Macon Community Hospital

Lafayette, TN

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution September 11, 2018[1]

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

Dear Community Member:

At Macon Community Hospital (MCH), we have spent more than 60 years providing high-quality compassionate healthcare to the greater Lafayette community. The “2018 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how MCH will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

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

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

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

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

Thank You,

Thomas J. Kidd
Chief Executive Officer
Macon Community Hospital

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EXECUTIVE SUMMARY

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

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

The 2018 Significant Health Needs identified for Macon County are:

1. Healthy Lifestyle Promotion and Education – 2015 Significant Need
2. Heart Disease – 2015 Significant Need
3. Accessibility/Affordability
4. Cancer – 2015 Significant Need
5. Mental Health
6. Diabetes – 2015 Significant Need

The Hospital will develop implementation strategies for these six needs including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

APPROACH

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

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

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

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

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

Project Objectives

The project objectives were to:[4]

- Complete a CHNA report, compliant with Treasury – IRS
- Provide the Hospital with information required to complete the IRS – Schedule H (Form 990)
- 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 part of the burden of providing compensation for such care.

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

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

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

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

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*

[5] Section 6652

(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the

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

assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."[7]

Additionally, all CHNAs developed after the very first CHNA must consider written commentary on the prior Assessment and Implementation Strategy efforts. The Hospital followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

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

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

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

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

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

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

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

Other (please specify)

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

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

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

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

existed in their portion of the county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Macon County compared to all Tennessee counties	June 5, 2018	2012-2014
IBM Watson Health (formerly known as Truven Health Analytics)	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 6, 2018	2017
http://svi.cdc.gov	To identify the Social Vulnerability Index value	June 6, 2018	2010-2014
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	June 6, 2018	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	June 6, 2018	2016

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

- A CHNA "Round 1" survey was deployed to the Hospital's 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. Community input from 21 Local Expert Advisors was received.

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

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

Survey responses started June 4, 2018 and ended with the last response on June 18, 2018.

- Information analysis augmented by local opinions showed how Macon county relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - Low income residents, residents of rural areas and older adults are the most prevalent priority groups
  - Accessible/affordable care was noted as an issue

When the analysis was complete, the information and summary conclusions were put before the Hospital's Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need.[14] Consultation with 16 Local Experts occurred again via an internet-based survey (explained below) beginning July 10, 2018 and ending July 24, 2018.

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

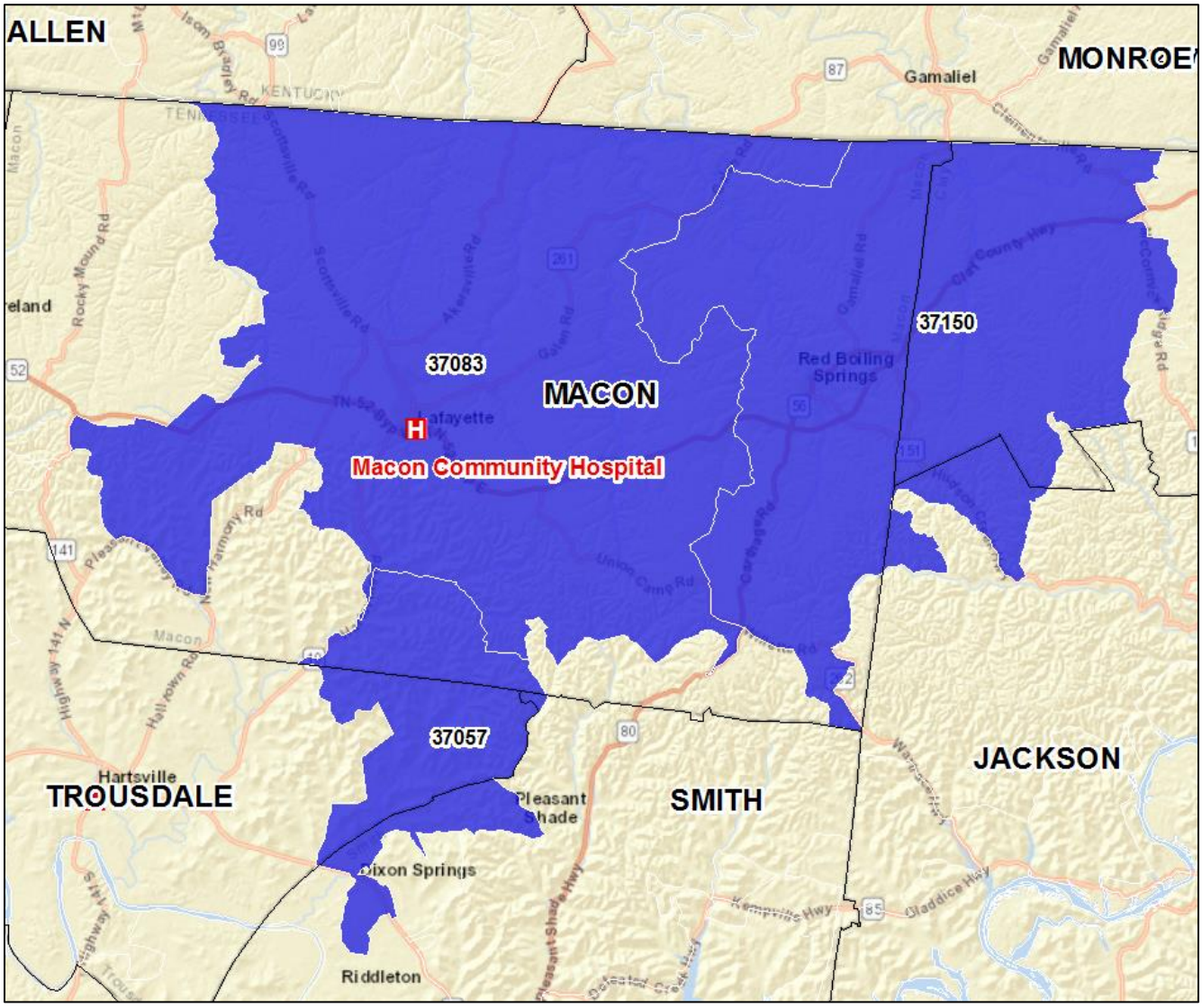
In the process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list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

The ranked needs were divided into two groups: "Significant" and "Other Identified Needs." The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least fifty percent (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 where a reasonable break point in rank order occurred.[16]

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



For the purposes of this study, MCH defines its service area as Macon County in Tennessee, which includes the following ZIP codes:[18]

37057 – Dixon Springs 37083 – Lafayette 37150 – Red Boiling Springs 37186 – Westmoreland

During 10/1/2015 – 9/30/2016, the Hospital received 93.0% of its inpatients from this area.[19]

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

Demographics of the Community[20] [21]

	Macon County	Tennessee	U.S.
2018 Population[22]	**20,725**	**2,081,335**	**326,533,070**
% Increase/Decline	**4.7%**	**1.0%**	**3.5%**
Estimated Population in 2023	**21,691**	**2,101,415**	**337,947,861**
Median Age	**39.2**	**39.4**	**38.2**
Median Household Income	**$35,858**	**$49,242**	**$59,039**
% Population over age 65	**17.7%**	**16.5%**	**15.9%**
% Women of Childbearing Age	**18.6%**	**19.4%**	**19.6%**
% White, non-Hispanic	**91.4%**	**73.7%**	**60.4%**
% Hispanic	**5.8%**	**5.5%**	**18.3%**
Unemployment Rate (February 2018)	**3.2%**	**3.4%**	**4.1%**

2018 Benchmarks
Area: Macon Community Hospital - 2018 CHNA
Level of Geography: ZIP Code

Area	2018-2023 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2018-2023	Females 15-44 % of Total Population	Females 15-44 % Change 2018-2023	Median Household Income
USA	3.5%	38.3	15.9%	17.0%	19.6%	1.4%	$59,039
Tennessee	3.9%	39.4	16.5%	18.0%	19.4%	1.6%	$49,242
Selected Area	4.7%	39.2	17.7%	15.9%	18.6%	3.1%	$35,858

[20] Responds to IRS Schedule H (Form 990) Part V B 3 b
[21] The tables below were created by IBM Watson Health
[22] All population information, unless otherwise cited, sourced from Claritas via IBM Watson Health (formally Truven)

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	19,432	308,745,538
2018 Total Population	20,725	326,533,070
2023 Total Population	21,691	337,947,861
% Change 2018 - 2023	4.7%	3.5%
Average Household Income	$49,009	$86,278

	2018	2023	% Change
Total Male Population	10,016	10,491	4.7%
Total Female Population	10,709	11,200	4.6%
Females, Child Bearing	3,847	3,968	3.1%

POPULATION DISTRIBUTION

Age Distribution

Age Group	2018	% of Total	2023	% of Total	USA 2018 % of Total
0-14	4,067	19.6%	4,261	19.6%	18.7%
15-17	830	4.0%	843	3.9%	3.9%
18-24	1,831	8.8%	1,882	8.7%	9.7%
25-34	2,481	12.0%	2,668	12.3%	13.4%
35-54	5,201	25.1%	5,017	23.1%	25.5%
55-64	2,637	12.7%	2,758	12.7%	12.9%
65+	3,678	17.7%	4,262	19.6%	15.9%
Total	20,725	100.0%	21,691	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

Income Distribution

2018 Household Income	HH Count	% of Total	USA % of Total
<$15K	1,392	17.2%	10.9%
$15-25K	1,097	13.6%	9.5%
$25-50K	2,725	33.7%	22.1%
$50-75K	1,180	14.6%	17.1%
$75-100K	786	9.7%	12.3%
Over $100K	899	11.1%	28.2%
Total	8,079	100.0%	100.0%

EDUCATION LEVEL

Education Level Distribution

2018 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	1,597	11.4%	5.6%
Some High School	2,084	14.9%	7.4%
High School Degree	6,202	44.3%	27.6%
Some College/Assoc. Degree	2,775	19.8%	29.1%
Bachelor's Degree or Greater	1,339	9.6%	30.3%
Total	13,997	100.0%	100.0%

RACE/ETHNICITY

Race/Ethnicity Distribution

Race/Ethnicity	2018 Pop	% of Total	USA % of Total
White Non-Hispanic	18,947	91.4%	60.4%
Black Non-Hispanic	130	0.6%	12.4%
Hispanic	1,200	5.8%	18.2%
Asian & Pacific Is. Non-H	210	1.0%	5.8%
All Others	238	1.1%	3.2%
Total	20,725	100.0%	100.0%

Customer Segmentation[23]

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

Claritas Prizm Segments	Characteristics	
Segment 1 (59%)	• Urbanicity: Rural • Income: Low Income • Household Technology: Below Average • Income Producing Assets: Low • Age Ranges: Age <55	• Presence of Kids: Mostly without Kids • Homeownership: Mix • Employment Levels: Mix • Education Levels: High School
Segment 2 (36%)	• Urbanicity: Rural • Income: Low Income • Household Technology: Below Average • Income Producing Assets: Low • Age Ranges: Age <55	• Presence of Kids: Family Mix • Homeownership: Mix • Employment Levels: Mix • Education Levels: High School
Segment 3 (5%)	• Urbanicity: Metro Mix • Income: Upper Mid-Scale • Household Technology: Average • Income Producing Assets: Low • Age Ranges: Age 55+	• Presence of Kids: Mostly without Kids • Homeownership: Mostly Owners • Employment Levels: Mix • Education Levels: Some College

[23] IBM Watson Health

Each of the 68 Claritas Prizm segments exhibits prevalence toward specific health behaviors. In the second column of the chart below, the national average is 100%, the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

Where Macon County varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered noteworthy. Items in the table with **red text** are viewed as **adverse** findings. Items with **blue text** are viewed as **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding.

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	128%	39.0%	Cancer Screen: Skin 2 yr	75.5%	8.1%
Vigorous Exercise	83.5%	47.7%	Cancer Screen: Colorectal 2 yr	96.2%	19.8%
Chronic Diabetes	104.5%	16.4%	Cancer Screen: Pap/Cerv Test 2 yr	86.3%	41.6%
Healthy Eating Habits	85.1%	19.8%	Routine Screen: Prostate 2 yr	76.5%	21.7%
Ate Breakfast Yesterday	93.0%	73.6%	**Orthopedic**		
Slept Less Than 6 Hours	139.5%	19.0%	Chronic Lower Back Pain	110.0%	34.0%
Consumed Alcohol in the Past 30 Days	64.9%	34.9%	Chronic Osteoporosis	147.3%	14.9%
Consumed 3+ Drinks Per Session	118.7%	33.4%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	100.6%	81.8%
Search for Pricing Info	87.9%	23.7%	NP/PA Last 6 Months	107.7%	44.7%
I am Responsible for My Health	99.9%	90.3%	OB/Gyn 1+ Visit	84.8%	32.6%
I Follow Treatment Recommendations	100.5%	77.3%	Medication: Received Prescription	101.3%	61.5%
Pulmonary			**Internet Usage**		
Chronic COPD	125.8%	6.8%	Use Internet to Look for Provider Info	77.5%	31.0%
Chronic Asthma	119.8%	14.1%	Facebook Opinions	103.8%	10.4%
Heart			Looked for Provider Rating	67.5%	15.8%
Chronic High Cholesterol	98.3%	24.0%	**Emergency Services**		
Routine Cholesterol Screening	86.0%	38.1%	Emergency Room Use	112.0%	38.9%
Chronic Heart Failure	152.7%	6.2%	Urgent Care Use	95.9%	31.6%

Leading Causes of Death[24]

The Leading Causes of Death are determined by official Centers for Disease Control and Prevention (CDC) final death total. Tennessee's Top 15 Leading Causes of Death are listed in the table below in Macon county's rank order. Macon county was compared to all other Tennessee counties, Tennessee state average and whether the death rate was higher, lower or as expected compared to the U.S. average.

Cause of Death			Rank among all counties in TN	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
TN Rank	Macon Rank	Condition	(#1 rank = worst in state)	TN	Macon	
10	1	Heart Disease	44 of 95	198.8	263.9	Higher than expected
4	2	Cancer	14 of 95	179.9	227.4	Higher than expected
11	3	Accidents	22 of 95	61.1	74.5	Higher than expected
8	4	Lung	11 of 95	54.7	73.0	Higher than expected
4	5	Stroke	72 of 95	46.0	51.4	Higher than expected
3	6	Flu - Pneumonia	28 of 95	20.1	29.6	Higher than expected
12	7	Diabetes	54 of 95	24.0	26.4	Higher than expected
6	8	Alzheimer's	71 of 95	44.1	25.4	Lower than expected
20	9	Kidney	1 of 95	14.9	22.5	Higher than expected
21	10	Suicide	24 of 95	16.2	19.1	Higher than expected
20	11	Blood Poisoning	1 of 95	11.9	18.9	Higher than expected
17	12	Liver	70 of 95	12.2	9.9	As expected
10	13	Homicide	19 of 95	8.8	6.7	As expected
15	14	Hypertension	73 of 95	9.0	6.2	Lower than expected
17	15	Parkinson's	53 of 95	8.6	5.5	Lower than expected

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

Priority Populations[25]

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

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

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[26]

- Low income residents, residents of rural areas and older adults are the most prevalent priority groups
- Accessible/affordable care was noted as an issue

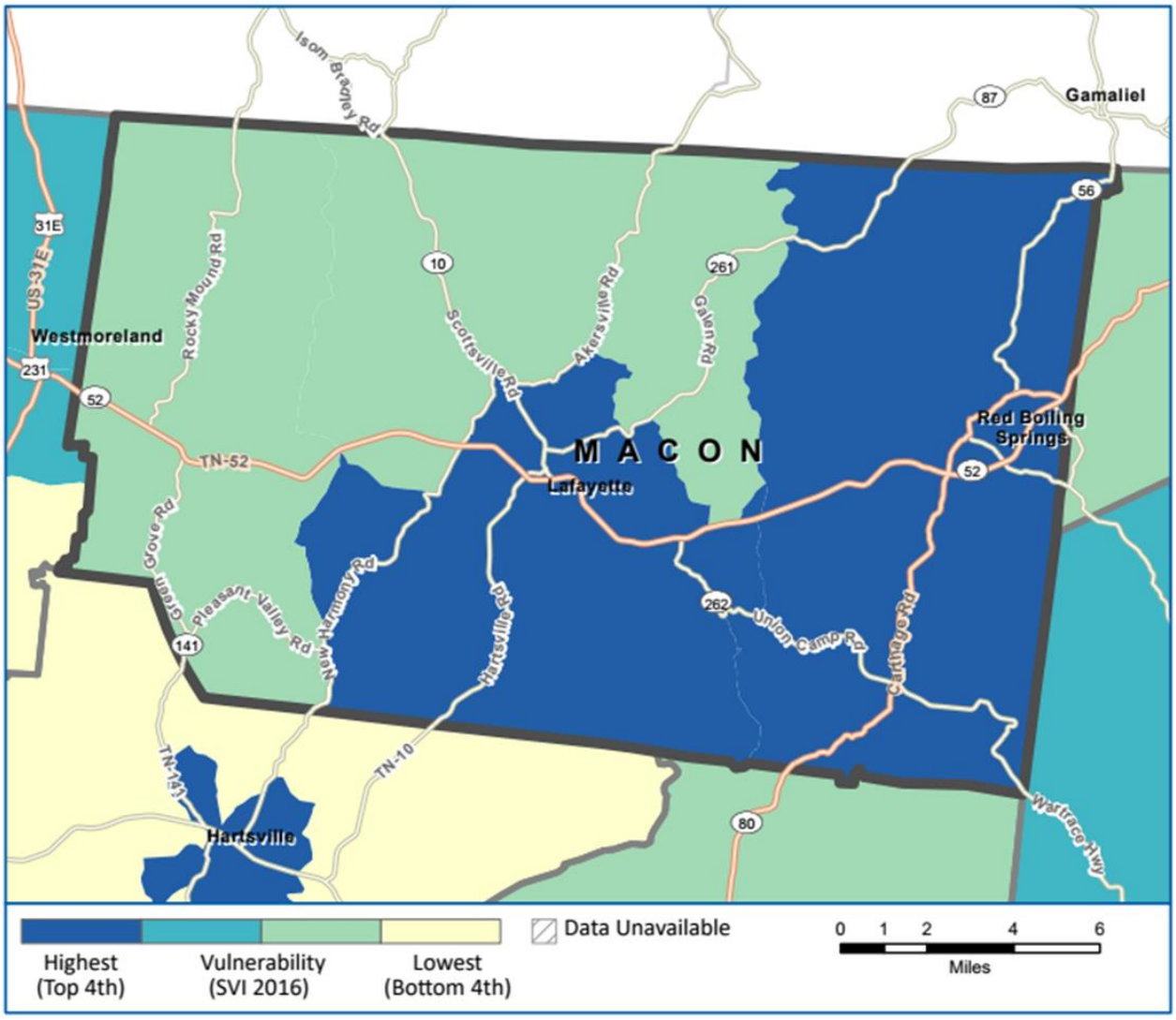
[25] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i
[26] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability[27]

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

Overall, Macon County falls into all two quartiles:

- The eastern part of the county, which cover Red Boiling Springs and Lafayette, fall into the highest quartile of vulnerability. Reducing social vulnerability in that area can decrease both human suffering and economic loss.
- The western part of the county fall in second lowest quartile of vulnerability (light green), making that area less vulnerable.

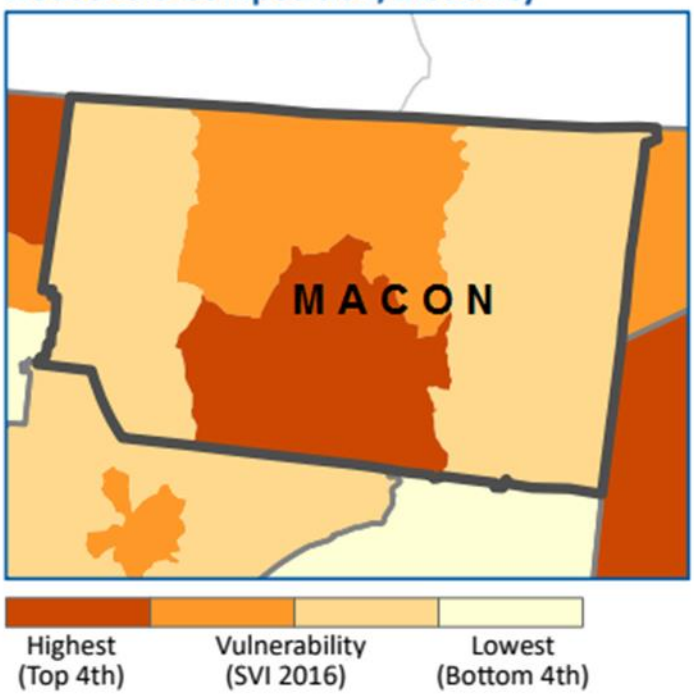


[27] http://svi.cdc.gov

SVI Themes

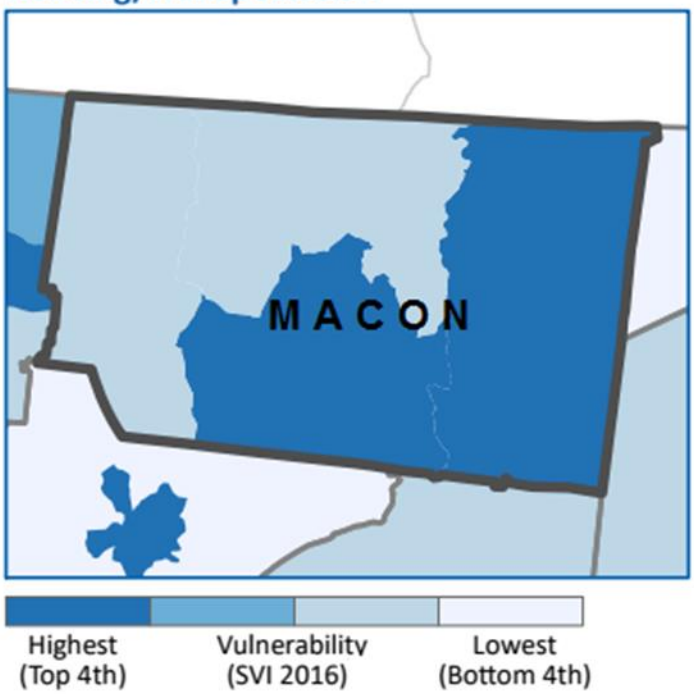
Socioeconomic Status

Household Composition/Disability



Race/Ethnicity/Language

Housing/Transportation



Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 21 individuals provided feedback on the 2015 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	10	7	17
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	8	7	15
3) **Priority Populations**	10	5	15
4) Representative/Member of **Chronic Disease Group** or Organization	1	13	14
5) Represents the **Broad Interest of the Community**	12	4	16
Other			0
Answered Question			21
Skipped Question			0

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

- Low-income groups
- Residents of rural areas
- Older adults

MCH received the following responses to the question: **"Should the hospital continue to consider the 2015 Significant Health Needs as the most important health needs currently confronting residents in the county?**

	Yes	No	Total
Cancer	18	0	18
Heart Disease	18	0	18
Healthy Lifestyle Promotion and Education	18	0	18
Diabetes	18	0	18

MCH received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?"**

	Yes	No	Total
Cancer	18	0	18
Heart Disease	18	0	18
Healthy Lifestyle Promotion and Education	18	0	18
Diabetes	16	1	17

Comparison to Other State Counties[28]

To better understand the community, Macon County has been compared to all 95 counties in the state of Tennessee 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).

	Macon County	Tennessee	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	74/95		
Premature Death	10,800	8,800	5,300
Health Behaviors			
Overall Rank *(best being #1)*	52/95		
Physical Inactivity	34%	30%	20%
Access to Exercise Opportunities	46%	71%	91%
Teen Births *(per 1,000 females age 15-19)*	66	36	15
Clinical Care			
Overall Rank *(best being #1)*	94/95		
Uninsured Rate	15%	12%	6%
Population to Primary Care Physician Ratio	5,790:1	1,380:1	1,030:1
Population to Dentist	5,860:1	1,890:1	1,280:1
Preventable Hospital Stays *(per 1,000 Medicare enrollees)*	142	59	35
Diabetes Monitoring	86%	87%	91%
Mammography Screening	47%	63%	71%
Social & Economic Factors			
Overall Rank *(best being #1)*	59/95		
High School Graduation	80%	88%	95%
Some College Attendance	38%	59%	72%
Children in Poverty	25%	23%	12%
Social Associations	4.3	11.3	22.1
Injury Deaths*	114	83	55
Physical Environment			
Overall Rank *(best being #1)*	61/95		
Air Pollution (PM2.5 concentration)	9.8 µg/m^3	9.7 µg/m^3	6.7 µg/m^3
Long Commute – Driving Alone	47%	34%	15%

[28] www.countyhealthrankings.org

Per 100,000

Comparison to Peer Counties[29]

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

In the below chart, Macon 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.)

	Macon County	Peer Ranking	U.S. Best
Health Behaviors			
Better			
Food Environment Index	8.2	1 of 30	8.6
Alcohol-Impaired Driving Deaths	13%	5 of 33	13%
Worse			
Adult Smoking	22%	27 of 30	14%
Physical Inactivity	34%	28 of 33	20%
Teen Births (per 1,00 population ages 15-19)	66	31 of 33	15
Clinical Care			
Worse			
Population to Primary Care Provider Ratio	5,790:1	29 of 32	1,030:1
Population to Dentist Ratio	5,860:1	25 of 31	1,280:1
Preventable Hospital Stays	142	33 of 33	35
Mammography Screening	47%	28 of 30	71%
Social and Economic Factors			
Better			
Unemployment	4.4%	4 of 33	3.2%
Children in Single-Parent Households	27%	3 of 33	20%
Worse			
High School Graduation	80%	25 of 32	95%
Some College	38%	31 of 32	72%
Social Associations	4.3	33 of 33	22.1
Injury Deaths*	114	31 of 33	55

Per 100,000

[29] www.countyhealthrankings.org

Conclusions from Demographic Analysis Compared to National Averages

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

- 28.0% more likely to have a **BMI of Morbid/Obese**, affecting 39.0%
- 16.5% less likely to **Vigorously Exercise**, affecting 47.7%
- 18.7% more likely to **Consume 3+ Drinks per Session**, affecting 33.4%
- 14.0% less likely to receive **Routine Cholesterol Screenings**, affecting 38.1%
- 13.7% less likely to receive **Cervical Cancer Screening every 2 years**, affecting 41.6%
- 10.0% more likely to have **Chronic Lower Back Pain**, affecting 34.0%
- 15.2% less likely to **Visit OB/Gyn Annually**, affecting 32.6%
- 12.0% more likely to use the **Emergency Room** (for non-emergent issues), affecting 32.6%

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

- 35.1% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 34.9%
- 7.7% more likely to **Visit NP/PA Last 6 Months**, affecting 44.7%

Conclusions from Other Statistical Data[30]

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

	Statistic	Change	Current Date of Data	Last Date of Data
Macon County measures that are **WORSE** than the U.S. average and **got worse**				
Female Life Expectancy	77.2 years	-1.4%	2014	1980
Female Tracheal, Bronchus, and Lung Cancer	64.3* cases	144.1%	2014	1980
Male Tracheal, Bronchus, and Lung Cancer	145.6* cases	15.9%	2014	1980
Female Breast Cancer	30.4* cases	4.3%	2014	1980
Female Malignant Skin Melanoma	3.0* cases	18.0%	2014	1980
Male Malignant Skin Melanoma	6.2* cases	61.1%	2014	1980
Female Diabetes, Urogenital, Blood and Endocrine	85.1* cases	85.5%	2014	1980
Male Diabetes, Urogenital, Blood and Endocrine	74.2* cases	41.4%	2014	1980
Female Self-Harm/Interpersonal Violence Deaths	16.3* cases	55.2%	2014	1980
Male Self-Harm/Interpersonal Violence Deaths	49.5* cases	8.1%	2014	1980
Female Mental and Substance Use Disorder Deaths	16.7* cases	1164.9%	2014	1980
Male Mental and Substance Use Disorder Deaths	19.8* cases	215.8%	2014	1980
Female Liver Disease Deaths	13.8* cases	75.6%	2014	1980
Male Liver Disease Deaths	34.1* cases	53.3%	2014	1980
Female Obesity	42.3%	19.8%	2011	2001
Male Obesity	40.1%	19.4%	2011	2001
Macon County measures that are **WORSE** than the U.S. average but **improved**				
Male Life Expectancy	71.2 years	3.5%	2014	1980
Female Heart Disease	171.3* cases	-28.8%	2014	1980
Male Heart Disease	296.7* cases	-40.8%	2014	1980
Female Stroke	60.6* cases	-30.4%	2014	1980
Male Stroke	69.2cases	-49.6%	2014	1980
Female Transport Injury Deaths	18.2* cases	-3.9%	2014	1980
Male Transport Injury Deaths	48.0* cases	16.5%	2014	1980
Female Smoking	28.6%	-4.2%	2012	1996
Male Smoking	30.5%	-15.5%	2012	1996
Macon County measures that are **BETTER** than the U.S. average but **got worse**				
Female Heavy Drinking	2.1%	23.8%	2012	2005

[30] http://www.healthdata.org/us-county-profiles

	Statistic	Change	Current Date of Data	Last Date of Data
Male Heavy Drinking	7.5%	40.1%	2012	2005
Female Binge Drinking	6.1%	102.1%	2012	2002
Male Binge Drinking	15.6%	35.1%	2012	2002
Macon County measures that are **BETTER** than the US average and **improved**				
Male Breast Cancer	0.3* cases	-7.7%	2014	1980

**Per 100,000 population*

Community Benefit

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

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

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

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

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

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

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

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

SCH H, Part VI, Line 2
Needs Assessment

Macon County General Hospital (MGCH) has conducted a formal community health needs assessment and are working with local organizations and the community to implement the assessment. We are actively engaged in providing for and improving the health of our community.

Macon County, Tennessee has a statistically high percentage of the population with diabetes and MCGH provides a diabetes education center to provide cooking classes, nutrition education and a question hotline for the community to manage their disease. Management of MCGH are also leaders and organizers of the annual Makin' Macon Fit Fitness Festival that promotes an active lifestyle that is in its 22nd year.

MCGH staff works with the Macon County School System and coordinated a school health program to provide classroom instruction on nutrition and fitness to the students of the school system.

MCGH staff are on the boards of the senior citizen center, Macon County Health Council, Macon County Chamber of Commerce and the Upper Middle TN Rural Health Network. Through these organizations, we learn of and provide education, training, screenings and other activities to assess and improve the health needs of our community.

IMPLEMENTATION STRATEGY

Significant Health Needs

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

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies MCH current efforts responding to the need including any written comments received regarding prior MCH implementation actions
- Establishes the Implementation Strategy programs and resources MCH will devote to attempt to achieve improvements
- Documents the Leading Indicators MCH will use to measure progress
- Presents the Lagging Indicators MCH 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, MCH is the major hospital in the service area. MCH is a 25-bed, acute care medical facility located in Macon, Tennessee. The next closest facilities are outside the service area and include:

- Trousdale Medical Center, Hartsville, TN; 15.5 miles (21 minutes)
- The Medical Center at Scottsville, Scottsville, KY; 22.5 miles (33 minutes)
- Riverview Regional Medical Center, Carthage, TN; 26.2 miles (33 minutes)
- Highpoint Health System (Sumner Regional Medical Center), Gallatin, TN; 30.0 miles (39 minutes)
- Monroe County Medical Center, Tompkinsville, KY; 29.5 miles (42 minutes)
- Tennova Healthcare – Lebanon, Lebanon, TN; 34.8 miles (45 minutes)
- Cumberland River Hospital, Celina, TN; 35.5 miles (46 minutes)
- TriStar Hendersonville Medical Center, Hendersonville, TN; 42.5 miles (54 minutes)

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

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

within the ability of the hospital to influence and measure.

1. **Healthy Lifestyle Promotion and Education – 2015 Significant Need; A healthy lifestyle has both short and long-term health benefits, can add years to life and reduce the risks of certain diseases including heart disease, diabetes, and cancer. Macon County has worse benchmarks for healthy lifestyles than Tennessee averages including a higher physical inactivity rate, lower access to exercise opportunities, lower mammography screening rate, and lower rate of diabetes monitoring. Given the impact of Healthy Lifestyle Promotion and Education on heart disease, diabetes, and cancer (other significant health needs in the service area), a combined implementation plan has been created to address all four needs. The table below identifies which services, programs and resources apply to which need.**

Public comments received on previously adopted implementation strategy (2015):

- *There are too many to list as what all the hospital does in this area!*
- *I like Macon Fits, and Weight Watchers that is offered at hospital.*
- *SB does an excellent job in the healthy lifestyle, promotion, and education. The hospital always seems to have something going on to help promote a healthier lifestyle.*
- *MCH provides information to anyone to help with promoting a healthy lifestyle.*
- *Further work with the schools and expanding the grades targeted might be helpful*

2. **Heart Disease – 2015 Significant Health Need; Heart Disease is the #1 leading cause of death in Macon County and higher than expected compared to the US; Diabetes is the #7 leading cause of death in Macon County and higher than expected compared to the US; Macon County's physical inactivity rate is higher than the Tennessee average and US best; access to exercise opportunities is below the Tennessee average and US best**

Public comments received on previously adopted implementation strategy (2015):

- *The hospital has gone above and beyond to offer a large variety of education on heart disease including types of exercises, eating healthy and understanding your BP values. They also already offer screenings to check for heart disease. I personally know a male that had a screening and found he had a severely blocked artery that was about to cause a life-threatening stroke or heart attack. He saw his cardiologist and had surgery immediately to resolve the issue. If not for MCH, he may not be here today.*
- *I do not see direct actions for this area*
- *A new ER will enable MCH to better treat patients who have suffered heart attacks to other heart issues.*
- *Expanded services at the hospital are helpful*

4. **Cancer – 2015 Significant Need; Cancer is the #2 leading cause of death in Macon County and higher than expected compared to the US; Macon County's mammography screening is lower than the Tennessee average and US best**

Public comments received on previously adopted implementation strategy (2015):

- *The hospital offers screenings and tests as well as educational material in regards to finding, diagnosis and dealing with cancer both during and after treatments and coping mechanisms for those diagnosed.*
- *Continue to advertise cancer screenings in local paper, radio, social media and billboards.*

- *Other than preventative exams—what are the actions for cancer?*
- *Screening for various types of cancer should be a priority.*
- *Suggest promotion of screening*

5. **Diabetes – 2015 Significant Health Need; Heart Disease is the #1 leading cause of death in Macon County and higher than expected compared to the US; Diabetes is the #7 leading cause of death in Macon County and higher than expected compared to the US; Macon County's physical inactivity rate is higher than the TN average and US best; access to exercise opportunities and Diabetes monitoring are below the TN average and US best**

Public comments received on previously adopted implementation strategy (2015):

- *The hospital again offers screenings and test for diabetes as well as a large variety of support groups, educational events/classes, recipe books, etc. for our local community to manage their diabetes.*
- *The hospital has monthly diabetes meeting for diabetics in the community to give them education. The hospital also has one on one education sessions with diabetics.*
- *Expand outreach to all MC schools*
- *MCH provides information about this disease and the lifestyle changes needed to help control this disease.*

Due to the similar nature of the above health needs, a combined implementation plan has been created to address all four needs. The table below identifies which services, programs and resources apply to each need.

MCH services, programs, and resources available to respond to these needs include:[32]

	Healthy Lifestyle Promotion and Education	Heart Disease	Cancer	Diabetes
MCH physical therapy department provides wellness program for patients' post physical therapy treatment; the program is also available to members of Weight Watchers, Silver Sneakers and Diabetes Support Group	✓	✓		✓
MCH's Diabetes Education Center offers Diabetes Education, assisting with individualized meal planning, understanding food labels and carbohydrate counting; Free diabetes support group meets once a month	✓	✓		✓
MCH provides a Workplace Wellness Program for employees	✓			

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

	Healthy Lifestyle Promotion and Education	Heart Disease	Cancer	Diabetes
MCH participates in the Makin' Macon Fit event in September which is designed to promote living a healthier lifestyle and encourages physical activity	✓	✓	✓	✓
MCH participates in 4-6 community health fairs a year offering education and screenings for chronic diseases	✓	✓	✓	✓
MCH offers healthy eating and diabetic carb counting classes to the community (quarterly)	✓	✓	✓	✓
MCH offers Sugar Shocker education to the community to raise awareness about the amount of added sugar in common beverages and learn how to make better beverage choices	✓			✓
MCH publishes a seasonal, promotional magazine (My Hometown Health) dedicated to healthy lifestyles	✓	✓	✓	✓
MCH offers a Cardiac Calcium Scoring test at a promotional price in February to coincide with National Heart Month		✓		
MCH offers free PSA (prostate) screenings in September, discounted mammograms in October for Breast Cancer Awareness Month, and discounted low-dose lung scans one month a year			✓	
MCH offers free A1C tests the month of November for National Diabetes Month				✓
MCH offers low cost vascular screenings in June, July and August		✓		
MCH offers blood pressure screenings at the Macon County Senior Citizen Center twice a month		✓		
MCH provides cardiac conditioning therapy (with physician's order)		✓		
MCH offers colonoscopies and provides education about colonoscopies and the importance of getting them			✓	
MCH offers speakers to provide education in the local schools and community. A calendar of scheduled programs is available on the Hospital website. Programs include healthy eating, physical activity, Project Wet (4th grade - empowerment), Girl Force and Boy Force (5th grade - tobacco us and health eating)	✓	✓	✓	✓

Additionally, MCH plans to take the following steps to address these needs:

	Healthy Lifestyle Promotion and Education	Heart Disease	Cancer	Diabetes
Launch an additional offering through the athletic trainer program focused on educating athletes about reducing risk of heart disease, diabetes and cancer	✓	✓	✓	✓
Offer lipid cholesterol screening alongside Cardiac Scoring starting in February 2019		✓		
Improve awareness of MCH health promotion opportunities (programs, education, screenings) through timely, relevant and targeted communication	✓	✓	✓	✓
Explore providing blood pressure screenings for walk-in patients at MCH		✓		
Offer Cardiac and Pulmonary Rehabilitation services at MCH		✓		
Offer Sleep Lab services at MCH	✓	✓		

MCH actions taken since the immediately preceding CHNA (2015):

	Healthy Lifestyle Promotion and Education	Heart Disease	Cancer	Diabetes
Included Healthy Lifestyle tips in the paper and on the hospital Facebook page	✓			
Participated in “Healthy Kids” 3 months of education in the Macon County School System that provides healthy eating and exercise to K-2nd grade	✓			
Provided water to children as a healthy alternative at Makin Macon Fit that is held in September	✓			
Participated in Makin Macon Fit in September that includes health eating and sugary beverages	✓			
Increased blood pressure screenings made available to various community sectors		✓		
Marketed wellness program to businesses throughout Macon County		✓		
Included Heart Healthy recipes in the local paper and face book page of the hospital		✓		
Provided CPR & First Aid classes monthly to the MCGH Service area		✓		
Increased the number of preventive exams performed at MCGH			✓	

	Healthy Lifestyle Promotion and Education	Heart Disease	Cancer	Diabetes
Included "Carb Conscious" recipes in the local newspaper and face book page				✓
Served as a community resource at various health fairs				✓
Tracked and reported the number of people screened for diabetes at health fairs (can we get numbers for these?)				✓

Anticipated results from MCH Implementation Strategy

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

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

- MCH will encourage additional participation in the MCH education and screenings
- MCH will increase communication efforts to better inform consumers of upcoming events/programs/resources available and increase participation count

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

- The average BMI value is anticipated to decline as increased awareness of healthy lifestyles emerge
- The Increase in health screenings will lead to earlier identification and mortality trends
- The increase in education participation will lead to healthier lifestyle choices and ultimately decrease cancer,

diabetes and heart disease prevalence

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

Organization	Contact Name	Contact Information
Macon County Health Department	Meghan Kinslow	http://www.maconcountytn.gov/government/departments/health_department.php 601 TN-52 Scenic, Lafayette, TN 37083 (615) 666-2142
Macon County Coordinated School Health	Casey Brawner	http://www.maconcountyschools.com/?DivisionID=21442&DepartmentID=25178 501 College Street, Lafayette, TN 37083 (615) 666.2125
Macon County Health Council	Josh Gipson	Stacey Brawner Meets at Macon County Welcome Center, 52 Bypass, West Lafayette, TN 37083 615-666-2147
Macon County Chronicle	Mark Darnell	https://www.maconcountychronicle.com/ 109 Public Square, Lafayette, TN 37083 (615) 688-6397
Macon County Times	Hope Green	http://maconcountytimes.com/ 1100A Scottsville Road, Lafayette, TN 37083 (615) 561-1031
NCTC North Central	Amy Phelps	http://www.nctc.com/ 872 Highway 52 by Pass East, P.O. Box 70, Lafayette, TN 37083 (615) 666-2151

Organization	Contact Name	Contact Information
WLCT Country 102.1 FM Lafayette Broadcasting	Linda McDonald	http://www.wlct.com/ 231 Chaffin Road, Lafayette, TN 37083 (615) 666-2169
Macon County Board-Education	Tony Bolles	http://www.maconcountyschools.com/ 501 College Street, Lafayette, TN 37083 (615) 666-2125
City of Lafayette	Richard Driver	http://www.lafayette-tn.org/
City of Red Boiling Springs	Joel Coe	http://www.maconcountytn.gov/community/city_of_red_boiling_springs.php 361 Lafayette Road, P.O. Box 190, Red Boiling Springs, TN 37150 (615) 699-2011
Senior Citizen Center	Brenda Filson	http://www.maconcountytn.gov/government/departments/senior_citizens_center.php 329 TN-52 Scenic, Lafayette, TN 37083 (615) 666-3780
Hope Family Health Services	Jennifer Dittes	http://hopefamilyhealth.org/ 1124 New Highway 52, Westmoreland, TN 37186 (615) 644-2000
Fast Pace Urgent Care	Sandy Jones	http://www.fastpaceurgentcare.com/lafayette-tn/ 522 Ellington Drive, Lafayette, TN 37083 (615) 561-1042

3. **Accessibility/Affordability – Macon County's population to primary care provider ratio and preventable hospital stays are worse than the TN average and US best**

Public comments received on previously adopted implementation strategy (2015):

This was not a significant health need in 2015, so no comments were solicited.

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

- MCH provides Charity Care Program
- MCH offers Health Insurance Navigator services to patient who need assistance signing up and accessing health insurance exchanges
- MCH offers a 40% self-pay discount for patients without insurance
- Contact information for the MCH financial assistance program is offered on the MCH website
- A day of service/prompt pay discount is offered to patients
- Translator services are provided at MCH
- Transportation options provided for patients without transportation through U-Carts and Moody's
- Through "Macon Helps," MCH can connect patients to one, no-cost prescription to Macon County citizens in need

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

- Currently working to recruit additional physicians in the community; commitments have been secured in 2018 from an additional OB/GYN provider and an Internal Medicine provider
- Specialty clinic services expansion
- Collaboration with Cigna Health Springs to identify specialty service needs in the service area

Anticipated results from MCH Implementation Strategy

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

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
6. Otherwise would become responsibility of government or another tax-exempt organization	✓	
7. Increases knowledge; then benefits the public	✓	

The strategy to evaluate MCH intended actions is to monitor change in the following Leading Indicator(s):

- Increase amount of financial assistance MCH provides
- Increase number of financial assistance applications MCH processes and enrolls
- Increase number of annual wellness visits

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

- ER utilization compared to national average
- Service area outmigration to other facilities = During 10/1/2015 – 9/30/2016, the Hospital received 93.0% of its inpatients from this area
- Population to primary care provider ratio = 5,790:1[33]

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

Organization	Contact Name	Contact Information
Cigna-HealthSpring	Mark Foulke	https://www.cigna.com/medicare/cigna-healthspring 500 Great Circle Road, Nashville, TN 37228 (888) 705-2933
Bernard Health, LLC	Amanda Maddox	https://www.bernardhealth.com/ 2817 West End Avenue #126-281, Nashville, TN 37203 (800) 505-0750

[33] www.countyhealthrankings.org

Organization	Contact Name	Contact Information
Hope Family Health Services	Jennifer Dittes	http://hopefamilyhealth.org/ 1124 New Highway 52, Westmoreland, TN 37186 (615) 644-2000
Hispanic Association – Dona Mary	Dona Marie	616 Highway 52 Bypass E, Lafayette, TN 37083 (615) 666-3307
Macon Helps	Tammy McClard	111 Main Street, Lafayette, TN 37083 (615) 666-6607
UCHRA Public Transportation Services	Tracey Powell	http://www.uchra.com/transportation.html 586 South Jefferson Avenue, Cookeville, TN 38501 (931) 372-8000
Moody's Transportation		1305 Roy Owens Road, Jamestown, TN 38556 (931) 879-7419

5. **Mental Health (including Substance Abuse) – Local expert concern; 1,164.9% increase in female mental health/substance abuse deaths from 1980-2014; 215.8% increase in male mental health/substance abuse deaths from 1980-2014**

Public comments received on previously adopted implementation strategy (2015):

This was not a significant health need in 2015, so no comments were solicited.

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

- Telehealth is provided in the ER for behavioral health/crisis evaluations through TriStar Health
- Mobile Crisis services offered through the Department of Mental Health and Substance Abuse Center
- Macon Memories suicide prevention education meeting/event held at the local park September 17, 2018

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

- Exploring 340B program partnership with Hope Family Health Services
- Provide grief counseling through a volunteer Chaplin
- Offer promotional suicide hotline
- Drug free coalition through the Macon County Health Council
- Explore Care Transition Programs – working with Upper Middle Tennessee Rural Health Network to bridge the gap between mental health/drug abuse and prevent the cycle of patients presenting to the ER for acute mental health services by identifying and providing resources available in the community for mental health primary care and medication management

Anticipated results from MCH Implementation Strategy

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

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
6. Otherwise would become responsibility of government or another tax-exempt organization	✓	
7. Increases knowledge; then benefits the public	✓	

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

- Increase number of tele-psych evaluations in the ER

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

- Number of drug overdoses in Macon county that require hospitalization
    - Macon county 2016 drug overdose inpatient hospitalization = 40[34]
    - Macon county 2016 drug overdose outpatient hospitalization = 56[35]
- Macon county suicide death rate
    - Number of suicides in Macon county in 2015 = 6[36]

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

Organization	Contact Name	Contact Information
Hope Family Health Services	Jennifer Dittes	http://hopefamilyhealth.org/ 1124 New Highway 52, Westmoreland, TN 37186 (615) 644-2000
TriStar Health	Charlotte Burns	https://tristarhealth.com/home/ 1000 Health Park Dr #500, Brentwood, TN 37027 (800) 242-5662

[34] Tennessee Department of Health Office of Informatics and Analytics
[35] Tennessee Department of Health Office of Informatics and Analytics
[36] https://contactlistens.org/wp-content/uploads/2016/09/Status-of-Suicide-in-Tennessee.pdf

Organization	Contact Name	Contact Information
Macon County Health Council	Josh Gipson	Stacey Brawner Meets at Macon County Welcome Center, 52 Bypass, West Lafayette, TN 37083 615-666-2147
Westmoreland Family Clinic	Warren Rose	100 Mallard Sunrise Drive E B, Westmoreland, TN 37186 (615) 644-3000
Larenda Whisenhunt – Counseling Interventions	Larenda Whisenhunt	40 Bratton Town Circle, Lafayette, TN 37083 (615) 997-1367
Lafayette Police Department	Stacy Gann	http://www.lafayette-tn.org/ 118 E Locust Street, Lafayette, TN 37083 (615) 666-4725
The Department of Mental Health and Substance Abuse Services – Mobile Crisis Services	Shirley Jennings	https://www.tn.gov/behavioral-health/need-help/crisis-services/mental-health-crisis-services/mobile-crisis-services.html 413 Spring Street, Chattanooga, TN 37405 (800) 704-2651

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

Organization	Contact Name	Contact Information
Valley Ridge Mental Health Center		www.vbhcs.org/locations/lafayette/ 907 Sycamore Street, Lafayette, TN 37083 1-800-704-2651

Other Needs Identified During CHNA Process

7. **Obesity**
8. **Substance Use/Abuse**
9. **Women's Health**
10. **Kidney Disease**
11. **Alzheimer's**
12. **Lung Disease**
13. **Tobacco Use**
14. **Chronic Disease**
15. **Alcohol Use**
16. **Stroke**
17. **Accidents**
18. **Suicide**
19. **Liver Disease**
20. **Flu/Pneumonia**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[37]

1. **Healthy Lifestyle Promotion and Education**
2. **Heart Disease**
3. **Accessibility/Affordability**
4. **Cancer**
5. **Mental Health (including Substance Abuse)**
6. **Diabetes**

Significant needs where hospital did not develop implementation strategy[38]

1. None

Other needs where hospital developed implementation strategy

1. None

Other needs where hospital did not develop implementation strategy

1. None

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

APPENDIX

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

Hospital solicited written comments about its 2015 CHNA.[39] 21 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	10	7	17
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	8	7	15
3) **Priority Populations**	10	5	15
4) Representative/Member of **Chronic Disease Group** or Organization	1	13	14
5) Represents the **Broad Interest of the Community**	12	4	16
Other			0
Answered Question			21
Skipped Question			0

Congress defines "Priority Populations" to include:

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

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

- *I feel that the older adults have unique needs that are not understood. For example, many have diabetes and are told by their doctors to eat a healthy diet and cut out sugar and processed food. However, many of them are on*

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

very fixed incomes along with do not have transportation and can only get groceries once or twice a month. Instead of buying a diabetic diet, that they cannot afford on their fixed income, they have to buy processed and sodium and sugar loaded foods that are non-perishable.

- *Affordable healthcare*
- *Access to care*
- *To have access to more availability of advanced, lifesaving, medical specialist and equipment without having to travel out of town would be of great benefit to all the above. As cost is always an issue when choosing to obtain healthcare. I have medical insurance through my employer and still have outstanding bills form 1 trip to ER ambulance transport to St Thomas, for Cardiac care. I can only imagine the hardship to those with ongoing medical issues.*

In the 2015 CHNA, there were four health needs identified as "significant" or most important:

1. **Cancer**
2. **Heart Disease**
3. **Healthy Lifestyle Promotion and Education**
4. **Diabetes**

3. Should the hospital continue to consider the 2015 Significant Health Needs the most important health needs currently confronting residents in the county?

	Yes	No	Total
Cancer	18	0	18
Heart Disease	18	0	18
Healthy Lifestyle Promotion and Education	18	0	18
Diabetes	18	0	18
Answered Question			18
Skipped Question			3

Comments:

- *Smoking cessation, Preventative care, colonoscopies, mammograms*
- *Cover more schools*

4. Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?

	Yes	No	Total
Cancer	18	0	18
Heart Disease	18	0	18
Healthy Lifestyle Promotion and Education	18	0	18
Diabetes	16	1	17
Answered Question			18
Skipped Question			3

Comments:

- *N/A*

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.**
   - *Make outpatient services more easily accessible and affordable to the community*
   - *Other important issues Macon County residents are facing: Importance of prenatal care Nutritional needs of infants and children Opioid Epidemic and Recovery Education Dangers of using drugs and Meth*
   - *Having more local access to Medical Specialist, ex. Cardiology, Oncology, etc. possibly through tele-communications in near future.*
   - *I think MCH is doing a wonderful job!*
   - *Opiate abuse, mental health*
   - *Chronic pain*
   - *Mental Health, childhood obesity*
   - *Mental Health but I believe they have addressed that by adding more holding beds for mental health patients in crisis waiting for transport to a Mental Health Facility.*

6. **Please share comments or observations about keeping <u>CANCER</u> among the most significant needs for the Hospital to address.**
   - *Macon County has a very high diagnosis rate for all types of cancer. I feel we need to continue our focus here and find out why our community has such high rates and what we may be able to do in preventative measures.*
   - *Have cancer treatment facilities available to residents of this county so they do not have to drive so far to treatment facilities*
   - *Cancer screenings should continue to be emphasized to the community: Breast cancer, colon cancer, etc.*
   - *Cancer is very prevalent among Macon Countians.*
   - *I think educating people about the early signs of the various cancers would be good.*
   - *MCH should continue to offer screenings for various types of cancer to allow detection in the early stages. Also, information concerning signs of various forms of cancer should be available to the public.*

7. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>CANCER</u>.**
   - *The hospital offers screenings and tests as well as educational material in regards to finding, diagnosis and dealing with cancer both during and after treatments and coping mechanisms for those diagnosed.*
   - *Continue to advertise cancer screenings in local paper, radio, social medial and billboards.*

- *Other than preventative exams--what are the actions for cancer?*
- *Screening for various types of cancer should be a priority.*
- *Suggest promotion of screening*

8. **Please share comments or observations about keeping <u>HEART DISEASE</u> among the most significant needs for the Hospital to address.**
   - *I work in geriatric health and heart disease is one of my most prevalent diagnosis I come across to treat. The more we can do, and continue to do at MCH, will greatly benefit our community.*
   - *Start earlier in schools re nutrition and exercise interventions. Smoking cessation campaigns needed*
   - *Heart disease is important, but also falls in the category with healthy lifestyles and nutrition. I think this could be covered under healthy lifestyle for nutrition and exercise.*
   - *Heart Disease is very prevalent among Macon Countians.*
   - *Many patients cannot afford a BP cuff for home use. Is there a grant out there to get patients BP cuffs. OR can MCGH have a ""free BP check"" program where people from the community can just walk in and have their BP checked. Just a thought*
   - *Heart disease continues to be a major health issue. Public awareness to symptoms of heart disease along with information concerning causes of heart disease should be a top priority in our community. MCH is doing their share to inform the public about prevention of heart disease.*
   - *Very important*

9. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>HEART DISEASE</u>.**
   - *The hospital has gone above and beyond to offer a large variety of education on heart disease including types of exercises, eating healthy and understanding your BP values. They also already offer screenings to check for heart disease. I personally know a male that had a screening and found he had a severely blocked artery that was about to cause a life-threatening stroke or heart attack. He saw his cardiologist and had surgery immediately to resolve the issue. If not for MCH, he may not be here today.*
   - *I do not see direct actions for this area*
   - *A new ER will enable MCH to better treat patients who have suffered heart attacks or other heart issues.*
   - *Expanded services at the hospital are helpful*

10. **Please share comments or observations about keeping <u>HEALTHY LIFESTYLE PROMOTION AND EDUCATION</u> among the most significant needs for the Hospital to address.**
    - *Macon County as well as the state of Tennessee has an obesity epidemic and any and all education we can offer*

is wonderful to keep us from having future geriatric patients from dealing with heart disease and diabetes.

- *Address all age groups*
- *Keeping education for school age children about healthy nutrition and exercise should be kept.*
- *If the community members of Macon County do not have education about different about healthy lifestyles, then I could see Macon County taking a down fall and the obesity rates along with other health rates going higher than they are now.*
- *Every time I go to Walmart in Lafayette you witness the serious decline in person's physical being. Needs to be more education about healthy lifestyles.*
- *All citizens need to be reminded how important a healthy lifestyle is to the quality of their lives.*

11. Please share comments or observations about the implementation actions the Hospital has taken to address <u>HEALTHY LIFESTYLE PROMOTION AND EDUCATION</u>.

- *There are too many to list as to what all the hospital does in this area!*
- *I like Macon Fits, and weight watchers that is offered at hospital.*
- *Stacey Brawner does an excellent job in the healthy lifestyle, promotion, and education. The hospital always seems to have something going on to help promote a healthier lifestyle.*
- *MCH provides information to anyone to help with promoting a healthy lifestyle.*
- *Further work with the schools and expanding the grades targeted might be helpful*

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

- *Between heart disease and diabetes, these are the two most prevalent diagnosis I deal with in home health. Our county needs continued education and reaffirmation in this area*
- *make access to dietitian more available*
- *Diabetes is important but is not the most crucial issue facing Macon County residents today.*
- *Diabetes is a serious health issue within Macon County. The community needs diabetes education to hopefully help make the members of the community suffering with this disease make matter choices for their health.*
- *Diabetes is very prevalent among Macon Countians.*
- *Affordable medications are a problem. Currently there are only 2 medications on the $4 list. Metformin is GREAT. The other medication is a sulfonylurea - which are TERRIBLE. The other, newer medications are too expensive. Even insulin is too expensive. It is sad*
- *Citizens with Diabetes seems to be increasing in our community.*
- *Very significant in the community*

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

- *The hospital again offers screenings and test for diabetes as well as a large variety of support groups, educational events/classes, recipe books, etc. for our local community to manage their diabetes.*
- *The hospital has monthly diabetes meeting for diabetics in the community to give them education. The hospital also has one on one education sessions with diabetics.*
- *Expand outreach to all MC schools*
- *MCH provides information about this disease and the lifestyle changes needed to help control this disease.*
- *More services in Spanish*

14. **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?**

- *Macon Community Hospital is doing a wonderful job in meeting the needs of our residents*
- *Addressing opioid abuse in the community*
- *Opioid epidemic/addiction of pain medication is the #1 issue in Macon Co in my opinion. Also, addiction recovery for drugs/meth is a very important issue locally.*
- *No, I think you all are doing a great job for your community needs!*
- *Local employers are in need of care givers (nurses/doctors) for workers comp; local physicians either won't accept w/c or are too easy to take employees off work; we are in desperate need of this service*
- *Just keep doing the wonderful outreach programs that you are presently doing.*
- *There is a huge meth and pill problem in the community--it would be great to have a stronger network locally for these individuals. Also, TN has the highest childhood obesity rate--another target area to focus on.*
- *I think the community is very lucky to have MCH*
- *Mental Health is a disease that will need more attention from hospitals in the future.*
- *Access to care for Spanish - speaking community*

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
Healthy Lifestyle Promotion and Education - 2015 Significant Need	152	11	11.69%	11.69%	Significant Needs
Heart Disease – 2015 Significant Need	145	10	11.15%	22.85%	
Accessibility/Affordability	131	11	10.08%	32.92%	
Cancer – 2015 Significant Need	123	11	9.46%	42.38%	
Mental Health	122	9	9.38%	51.77%	
Diabetes- 2015 Significant Need	101	10	7.77%	59.54%	
Obesity	97	9	7.46%	67.00%	Other Identified Needs
Substance Use/Abuse	79	9	6.08%	73.08%	
Women's Health	50	8	3.85%	76.92%	
Kidney Disease	44	7	3.38%	80.31%	
Alzheimer's	42	7	3.23%	83.54%	
Lung Disease	33	5	2.54%	86.08%	
Tobacco Use	31	7	2.38%	88.46%	
Chronic Disease	28	6	2.15%	90.62%	
Alcohol Use	27	6	2.08%	92.69%	
Stroke	25	6	1.92%	94.62%	
Accidents	22	6	1.69%	96.31%	
Suicide	22	5	1.69%	98.00%	
Liver Disease	15	5	1.15%	99.15%	
Flu/Pneumonia	11	5	0.85%	100.00%	
Total	1300		100.00%		

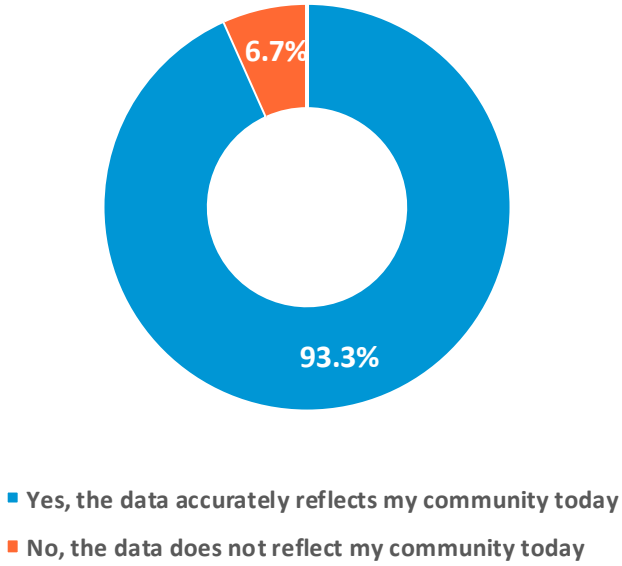
Individuals Participating as Local Expert Advisors[40]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	6	7	13
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	6	7	13
3) **Priority Populations**	4	9	13
4) Representative/Member of **Chronic Disease Group** or Organization	2	11	13
5) Represents the **Broad Interest of the Community**	14	2	16
Other			0
Answered Question			16
Skipped Question			0

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

Advice Received from Local Expert Advisors

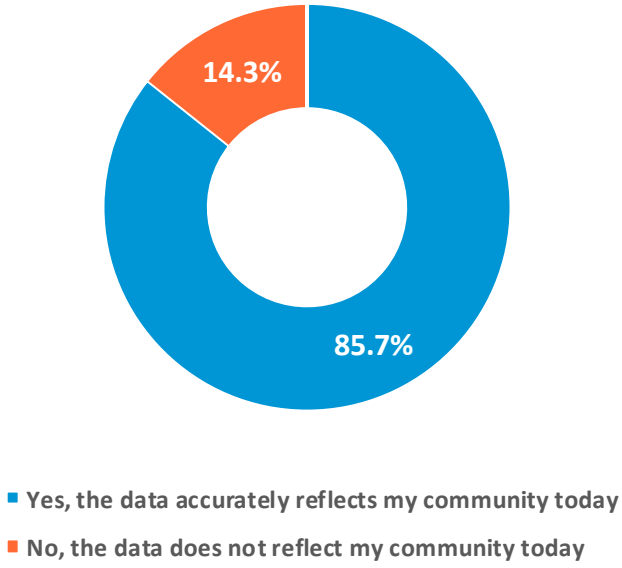
Question: Do you agree with the comparison of Macon County to all other Tennessee counties?



Comments:

- *I would be very surprised if these results accurately reflect our community. The hospital plays a very active role in our community and with the new additions and improvements, I feel they will become even more visible and active within the community.*

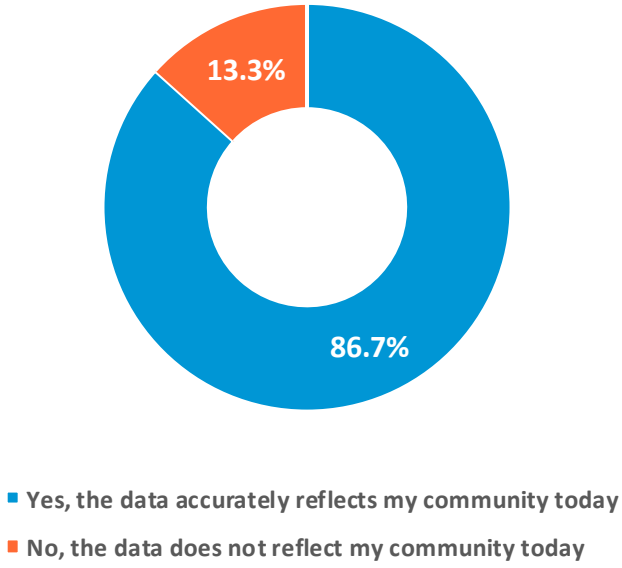
Question: Do you agree with the comparison of Macon County to its peer counties?



Comments:

- *I would have thought smoking and physical inactivity would both be much worse.*
- *The High School graduation rate seems too low, if you count RBS and not just Macon. And social associations seems way too low. Perhaps religious associations were not included in the count. Population to primary care provider is closer to 2,781:1.*
- *I just don't think that this reflects our community. I feel we are much healthier than the statistics show.*

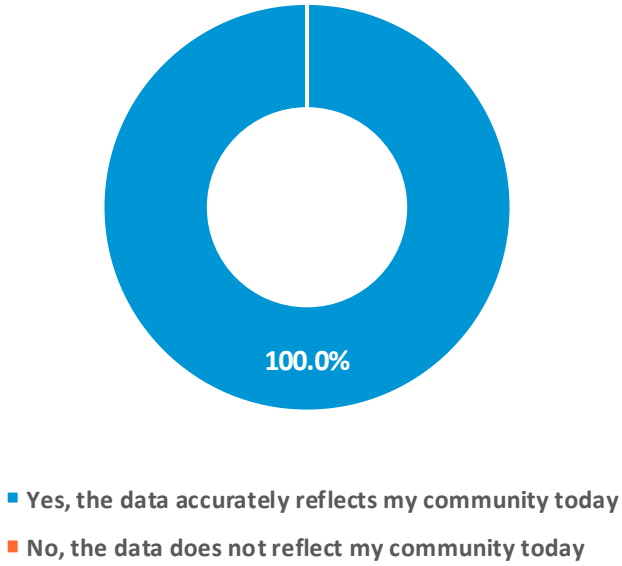
Question: Do you agree with the demographics and common health behaviors of Macon County?



Comments:

- *The population numbers for Macon County are off by at least 10%-15%.*
- *I expected a higher Hispanic population percentage*

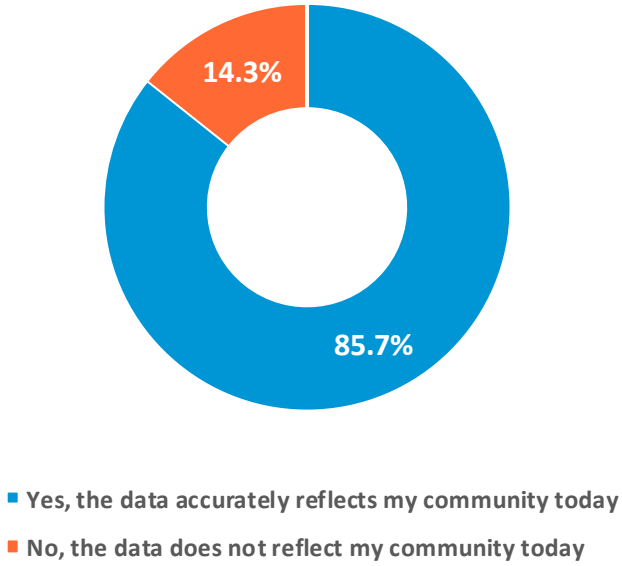
Question: Do you agree with the overall social vulnerability index for Macon County?



Comments:

- *NA*

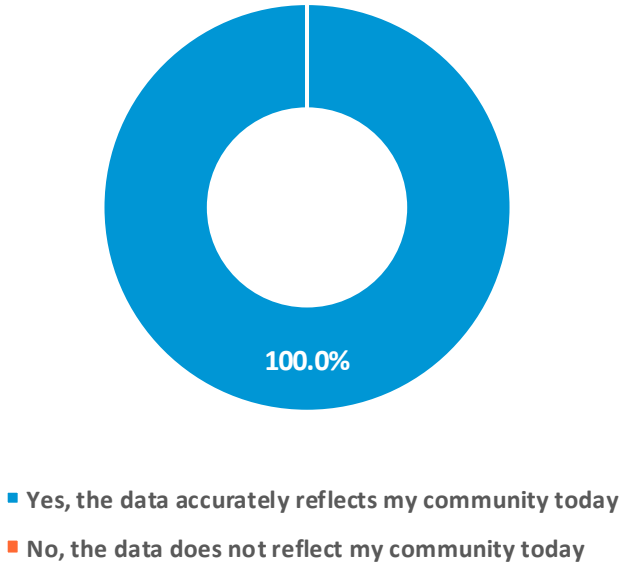
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *Interesting, however I would suspect drug overdose would be in the list.*
- *No, I believe Cancer and Lung disease is much higher.*
- *I question #1 in Kidney Disease.*
- *I would have thought cancer would have been higher and can't figure out why kidney disease is so prevalent.*

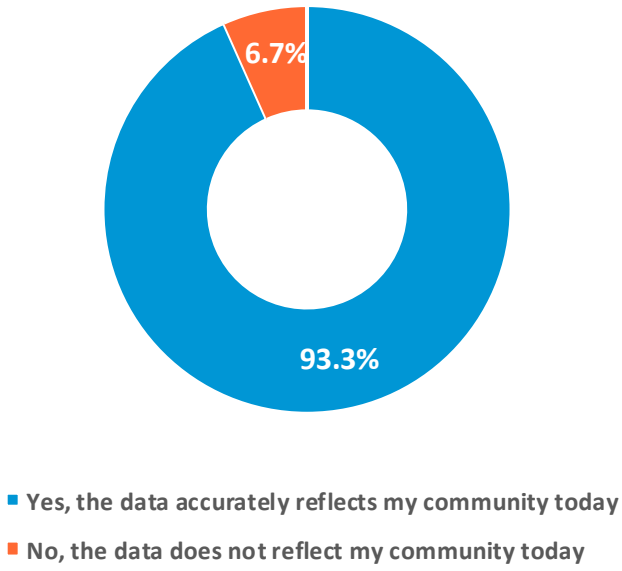
Question: Do you agree with the health trends in Macon County?



Comments:

- *NA*

Question: Do you agree with the written comments received on the 2015 CHNA?



Comments:

- *I have personally experienced a trip to their ER and was very pleased with the nursing care and knowledge. MCH is our best community resource for educating our public on health ed. I'm very impressed with the hospital Nutritionist, and their efforts to educate others on the link between foods and health issues. ex diabetes etc.*
- *Access to OB/Gyn clinics is needed.*

Appendix C – National Healthcare Quality and Disparities Report[41]

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,[42] consistent with these trends.

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

[42] 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.[43]

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.[44]

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

[44] 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.[45]
- 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.

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

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

Trends

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

Disparities

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

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

Trends

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

Disparities

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

Disparities Trends

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

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

Trends

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

- About half of all Healthy Living measures tracked in the QDR improved.
- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; 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.[46]
- 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

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

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

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

CONCLUSION

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

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

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

Illustrative IRS Schedule h Part V Section B (Form 990)[47]

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnote 17 on page 11

   b. **Demographics of the community**

      See footnote 20 on page 12

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

      See footnote 32 on page 33

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 31 on page 30

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

      See footnote 12 on page 9

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

      See footnote 40 on page 54

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

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

See footnote 8 and 9 on page 7

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

See footnote 10 on page 8, footnotes 13 and 14 on page 9, and footnote 25 on page 17

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

N/A

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

2015

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

Yes; see footnote 15 on page 9 and footnote 39 on page 48

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

No

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

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

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

Suggested Answer –

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

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

http://mcgh.net/

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

No other website

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

Yes

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

No other effort

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

Yes

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

   2015

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

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

      http://mcgh.wpengine.com/wp-content/uploads/2018/01/2015-Community-Needs-Assessment.pdf

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

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

    See footnote 32 on page 33

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

    None incurred

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

    Nothing to report

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

    Nothing to report