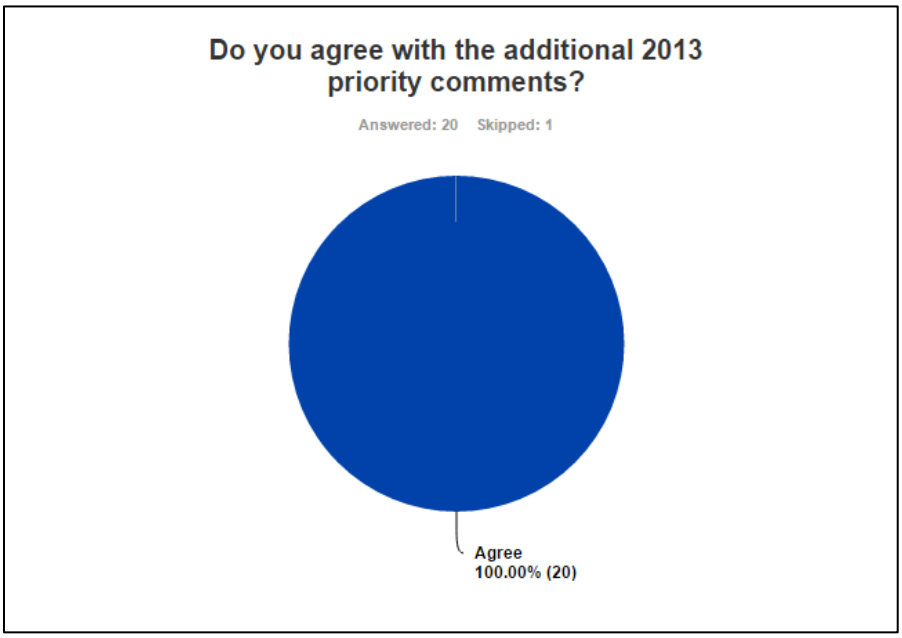
**Question: Do you agree with the written comments received on the 2013 CHNA?**




Comments:

- *There is a program that encourages work, and you can still get assistance in your home. This program information could be provided to make more aware.*
- *I would like some of the coaches at NCCC and Health care providers form a group to mentor kids of all ages into healthy eating and exercise programs. They would monitor their weight, food intake and exercise. Maybe buy fit bits for all of them.*
- *Indoor swimming pool for winter fitness*

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




Comments:

- *The hospital has in no way intervened in the obesity / smoking / lifestyle issues which are at the heart of our health problems*

## Appendix C – National Healthcare Quality and Disparities Report[20]

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

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

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

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

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

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

**Trends**

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[21] consistent with these trends.

[20] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html
[21] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.

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

**Trends**

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

**Disparities**

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

**Trends**

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

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

**Trends**

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[22]

**Disparities**

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[23]

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

**Disparities**

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

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

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

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

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

**Disparity Trends**

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

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

**Trends**

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

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

**Trends**

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

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

**Achieved Success**

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

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

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

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

**Improving Quickly**

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

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

time of surgery

**Worsening**

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

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

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

**Disparities**

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

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

**Disparity Trends**

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

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

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

**Disparities Trends**

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

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

**Geographic Disparities**

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

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

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

**Trends**

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[24]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

**Disparities Trends**

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

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

**Trends**

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

**Disparities**

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

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

**Disparities Trends**

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

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

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

**Trends**

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

**Disparities**

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

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

**Trends**

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

**Disparities**

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

**Disparities Trends**

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

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

**Trends**

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

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

**Disparities**

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

**Disparities Trends**

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

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

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

**Trends**

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[25]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

**Disparities**

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

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

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

**CONCLUSION**

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

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