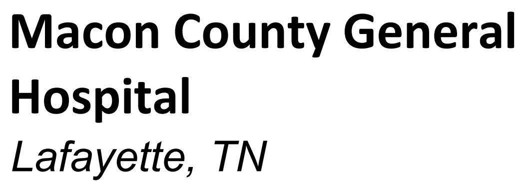

Macon County General Hospital

Lafayette, TN

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution September 8th, 2015

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

Dear Community Member:

In compliance with the Affordable Care Act, all not-for-profit hospitals are now required to develop a report on the medical and health needs of the communities they serve. At Macon County General Hospital (MCGH), we have spent more than 60 years providing high-quality compassionate health care to the greater Lafayette community. We welcome you to review this document not just as part of our compliance with federal law, but of our continuing efforts to meet your health and medical needs.

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

MCGH 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 MCGH and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other area organizations and agencies, can collaborate to bring the best each has to offer to support change and to address the most pressing identified needs.

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

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

Thank You,

Chief Executive Officer
Macon County General Hospital

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EXECUTIVE SUMMARY

Executive Summary

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

This study is designed to comply with standards required of a not-for-profit hospital.[1] Tax reporting citations in this report are superseded by the most recent 990 h filings made by the hospital.

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

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

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury.[2]

Project Objectives

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

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

Overview of Community Health Needs Assessment

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

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals

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[1] 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

[2] As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 schedule h instructions i990sh—dft(2) and tax form

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

promote the health of a broad class of individuals in the community, based on factors including:

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

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c) (3) hospital facility is required to conduct a CHNA at least once every three taxable years and to adopt an implementation strategy to meet the community needs identified through such assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization and may be conducted together with one or more other organizations, including related organizations.
- The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources).
- Each hospital facility is required to make the assessment widely available and downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[4]

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[4] Section 6652

sources:

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

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

(3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.[5]

…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must ''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.

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

APPROACH

APPROACH

To complete a CHNA:

> *"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:*
>
> *(1) A definition of the community served by the hospital facility and a description of how the community was determined;*
>
> *(2) a description of the process and methods used to conduct the CHNA;*
>
> *(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*
>
> *(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and*
>
> *(5) a description of resources potentially available to address the significant health needs identified through the CHNA.*
>
> *… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."*[6]

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

> *"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments."*[7]

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

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

---

[6] Federal Register Op. cit. P 78966 As previously noted the hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources (QHR). & Response to Schedule h (Form 990) B 6 b
[7] Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) B 3 h

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

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

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

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

QHR also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[8] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.[9]

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

Data sources include:[10]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Macon County compared to all State counties	March 15, 2015	2005 to 2013
www.communityhealth.hhs.gov	Assessment of health needs of Macon County compared to its national set of "peer counties"	March 15, 2015	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate	March 15, 2015	2012 to 2014

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

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

[10] 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

	composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics		
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	March 15, 2015	2014
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	March 15, 2015	2014
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	March 15, 2015	2000 to 2010
www.dataplace.org	To determine availability of specific health resources	March 15, 2015	2006
www.cdc.gov	To examine area trends for heart disease and stroke	March 15, 2015	2008 to 2010
http://svi.cdc.gov/map.aspx?txtzipcode=37083&btnzipcode=Submit	To identify the Social Vulnerability Index value	June 17, 2015	2010
www.CHNA.org	To identify potential needs from a variety of resource and health need metrics	March 15, 2015	2003 to 2014
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	March 15, 2015	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	March 15, 2015	CDC official final deaths 2013 published 1/26/2015

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

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from seventeen Local Expert Advisors. Survey responses started Tuesday March 24, 2015 at 8:29 PM and ended with the last response on Thursday April 2, 2015 at 2:45 PM.
- 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.[11]

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

- 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
  - ... a High population of 13 - 25 year olds ...have issues with knowing their sexual orientation... this I feel ...is the underlying factor of WHY ... a high rate of drug and alcohol use as well as being bullied by their peers ... hence, the numbing of drugs and suicide options.
  - Hispanic population – Diabetes Rural area, low income population Adult Mental Health Services needed Lack of medical providers in Macon County in all medical disciplines, Dental, OB, etc.
  - No unique needs known.

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[12] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[13] Consultation with sixteen (16) Local Experts occurred again via an internet-based survey (explained below) beginning Wednesday April 22, 2015 at 9:22 PM and ending Monday May 18, 2015 at 8:38 PM.

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.[14]

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

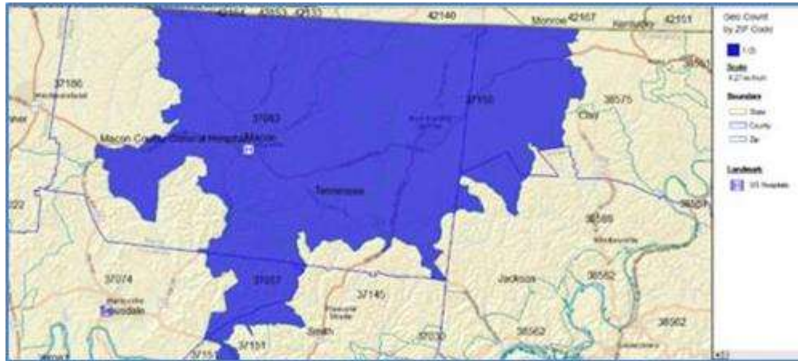
We dichotomized the rank order of prioritized needs into two groups: "Significant" and "Other Identified Needs." Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — "Significant" as opposed to "Other" — was a qualitative interpretation by QHR and the MCGH executive team where a reasonable break point in rank order occurred.[15]

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

FINDINGS

FINDINGS

Definition of Area Served by the MCGH[16]



MCGH, in conjunction with QHR, defines its service area as Macon County in Tennessee, which includes the following ZIP codes:[17]

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

In 2013, the MCGH received 80.5% of its patients from this area.[18]

Demographic of the Community[19]

The 2014 population for Macon County is estimated to be 19,692[20] and expected to increase at a rate of 2.3%. The State of Tennessee disputes this data with the 2015 estimate to be 23,750 and developed population projections stipulating the expectation by 2020 of Macon County growing to 24,848[21] . This is in contrast to the 3.5% national rate of growth, while Tennessee's population is expected to grow 3.93%. Truven anticipates Macon County in 2020 as having a population of 20,509.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2015 median age for the county is 39.9 years, older than the Tennessee median age (38.7 years) and older than the national median age of 37.9 years. The 2015 Median Household Income for the area is $38,140, lower than the Tennessee median income of $44,877 and the national median income of $53,375. Median Household Wealth value is also lower than the National and the Tennessee value. Median Home Values for Macon ($102,613) is lower than the comparison values, the Tennessee median of $148,688 and the national median of $190,970.

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[16] Responds to IRS Schedule h (Form 990) Part V B 3 a
[17] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[18] Truven MEDPAR patient origin data for MCGH; Responds to IRS Schedule h (Form 990) Part V B 3 a
[19] Responds to IRS Schedule h (Form 990) Part V B 3 b
[20] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[21] TN Advisory Commission on Intergovernmental Relations and The University of Tennessee Center for Business and Economic Research, Population Projections For The State of Tennessee, 2010 – 2030 p. 8.

Mason's unemployment rate as of April, 2014 was 4.8%[22], which is better than the 6.0% statewide and the 5.4% national civilian unemployment rate.

The portion of the population in the county over 65 is 17%, compared to Tennessee (15.3%) and the national average (14.7%). The portion of the population of women of childbearing age is 18.4%, over a percent lower than the Tennessee average of 19.6% and the national rate of 19.7%. 92.6% of the population is White non-Hispanic, the largest minority. The Hispanic population comprises 5.5% of the total.[23]

2015 Demographic Snapshot
Area: Macon County, TN
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	19,410	308,745,538
2015 Total Population	19,904	319,459,991
2020 Total Population	20,509	330,689,365
% Change 2015 - 2020	3.0%	3.5%
Average Household Income	$48,017	$74,165

	2015	2020	% Change
Total Male Population	9,744	10,046	3.1%
Total Female Population	10,160	10,463	3.0%
Females, Child Bearing Age (15-44)	3,664	3,695	0.8%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2015	% of Total	2020	% of Total	USA 2015 % of Total
0-14	3,926	19.7%	4,008	19.5%	19.1%
15-17	823	4.1%	812	4.0%	4.0%
18-24	1,787	9.0%	1,841	9.0%	9.9%
25-34	2,284	11.5%	2,503	12.2%	13.3%
35-54	5,138	25.8%	4,843	23.6%	26.3%
55-64	2,570	12.9%	2,591	12.6%	12.7%
65+	3,376	17.0%	3,911	19.1%	14.7%
Total	19,904	100.0%	20,509	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2015 Household Income	HH Count	% of Total	USA % of Total
<$15K	1,464	18.9%	12.7%
$15-25K	959	12.4%	10.8%
$25-50K	2,422	31.2%	23.9%
$50-75K	1,486	19.2%	17.8%
$75-100K	803	10.4%	12.0%
Over $100K	621	8.0%	22.8%
Total	7,755	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2015 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	1,585	11.9%	5.9%
Some High School	1,798	13.5%	8.0%
High School Degree	5,885	44.0%	28.1%
Some College/Assoc. Degree	2,853	21.3%	29.1%
Bachelor's Degree or Greater	1,247	9.3%	28.9%
Total	13,368	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2015 Pop	% of Total	USA % of Total
White Non-Hispanic	18,437	92.6%	61.8%
Black Non-Hispanic	104	0.5%	12.3%
Hispanic	1,097	5.5%	17.6%
Asian & Pacific Is. Non-Hispanic	71	0.4%	5.3%
All Others	195	1.0%	3.1%
Total	19,904	100.0%	100.0%

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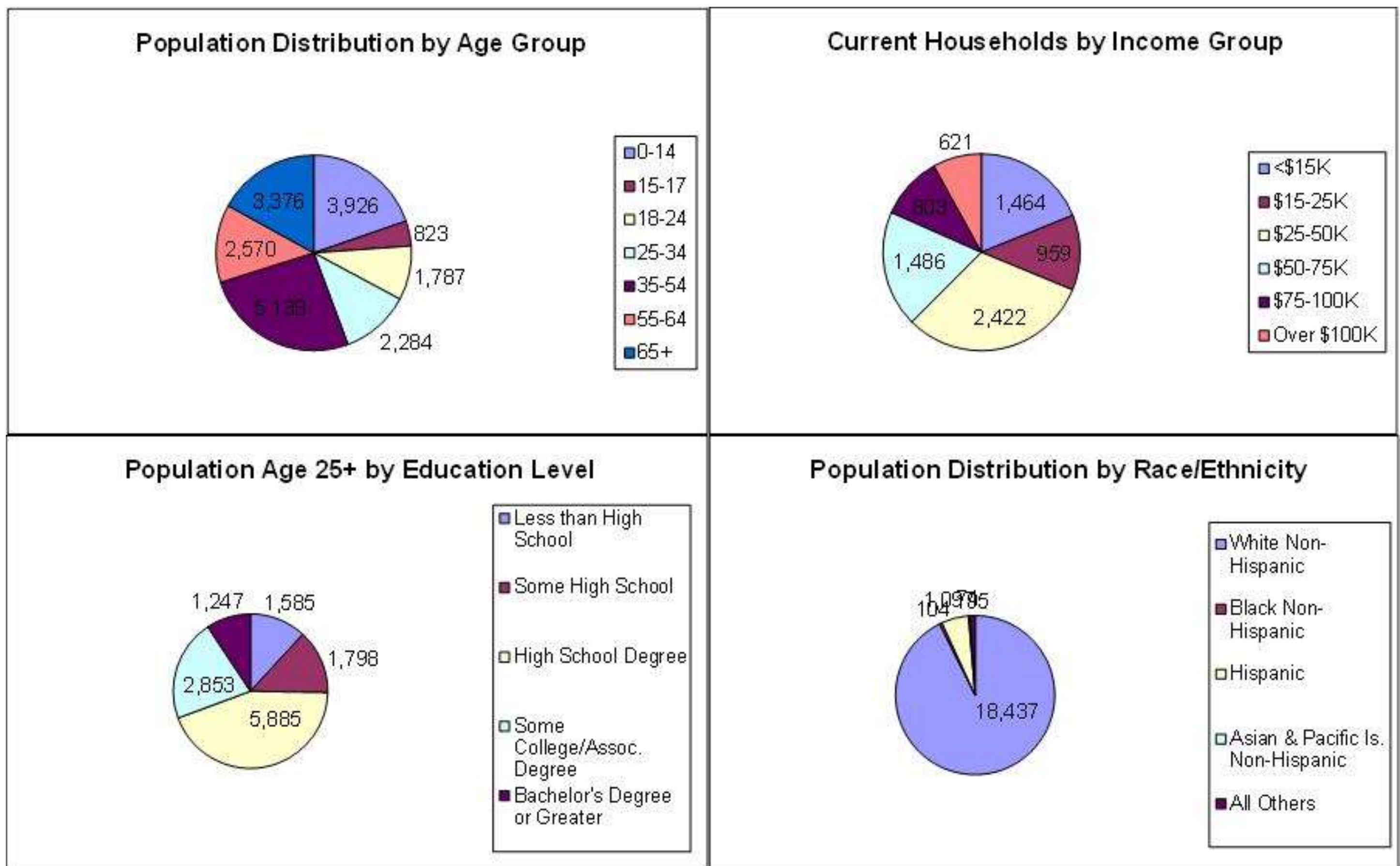
22 http://research.stlouisfed.org/fred2/series/TNMACO1URN; http://research.stlouisfed.org/fred2/series/TNUR; http://research.stlouisfed.org/fred2/series/UNRATE
23 The tables below were created by Truven Market Planner, a national marketing company.

2015 Demographic Snapshot Charts



2015 Benchmarks
Area: Macon County, TN
Level of Geography: ZIP Code

Area	2015-2020 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2015-2020	Females 15-44 % of Total Population	Females 15-44 % Change 2015-2020	Median Household Income	Median Household Wealth	Median Home Value
USA	3.5%	37.9	14.7%	17.7%	19.7%	1.2%	$53,375	$48,894	$190,970
Tennessee	3.5%	38.7	15.3%	18.6%	19.6%	0.9%	$44,877	$46,367	$148,688
Selected Area	3.0%	39.9	17.0%	15.8%	18.4%	0.8%	$38,140	$45,282	$102,613

Demographics Expert 2.7 DEMO0003.SQP © 2015 The Nielsen Company, © 2015 Truven Health Analytics Inc.

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

The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to determine probable lifestyle and medical conditions present in the

population. The national average, or norm, is represented as 100%. Where Macon County varies more than 5% above or below that norm (that is, less than 95% or greater than 105%), it is considered significant.

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

Health Service Topic	Demand as % of National	% of Population Effected	Health Service Topic	Demand as % of National	% of Population Effected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	114.1%	33.4%	Mammography in Past Yr	87.4%	39.8%
Vigorous Exercise	97.4%	54.1%	Cancer Screen: Colorectal 2 yr	87.6%	22.3%
Chronic Diabetes	143.2%	17.1%	Cancer Screen: Pap/Cerv Test 2 yr	84.2%	50.6%
Healthy Eating Habits	82.9%	24.6%	Routine Screen: Prostate 2 yr	92.7%	29.7%
Ate Breakfast Yesterday	111.9%	54.4%	**Orthopedic**		
Slept Less Than 6 Hours	120.9%	22.4%	Chronic Lower Back Pain	136.3%	31.7%
Consumed Alcohol in the Past 30 Days	75.4%	42.0%	Chronic Osteoporosis	124.9%	12.2%
Consumed 3+ Drinks Per Session	110.0%	28.4%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	102.8%	90.8%
I Will Travel to Obtain Medical Care	94.6%	23.3%	Used Midlevel in last 6 Months	105.6%	43.8%
I am Responsible for My Health	90.4%	59.0%	OB/Gyn 1+ Visit	87.1%	40.4%
I Follow Treatment Recommendations	91.1%	47.3%	Medication: Received Prescription	94.1%	45.6%
Pulmonary			**Internet Usage**		
Chronic COPD	122.0%	4.8%	Use Internet to Talk to MD	73.0%	9.4%
Tobacco Use: Cigarettes	125.8%	32.2%	Facebook Opinions	76.7%	7.9%
Heart			Looked for Provider Rating	89.2%	12.8%
Chronic High Cholesterol	123.5%	27.2%	**Emergency Service**		
Routine Cholesterol Screening	84.9%	43.2%	Emergency Room Use	110.9%	37.6%
Chronic Heart Failure	140.9%	7.2%	Urgent Care Use	96.9%	22.7%

Leading Causes of Death

Cause of Death			Rank among all counties in TN (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
TN Rank	Macon Rank	Condition		TN	Macon	
1	1	Heart Disease	51 of 95	204.1	261.7	Higher than expected
2	2	Cancer	10 of 95	185.5	228.1	Higher than expected
4	3	Accidents	21 of 95	52.7	75.4	Higher than expected
3	4	Lung	12 of 95	53.2	70.6	Higher than expected
5	5	Stroke	60 of 95	44.4	55.5	As expected
8	6	Flu - Pneumonia	32 of 95	22.1	29.7	Higher than expected
7	7	Diabetes	53 of 95	24.8	27.2	As expected
9	8	Kidney	1 of 95	14.8	23.8	Higher than expected
6	9	Alzheimer's	74 of 95	36.9	23.2	As expected
10	10	Suicide	32 of 95	15.4	17.9	Higher than expected
12	11	Blood Poisoning	2 of 95	11.5	17.2	Higher than expected
11	12	Liver	60 of 95	11.6	10.2	As expected
13	13	Hypertension	62 of 95	9.6	7.1	As expected
15	14	Homicide	22 of 95	6.4	7.0	Higher than expected
14	15	Parkinson's	70 of 95	7.0	3.9	Lower than expected

National Healthcare Disparities Report – Priority Populations[24]

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

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

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

quality and access that are tracked in the reports and support trends over time, Blacks had worse care than Whites in the most recent year for 78 measures.

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

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

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

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

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

Asians

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

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

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

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

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

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

American Indians and Alaska Natives

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

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

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

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

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

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

Hispanics or Latinos

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

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

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

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

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

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

Low-Income Groups

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

measures for preventive care for children, diabetes care, asthma care, obesity prevention, patient safety, and access to care.

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

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

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

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

Residents of Rural Areas

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

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

Many rural residents depend on small rural hospitals for their care. There are approximately 2,000 rural hospitals throughout the country. Most of these hospitals are critical access hospitals

that have 25 or fewer beds. Rural hospitals face unique challenges due to their size and case mix. During the 1980s, many were forced to close due to financial losses. More recently, finances of small rural hospitals have improved and few closures have occurred since 2003.

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

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

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

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

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

Individuals with Disabilities or Special Healthcare Needs

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

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

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

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

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

- *People under age 65 with health insurance*

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

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

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

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[25]

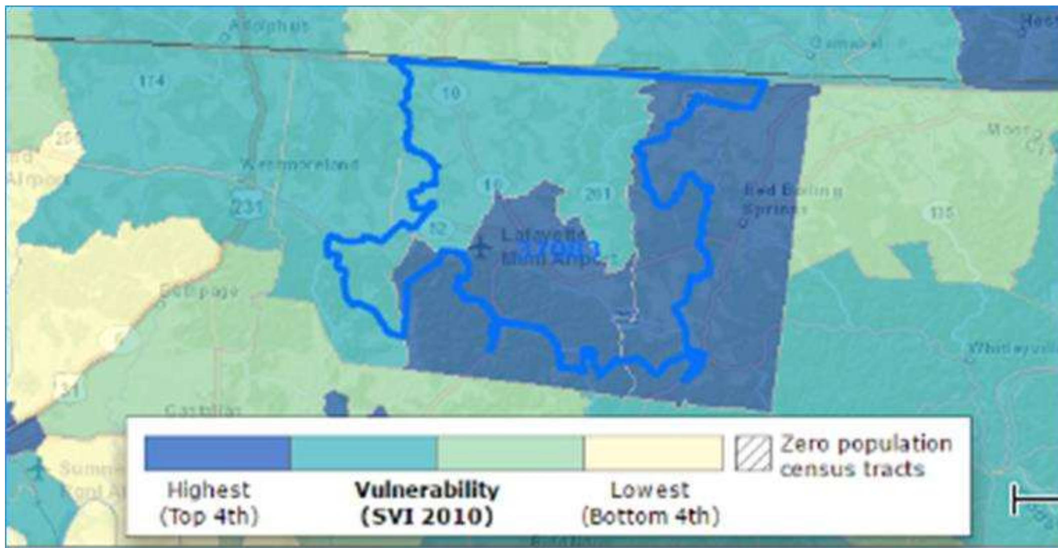
- ... a High population of 13 to 25 year olds ...have issues with knowing their sexual orientation... this I feel ...is the underlying factor of WHY ... a high rate of drug and alcohol use as well as being bullied by their peers ... hence, the numbing of drugs and suicide options.
- Hispanic population Diabetes; Rural area, low income population Adult Mental Health Services needed Lack of medical providers in Macon County in all medical disciplines, Dental, OB, etc.
- No unique needs known.

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

Social Vulnerability

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

The eastern and southern portions of Macon County are noted as being in the highest national quartile of vulnerability. The northwestern portion of Macon County is noted as being in the second highest national quartile of vulnerability.



Findings

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

Consideration of Written Comments from Prior CHNA

A group of 17 individuals provided written comment in regard to the 2012 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2012 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	2	10	12
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	9	13
3) Priority Populations	5	8	12
4) Representative / member of chronic disease group or organization	1	11	12
5) Represents the Broad Interest of the Community	10	3	13
Other Advanced Practice Nurse-Long time member of local healthcare community	1		1
Answered Question			17
Skipped Question			0

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

- Cancer
- Heart Disease
- Diabetes

There were other areas that are clearly important in improving the health of the community. However, they are deemed to have less immediate impact and will be addressed in a future plan, or if the community arises, integrated into this plan as a sub-objective activity only.

- The most notable health needs not addressed are this time are Drug and Alcohol abuse and Teenage Pregnancy. Unfortunately, most rural America is without the necessary resources to adequate address the pandemic increase in drug and alcohol Abuse. Macon County General Hospital will work in collaboration with other agencies to provide education in our community about Drug and Alcohol Abuse.
- Macon County General does not have the resources that would be required to effect the changes that are needed to adequately address Teenage Pregnancy. However, we will continue to explore potential partnerships and internal strategies to find a way to provide these essential services to our patients. Every effort will be made to assist in teenage pregnancy.

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

- Should the hospital continue to consider each need identified as most important in the 2012 CHNA report as the most important set of health needs currently confronting residents in the County?

	Cancer	Heart	Diabetes
Yes	15	15	16
No	1	1	0
No Opinion	1	1	1

- Specific comments or observations about Cancer as being among the most significant needs for the Hospital to work on to seek improvements?
    - Education still needs to be a priority and maybe even cessation of smoking and other things that attribute to the CAUSE of cancer. I t would also benefit the community to have more available treatment available other than having these patients drive to Gallatin or Lebanon for their treatment.
    - Cancer in general continues to have a great impact on individuals in the county. There is much perceived alarm and concern about the incidences locally. I'm not sure if there is as much concern however about prevention and screening.
    - No
    - none
    - I believe that several Macon County residents gets cancer so I believe more research as to why could be explored.
    - It effects a large amount of people in our community.
    - Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.
- Specific comments or observations about Heart Disease as being among the most significant needs for the Hospital to work on to seek improvements?
    - i have recently had a friend who had issues with a clinic because of heart failure. It was over the Veterans Day holiday weekend. She was not feeling well but opted to wait and go to her doctor at the clinic as opposed to going to our local hospital emergency room. i believe this contributed to her death. On Monday the Veterans Day holiday the clinic was not open therefore she was going to wait and go to the clinic on Tuesday when they were open. My belief is that she would still be alive today if she had gone to our local ER. Why did she not go it was because she trusted the Clinic as her husband had kidney failure previously and the clinic NOT our hospital was instrumental in finding him a kidney. This community is VERY loyal to the help rendered in ALL of its endeavors. In this instance I believe her loyalty cost her life. This is indicative of HOW this community thinks. I guess my answer to the question asked a significant NEED is to build trust in our local hospital to address the needs this community has be it cancer

diabetes or Heart disease.

- Culturally there are dietary and other barriers to overcoming heart disease in this community (inactive/overweight community). There is apathy here, as heart disease is "not as bad as cancer" and there does not seem urgency among the population to change this.
- No
- none
- Nutrition education and smoking cessation programs need to be easily accessible.
- Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.

- Specific comments or observations about Diabetes as being among the most significant needs for the Hospital to work on to seek improvements?
    - Similar here as to heart disease.
    - No
    - none
    - We have a high number of diabetics in our community.
    - Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.

Conclusions from Public Input

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

MCGH received the following responses to the question: "*Should the hospital continue to consider each need identified as most important in the 2012 CHNA report as the most important set of health needs currently confronting residents in the County? Please add any additional information you would like us to understand.*"

- Primary resources however could be applied to one priority area.
- The hospital has been involved in the community, and I believe that throwing money at the problem will not make it go away. Until the welfare mentality that produces lazy individuals that have no concern for their individual or collective well being is fixed, these three ailments will continue to plague "Priority Populations".

Summary of Observations: Comparison to Other TN Counties

In general, Macon County residents are in worse than average health compared to the healthiest in Tennessee.

In a health status classification termed "Health Outcomes", Macon ranks number 60 among the 95 Tennessee ranked counties (best being #1). Premature Death (deaths prior to age 75) shows 11 years of deterioration, presenting poor values (shorter survivability) than on average for the US and Tennessee.

In another health status classification "Health Factors", Macon County ranks number 89 among the 95 ranked Tennessee counties. The following indicators compared to TN average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Adult smoking – Macon 35% of residents compared to TN 23% and US best of 14%
- Teen births – Macon 73 births/1,000 age 15 to 19 females compared to TN 47 and US best of 20 births
- Adult Obesity – Macon 32% has declined to the TN average of 32% but is higher than the US value of 25%.

In the “Clinical Care” classification, Macon County ranks number 95, worst among Tennessee counties. The following indicators compared to TN average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Uninsured – Macon 20% of residents compared to TN 16% and US best of 11%
- Population to Primary care Physician – Macon 5,625:1 which is more than 4 times worse than the TN 1,388:1and the US best of 1,045:1
- Population to Dentist – Macon 5,674:1 which is almost 3 times worse than the TN 1,996:1 and over 4 times worse than US best of 1,377:1
- Population to Mental Health Provider – Macon 22,701:1 which is 28.8 times worse than the TN 786:1 and 58.8 times worse than US best of 386:1
- Preventable hospital stays (a measure of potential physician shortage) – Macon 169 admissions per 1,000
- Medicare beneficiaries which is 2 and 1/3 worse than TN average of 73 and 4 times worse than US best of 41
- Mammography screening – Macon 47.3% of Medicare women age 67 to 69 compared to TN average of 61.8% and US best of 70.7%

In the “Social and Economic Factors” classification, Macon County ranks number 69 among the 95 ranked Tennessee counties. The following indicators compared to TN average and to national top 10% performance present such poor values it warrants investigating how to improve:

- High School Graduation – Macon 85% which is below TN average of 87%
- Some College – Macon 35.1% which is considerably below TN avg. of 57.7% and US best of 71%

- Children in Poverty – Macon 33% which is above TN average of 27% and 2 ½ times US best of 13%
- Number of Social Associations per 10,000 residents – Macon 4.9 less than half of TN average of 11.5 and about 25% of US best of 22 per 10,000
- Injury deaths – Macon 127 per 100,000 residents which is 2/3 above TN average of 78 and 2 and ½ times US best of 50

Summary of Observations: Peer Comparisons

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

Mortality

Better

- Diabetes deaths

Worse

- Cancer deaths – 236.3 deaths per 100,000; 5th worse among 40 peer counties US Avg. 185.0
- Chronic lower respiratory disease (CLRD) deaths – 71.4 deaths per 100,000; 8th worse among peers, US avg. 49.6
- Coronary heart disease deaths – 172.3 deaths per 100,000; 9th worse among peers, US avg. 126.7
- Male life expectancy – 70 years; 6th worse, US avg. 75.0
- Unintentional injury (including motor vehicle) – 83.8 deaths per 100,000; 5th worse among peers, US avg. 50.8

Morbidity

Better

- Gonorrhea
- HIV
- Preterm births
- Syphilis

Worse

- Adult overall health status – 25.7% Adults reporting fair/poor status; 8th worse among peers, US

avg. 16.5%

- Alzheimer's diseases/dementia – 13.8% Adults living with condition; 3rd worse among peers. US avg. 10.3%
- Cancer – 530.7 cases per 100,000; 4th worse among peers, US avg. 457.6 cases
- Older adult depression – 16.4% older adults with condition; 5th worse among peers, US avg. 12.4%

Health Care Access and Quality

Better

- Nothing

Worse

- Cost barrier to care – 27.7% adults not visiting doctor due to cost; 3rd worse among peers, US avg. 15.6%
- Older adult preventable hospitalizations – 176.2 hospitalizations per 1,000; Worse among peers, US avg. 71.3

Health Behaviors

Better

- Adult female routine pap tests; Adult physical inactivity

Worse

- Adult smoking – 34.7% of adults; 5th worse among peers, US avg. 21.7%
- Teen Births – 72.7 births per 1,000 teens; 5th worse among peers, US avg. 42.1

Social Factors

Better

- Children in single parent households

Worse

- Nothing

Physical Environment

Better

- Drinking water violations
- Housing stress
- Limited access to healthy food
- Living near highways

Worse

- Nothing

Conclusions from Demographic Analysis Compared to National Averages

We solicited opinions based on QHR Truven database of population characteristics as we were unaware of Tennessee statistics indicating projected larger population growth rather than anticipating slow increase to a lower total projected population. The population commentary for which we obtained local opinions was as follows.

The 2014 population for Macon County is estimated to be 19,692 and expected to increase at a rate of 2.3% through 2019. This is lower than the 3.5% national rate of growth, while Tennessee's population is expected to increase by 3.8%. Macon County in 2019 anticipates a population of 20,151.

Population estimates indicate the 2014 median age for the county is 39.7 years, older than the Tennessee median age (38.6 years) and the national median age of 37.7 years. The 2014 Median Household Income for the area is $37,269, lower than the Tennessee median income of $42,971 and the national median income of $51,423. Median Household Wealth value is lower than both the National and the Tennessee value. Median Home Values for Macon ($104,197) is also lower than both the Tennessee median of $143,820 and the national median of $179,326. Macon's unemployment rate as of February 2015 was 6.0%, which is slightly lower than the 6.4% statewide and the 5.5% national civilian unemployment rate.

The portion of the population in the county over 65 is 16.4%, compared to Tennessee (14.8%) and the national average (14.2%). The portion of the population of women of childbearing age is 18.6%, slightly lower than the Tennessee average of 19.6% and the national rate of 19.8%. 91.6% of the population is White nonHispanic. The largest minority is Hispanic population which comprises 5.9% of the total.

The following areas were identified from a comparison of the county to national averages. Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered adverse:

- I am Responsible for My Health is 9.6% below average impacting 59% of the population
- Cervical Cancer screening in last two years is 15.8% below average impacting 50.6% of the population
- Compliant with treatment recommendations is 8.9% below average impacting 47.3% of residents
- Routine cholesterol screening is 15.1% below average impacting 43.2% of the population
- Had an OB/GYN visit is 12.9% below average impacting 40.4% of the population

- Had a mammogram is 12.6% below average impacting 39.8% of the population
- Used an Emergency Room in last year is 10.9% above national average impacting 37.6% of the population
- Morbid Obese is 14.1% above average impacting 33.4% of residents
- Use smoking tobacco is 25.8% above average impacting 32.2% of area residents
- Chronic lower back pain is 36.3% above average impacting 31.7% of area residents

Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered beneficial:

- Ate breakfast 11.9% above average, impacting 54.4% of residents
- Received a prescription is 5.9% below average, impacting 45.6% of residents
- Used a Midlevel in last 6 months is 5.6% above average, impacting 43.8% of area residents
- Consumed alcohol in last 6 months is 24.6% below average, impacting 42% of residents

Conclusions from Other Statistical Data

Additional data examinations for Macon County observed the following:

Priority Populations Macon Co. zip codes primarily fall into the "higher" categories of Social Vulnerability. Social Vulnerability is a composite score of the area's ability to prepare for and respond to natural disaster, including disease outbreaks and human caused threats. Roughly the eastern half of the county (including Lafayette) falls into the highest (adverse) category while the western half falls into the second highest (adverse) performing category of Social Vulnerability.

A prior survey asked for comments about Priority Population unique needs. Opinions are summarized as follows:

- ... a High population of 13 to 25 year olds ...have issues with knowing their sexual orientation... this I feel ...is the underlying factor of WHY ... a high rate of drug and alcohol use as well as being bullied by their peers ... hence, the numbing of drugs and suicide options.
- Hispanic population – Diabetes. Rural area, low income population Adult Mental Health Services needed. Lack of medical providers in Macon County in all medical disciplines, Dental, OB, etc.
- No unique needs known.

Palliative Care (programs relieving pain and stress from serious illness) do not exist

Hospice program do not exist closer than Madison, TN over an hour away.

Heart Disease Macon Co deaths 2010 through 2012 (486.3 per 100,000) is higher than (403.8) TN and (338.6) US avg.

Stroke deaths (97.9 / 100,000) is higher than TN (91.2) and US rate (73.7)

Hypertension deaths exceed TN and US rates but death rates for Blacks are unusually low, both in comparison to TN and US rates but also lower than Macon Co white population

Shortage Area Macon is designated a Health Professional Shortage Area (HPSA) for primary care, dental care and mental health, and qualifies as a Medically Underserved Area (MUA).

Poverty 21.4% of the population lives in poverty, above the 14.5% US and 17.8% TN averages. 15% of the population has no health insurance coverage.

Leading causes of death, Macon Co. has a significantly lower death rate in 1 of the 15 leading causes of death (Parkinson) and a significantly higher death rate in 9 of the 15 leading causes of death (Heart, Cancer, Lung, Accidents, Influenza, Kidney, Blood Poisoning, Suicide and Homicide).

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

1. **Heart Disease** – Macon Co ranks 51 of 95 TN counties (being ranked as #1 means you are the worst county in the state) with a death rate of 261.7 / 100,000, a rate higher than expected
2. **Cancer** – Macon Co ranks 10 of 95 with a death rate of 228.1 / 100,000, a rate higher than expected
3. **Accidents** – Macon Co ranks 21 of 95 with a death rate of 75.4 / 100,000 a rate higher than expected
4. **Lung** – Macon Co ranks 12 of 95 with a death rate of 70.6 / 100,000, a rate higher than expected
5. **Stroke** – Macon Co ranks 60 of 95 with a death rate of 55.5 / 100,000 an expected rate
6. **Flue/Pneumonia** – Macon Co ranks 32 of 95 with a death rate of 29.7 / 100,000 a rate higher than expected
7. **Diabetes** – Macon Co ranks 53 of 95 with a death rate of 27.2 / 100,000 an expected rate
8. **Kidney** – Macon Co ranks #1 of 95 with a death rate of 23.8 / 100,000, higher than expected
9. **Alzheimer's** – Macon Co ranks 74 of 95 with a death rate of 23.2 / 100,000 an expected rate
10. **Suicide** – Macon Co ranks 32 of 95 with a death rate of 17.9 / 100,000, higher than expected

Conclusions from Prior CHNA Implementation Activities

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

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

- *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

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

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

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

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and 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 MCGH in its implementation efforts and/or its prior year tax reporting included:

- 2013 MCGH Expended. The cost of our charity program for 2013 was $165,106 and the total cost for uncompensated care was $700,355 for a total of $827,787. The amount of expenses incurred to provide the community benefits was $64,565. offsets to benefit 8983 individuals

Existing Healthcare Facilities, Resources, & Implementation Strategy

SIGNIFICANT HEALTH NEEDS

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by MCGH.[26] 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 MCGH current efforts responding to the need including any written comments received regarding prior MCGH implementation actions
- Establishes the Implementation Strategy programs and resources MCGH will devote to attempt to achieve improvements
- Documents the Leading Indicators MCGH will use to measure progress
- Presents the Lagging Indicators MCGH 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, MCGH is the major hospital in the service area. Macon County General Hospital is a twenty-five bed Critical Access Hospital located in Lafayette, Tennessee. The hospital is a member of the American Hospital Association and the Tennessee Hospital Association. Macon County General Hospital is accredited by DNV Healthcare, Inc. The next closest facilities are outside the service area and include:

- Trousdale Medical Center – 25 bed critical access hospital in Hartsville, TN; 15.4 miles from Lafayette (21 minutes)
- Monroe County Medical Center – 49 bed hospital in Tompkinsville, KY; 30.5 miles from Lafayette (39 minutes)
- Riverview Regional Medical Center –25 bed hospital in Carthage, TN; 26.2 miles from Lafayette (32 minutes)
- Sumner Regional Medical Center – 155 bed hospital in Gallatin, TN; 29.9 miles from Lafayette (39 minutes)

All data items analyzed to determine significant needs are "Lagging Indicators," measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the MCGH Implementation Strategy uses "Leading Indicators." Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and

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

if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading Indicators also must be within the ability of the MCGH to influence and measure. Typically, but not always, the Lagging Indicator is a data element developed by an organization which is not the hospital and was used as information during the Significant Need identification process.

Tennessee Community Benefit Requirements

Tennessee does require hospitals to report charity care. All hospitals licensed by the Department of Health must file a joint annual report "of the statistical particulars relative to their patients for the fiscal year," including financial data relating to charity care and bad debt. Tenn. Code 68-11-310(a)(1); Tenn. Code §68-1-109

Tennessee does not require nonprofit hospitals to provide community benefit to develop community benefit plans or implementation strategies.

Tennessee does not require hospitals to adopt or implement financial assistance policies but requires hospitals that have charity care policies to develop a "concise statement" of these policies.[27]

General Written Comments About Prior Implementation Plan

The following responses were received in response to the following question: "*Do you have opinions about **new or additional** implementation efforts or community needs the Hospital should pursue?"*

- We have a place here called Valley Ridge to address the mental needs let us just say it is less than adequate. The hospital needs to do MORE to address mental disorders especially our youth. More counselors and social/psychological help is needed. An understanding of more disorders is needed.
- Programs to address obesity are desperately needed.
- Alzheimer's disease prevention/treatment
- Childhood obesity
- No
- Living a healthy lifestyle is important and keeping one's weight under control and exercising often can help to maintain an overall improvement in health. So, educating the community about the importance of being healthy and how unhealthy decisions can affect one negatively in the future needs to be emphasized more.
- I think the hospital should pursue getting some new Primary care Physicians into the community.
- They community leaders should promote the benefits of working and being self-supporting.

[27] http://www.hilltopinstitute.org/hcbpDocs/HCBP_CBL_tn.pdf

Significant Needs

1. Cancer – 2012 Significant Need and recommended in public comments to continue a focus for hospital improvement efforts; 2nd leading cause of death with higher than expected rate; Macon 10th highest rate in TN; Cervical testing below avg.; Mammogram testing below avg.; 4th worse among Peers

Problem Statement: Educate our community on the importance of annual preventive testing/screenings.

Public comments received on previously adopted implementation strategy:

- I would like more information about how/what actions were implemented.
- No
- None
- Continuing to stress the importance of early detection being the best fight against cancer.
- Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.

MCGH services, programs, and resources available to respond to this need include:[28]

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

- MCGH provides a full range of diagnostic services imaging services to support early diagnosis of cancer including digital mammography, low dose CT, nuclear imaging and laboratory services.
- MCGH provides screening colonoscopy and endoscopy with surgical intervention if indicated.
- MCGH will provide cancer screenings in the community.

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

- Increase the number of preventive exams performed at MCGH.

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

Since the 2012 CHNA, MCGH has taken efforts to make improvement in the cancer concerns impacting our area. Our efforts delivered the following results:

- MCGH added a Digital Mammography
- MCGH has a General surgeon every Monday providing colonoscopy and endoscopy.
- Susan G. Komen Grant for uninsured to receive mammograms.
- Upgrade to CT scanner to allow low dose scanning.

[28] 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

Anticipated results from MCGH Implementation Strategy

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

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

- Increase percentage of Macon County women having mammograms performed at MCGH from 950.

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

- Lead to an increase in mammogram testing and an earlier identification of disease which would result in a higher potential for positive outcomes.

Other local resources identified during the CHNA process believed available to respond to this need:[29]

Organization	Contact Name	Contact Information
American Cancer Society	http://www.cancer.org	800.227.2345
Susan G Komen	http://ww5.komen.org/	614.297.8155
Macon County Health Dept.	Michal Dever	615-666-2142
Sherry's Run	sherrysrun.org	615-925-2592
Haydenfest	Felecia Shrum	6153886746

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

2. **Heart Disease** – 2012 Significant Need and recommended in public comments to continue a focus for hospital improvement efforts; leading cause of death, occurring at higher than expected rate; four years death rate worse than TN and US avg.; 9th worse among Peers

   Problem Statement: Support prevention of Heart Disease, increase preventive procedures and improve worksite initiatives

Public comments received on previously adopted implementation strategy:

- I would like more information about how/what actions were implemented.
- No
- none
- continue education of the population
- Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.

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

- The MCGH employee wellness program provides lipid panels and evaluation of heart disease risk.
- MCGH provides free blood pressure screenings to community organizations.
- MCGH promotes exercise education at the Senior Center with Silver Sneakers Program.
- MCGH provides an education community event on Heart Healthy in the community.
- MCGH participates with Makin Macon Fit in promoting wellness and physical activity within our community.

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

- Increase blood pressure screenings made available to various communities sectors.
- Market wellness program to industries throughout Macon County.
- Include Heart Healthy recipes in the local paper and face book page of the hospital.
- Provide CPR & First Aid classes monthly to the MCGH Service area.

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

- MCGH has observed a 10% increase in the number of community members that participate in the health screenings in Macon County.

Anticipated results from MCGH Implementation Strategy

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

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

- Increase Blood Pressure Screenings from 300..

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

- MCGH believes an increase in Blood Pressure Screenings will lead to earlier identification and treatment of heart disease and bring Macon County in line with the heart disease death rate and incident rate experience of our Peer Counties.

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

Organization	Contact Name	Contact Information
Macon County Health Department	Michal Deaver	615-666-2142
UT Extension	http://www.maconcountyschools.com/	615666-3341
Macon County Coordinated School Health	http://www.maconcountyschools.com/	6156888010

3. **Mental issues including Substance Abuse** – Identified from public comment; depression impacts 14% of adults; 5th worse among Peers; Professional availability 28.8 times worse than TN avg. 58.8 times worse than US best

   Problem Statement: Macon County is without resources to address this need

   Lack of expertise MCGH does not have psychiatry facilities or providers at its facility.

Public comments received on previously adopted implementation strategy:

- This need was not identified as a significant need in the 2012 CHNA however as additional commentary the following comment was received:
  - Alcohol and drug addiction seems to be an issue and should be addressed.

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

- We are choosing not to respond to Mental Issues including Substance Abuse at this time, because MCGH resources have been focused on physical health issues and others are better suited to respond to this need. We feel we can have a greater impact by putting new attention and dollars toward the other needs.

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

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

Organization	Contact Name	Contact Information
TN Poison Center	http://www.mc.vanderbilt.edu/root/vumc	615-936-0760
Valley Ridge	https://www.vbhcs.org/locations/lafayette/	615-666-8070
Hope Clinic	http://hopefamilyhealth.org/	615-644-2000
AA	www.aa.org	615-666-8070
NA	www.na.org	615-666-8070

4. **Healthy Lifestyle promotion and education** – identified from public comment

Problem Statement: Educational resources designed to inform residents about how to adopt a healthier lifestyle need enhancement

Public comments received on previously adopted implementation strategy:

- This need was not identified as a significant need in the 2012 CHNA however as additional commentary the following comment was received:
  - As I have stated, promoting a healthy, working lifestyle would greatly improve the lives of the individuals that actually want improvement. Convincing people to improve will be difficult, however, as there is little incentive in our current socialist state of affairs.
  - An increased awareness of the relationship of nutrition and exercise to obesity.
  - Your questions address systems or consequences. It seems to me that the needs of the county should include a focus on the causes of these health issues: obesity, poor nutrition, smoking, lack of exercise, etc. While we need to treat serious diseases and health conditions, our county needs to promote healthier lifestyles.
  - MCGH is paramount in education of issues in the community.

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

- MCGH has an integrated approach to healthy lifestyle changes through the diabetes education program.
- MCGH wellness program promote healthy eating and exercise.
- MCGH offers health eating and diabetic carb counting classes to the community.
- MCGH provides and staffs a booth at the annual Macon County Fair that offers healthy foods verses candy/coke products.

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

- Include Healthy Lifestyle tips in the paper and on the hospital Facebook page.

- Participates in "Healthy Kids" 3 months of education in the Macon County School System that provides healthy eating and exercise to K-2nd grade.
- Provide water to children as a healthy alternative at Makin Macon Fit that is held in September.
- MCGH participates in Makin Macon Fit in September that includes health eating and sugary beverages.

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

- None as this Significant Need was identified during the current need identification process.

Anticipated results from MCGH Implementation Strategy

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

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

- MCGH will partner with Macon county Coordinated School Health to provide BMI's in the school system in Macon County with the intent to achieve 100% involvement and a decrease in the average BMI.

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

- The average BMI value is anticipate to decline over time as increased awareness of healthy lifestyles emerge.

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

Organization	Contact Name	Contact Information
Macon County Health Council	http://www.maconcountytn.com/health_department.htm	615-666-2142
Macon County Health Department	http://www.maconcountytn.com/health_department.htm	615-666-2142
Healthier TN	http://healthiertn.com/communities	615-666-2363
UT Extension	http://www.maconcountyschools.com/	615-666-3341
Macon County Coordinated School Health	http://www.maconcountyschools.com/	615-688-8010

5. **Diabetes** – 2012 Significant Need and recommended in public comments to continue a focus for hospital improvement efforts

Problem Statement: Prevent and /or reduce risk factors; increase the detection and treatment risk factors; and, collaborate to increase community capacity to deliver evidenced-based programs that support prevention and management of risk factors among high risk populations.

Public comments received on previously adopted implementation strategy:

- see above
- No
- none
- Due to the poor eating habits of Macon County residents, I am sure that the diabetes rate is very high. Possibly, more diabetes counseling/education could be a focus for the hospital. Although, we are sure that it is hard to change someone's diet and eating habits.
- Continue offering education programs, nutrition programs and exercise programs.
- Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.

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

- MCGH provides diabetic screenings at the health fairs, employees' wellness programs and at the Macon County Senior Center.
- MCGH wellness program promotes healthy diet and exercise.
- MCGH provides Diabetes Support Group and Diabetes Classes monthly.

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

- Include "Carb Conscious" recipes in the local newspaper and face book page.
- Serve as a community example through health food booths at various health fairs.
- MCGH will track and report the number of people screened for diabetes at health fairs.

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

- 2014 we made contact with 150 individuals in providing Diabetes Ed and Diabetes Support Group meetings.

Anticipated results from MCGH Implementation Strategy

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

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

- We will encourage additional participants in the MCGH Diabetes Education and the Diabetes Support Group above the 2014 level of participation.

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

- We believe additional Diabetic education participants will lead to greater self-control and a reduction of disease

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

Organization	Contact Name	Contact Information
Macon County Health Council	http://www.maconcountytn.com/health_department.htm	615-666-2142
Macon County Health Department	http://www.maconcountytn.com/health_department.htm	615-666-2142
Macon County Coordinated School Health	http://www.maconcountyschools.com/	615-688-8010
Healthier TN	http://healthiertn.com/communities	615-666-2363
UT Extension	https://extension.tennessee.edu/macon/page	615-666-3341

6. **Obesity** – identified from public comment; Morbid Obesity above avg.; Obesity declined to TN avg., exceeds US best rate

    Problem Statement: MCGH will not address this need.

Public comments received on previously adopted implementation strategy:

- This need was not identified as a significant need in the 2012 CHNA however as additional commentary the following comment was received:
    - As I have stated, promoting a healthy, working lifestyle would greatly improve the lives of the individuals that actually want improvement. Convincing people to improve will be difficult, however, as there is little incentive in our current socialist state of affairs.
    - An increased awareness of the relationship of nutrition and exercise to obesity.
    - Your questions address systems or consequences. It seems to me that the needs of the county should include a focus on the causes of these health issues: obesity, poor nutrition, smoking, lack of exercise, etc. While we need to treat serious diseases and health conditions, our county needs to promote healthier lifestyles.
    - MCGH is paramount in education of issues in the community.

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

- MCGH has not dedicates specific resources to address this newly identified Significant Need.

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

- We are choosing not to respond to Obesity at this time, because MCGH resources have been focused on other physical health issues and we believe the primary care system is better suited to respond to this need. We feel we can have a greater impact by putting new attention and dollars toward the other acute care needs.

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

Other Needs Identified During CHNA Process

(Note: lower case text indicates a need identified by Local Experts while capital text represents a data defined need.)

7. COST
8. POVERTY
9. ALZHEIMER'S
10. SMOKING
11. MATERNAL AND CHILD ISSUES - including preventing Teen pregnancy
12. DENTIST
13. PRIMARY CARE PHYSICIANS
14. PREVENTION
15. PHYSICIANS - including after-hours/weekend availability
16. ACCIDENTS
17. HYPERTENSION
18. PRIORITY POPULATIONS - including children with developmental delays
19. EDUCATIONAL ATTAINMENT
20. Fraud and Abuse Programs for Seniors
21. COMPLIANCE
22. PALLIATIVE / HOSPICE
23. LUNG
24. STROKE
25. CHRONIC LOWER BACK PAIN

Overall Community Need Statement and Priority Ranking Score

Significant needs where MCGH has implementation responsibility[30]

1. CANCER – 2012 SIGNIFICANT NEED
2. HEART DISEASE – 2012 SIGNIFICANT NEED
4. HEALTHY LIFESTYLE PROMOTION AND EDUCATIONDIABETES
5. DIABETES – 2012 SIGNIFICANT NEED

[30] Responds to Schedule h (Form 990) Part V B 8

Significant needs where MCGH did not develop implementation strategy[31]

3. MENTAL ISSUES - Including Substance Abuse
6. OBESITY

Other needs where MCGH developed implementation strategy

- None

Other needs where MCGH did not develop implementation strategy

7. COST
8. POVERTY
9. ALZHEIMER'S
10. SMOKING
11. MATERNAL AND CHILD ISSUES - including preventing Teen pregnancy
12. DENTIST
13. PRIMARY CARE PHYSICIANS
14. PREVENTION
15. PHYSICIANS - including after-hours/weekend availability
16. ACCIDENTS
17. HYPERTENSION
18. PRIORITY POPULATIONS - including children with developmental delays
19. EDUCATIONAL ATTAINMENT
20. Fraud and Abuse Programs for Seniors
21. COMPLIANCE
22. PALLIATIVE / HOSPICE
23. LUNG
24. STROKE
25. CHRONIC LOWER BACK PAIN

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

Appendix

Appendix A – Written Commentary on Prior CHNA

MCGH solicited written comments about its 2012 CHNA.[32] 17 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the MCGH. No unsolicited comments have been received.

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

Local Experts Offering Solicited Written Comments on 2012 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	2	10	12
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	9	13
3) Priority Populations	5	8	12
4) Representative / member of chronic disease group or organization	1	11	12
5) Represents the Broad Interest of the Community	10	3	13
Other			
Advanced Practice Nurse-Long time member of local healthcare community	1		1
Answered Question			17
Skipped Question			0

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

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

  - **Cancer** – Educate our community on the importance of annual preventive testing/screenings
  - **Heart Disease** – Decrease population risk factors through cultural appropriate support; and, Enhance patient awareness of heart disease and the skills needs for self-management; and, Improve cardiovascular health through work site wellness initiatives.
  - **Diabetes** – Increase awareness of prevention and control /self-management of diabetes; and, Develop relationships with organizations/ others who provide services /resources to underserved, low –income and racial/ethnic groups to provide culturally appropriate education to community members; and, Focus diabetes prevention efforts on reaching children and parents in an effort to prevent the development of the disease in children.

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

- **Comments or observations about this set of needs being the most appropriate for the MCGH to take on in seeking improvements?**
  - The three aforementioned ailments are leading health problems in most populations.
  - Primary resources however could be applied to one priority area.
  - The hospital has been involved in the community, and I believe that throwing money at the problem will not make it go away. Until the welfare mentality that produces lazy individuals that have no concern for their individual or collective well-being is fixed, these three ailments will continue to plague "Priority Populations".
  - Specific comments or observations about Cancer as being among the most significant needs for the Hospital to work on to seek improvements:
    - Education still needs to be a priority and maybe even cessation of smoking and other things that attribute to the CAUSE of cancer. I t would also benefit the community to have more available treatment available other then having these patients drive to gallatin or Lebanon for their treatment.
    - Cancer in general continues to have a great impact on individuals in the county. There is much perceived alarm and concern about the incidences locally. I'm not sure if there is as much concern however about prevention and screening.
    - No
    - None
    - I believe that several Macon County residents gets cancer so I believe more research as to why could be explored.
    - It effects a large amount of people in our community.
    - Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.
  - Specific comments or observations about Heart Disease as being among the most significant needs for the Hospital to work on to seek improvements?
    - I have recently had a friend ro die here because of heart failure. It was over the Veterans day holiday weekend. She was not feeling well but opted to wait and go to her doctor at the Hope Clinic as oppossed to going to our local hospital emergency room. i believe this contributed to her death. On Monday the veterans day holiday the Hope clinic was not open therefore she was going to wait and go to the Hope clinic on Tuesday when they were open. My belief is that she would still be alive today if she had gone to our local ER. Why did she not go it was because she trusted the Hope Clinic as her husband had kidney failuer previously and the HOPE clinic NOT our hospital was instrumental in finding him a kidney. This community is VERY loyal to the help rendered in ALL of its endeavors. In this instance I believe her loyalty cost her her life. This is indicative of HOW this community thinks.I guess

my answer to the question asked a significant NEED is to build trust in our local hospital to address the needs this community has be it cancer diabetes or Heart disease.
    - Culturally there are dietary and other barriers to overcoming heart disease in this community (inactive/overweight community). There is apathy here, as heart disease is "not as bad as cancer" and there does not seem urgency among the population to change this.
    - No
    - none
    - nutrition education and smoking cessation programs need to be easily accessible.
    - Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.
  - Specific comments or observations about Diabetes as being among the most significant needs for the Hospital to work on to seek improvements?
    - see above
    - similar here as to heart disease.
    - No
    - none
    - we have a high number of diabetics in our community.
    - Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.

4. **Comments and observations about the implementation actions of the MCGH to seek health status improvement?**
   - Specific comments and observations about the implementation actions of the Hospital seeking improvement in Cancer.
     - See above.
     - I would like more information about how/what actions were implemented.
     - No
     - None
     - continuing to stress the importance of early detection being the best fight against cancer.
     - Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.
   - Specific comments and observations about the implementation actions of the Hospital seeking improvement in Heart Disease.
     - I would like more information about how/what actions were implemented.
     - No

- None
- continue education of the population
- Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.

- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Diabetes.
  - see above
  - No
  - None
  - Due to the poor eating habits of Macon County residents, I am sure that the diabetes rate is very high. Possibly, more diabetes counseling/education could be a focus for the hospital. Although, we are sure that it is hard to change someone's diet and eating habits.
  - continue offering education programs, nutrition programs and exercise programs.
  - Improvements can always be made, but the hospital seems to be making the best improvements possible with their extremely limited resources.
  - As I have stated, promoting a healthy, working lifestyle would greatly improve the lives of the individuals that actually want improvement. Convincing people to improve will be difficult, however, as their is little incentive in our current socialist state of affairs.
  - An increased awareness of the relationship of nutrition and exercise to obesity.
  - Your questions address systems or consequences. It seems to me that the needs of the county should include a focus on the causes of these health issues: obesity, poor nutrition, smoking, lack of exercise, etc. While we need to treat serious diseases and health conditions, our county needs to promote healthier lifestyles.
  - MCGH is paramount in education of issues in the community.

5. Should the MCGH continue to allocate resources to assist improving the needs last identified?

	Cancer	Heart	Diabetes
Yes	15	15	16
No	1	1	0
No Opinion	1	1	1

6. **Within the County, do you perceive the local Priority Populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.**
    - Within the County, do you perceive the local Priority Populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.
    - There is a High population of 13-25 year olds who have issues with knowing their sexual orientation. Because of this I feel it is the underlying factor of WHY this age group has a high rate of drug and alcohol use as well as being bullied by their peers. The peer pressure on this group is the WHY as to why teen pregnancy and misuse of drugs is utilized. The schools are NOT doing enough to identify this and deal with it appropriately hense, thge numbing of drugs and suicide options..
    - Priority in our county needs to be geared to the pre teen and teen aged groups on bullying and education of drugs. The schools need to do a better job in identifying these needs
    - Educational programs to address causes and treatment of obesity, diabetes and cancer. Assistance with implementation is necessary. Must become priorities with county leadership, school system, healthcare professionals and the community at large.
    - No
    - No unique needs known.
    - I feel that our local hospital provides very adequate care to the county's population.
    - Hispanic population-Diabetes Rural area, low income population-Adult Mental Health Services Needed Lack of medical providers in Macon County-in all medical disciplines, Dental, OB, etc.
    - Yes, given the rural area we live in, such populations lack the support needed such as support groups and/or groups or organizations that one may feel welcomed or a part of. Since we do live in such a rural area, getting the needed services, transportation and/or insurance and limited to no income plays a tremendous role in the accessible services.
    - low income group; end of life care
    - Dental needs aren't always being met.
    - According to this survey, I am not a "Priority Population" so I do not wish to comment on that which I know nothing about. I personally find the definition set forth by Congress to be discriminatory and offensive.

Appendix B – Identification & Prioritization of Community Needs

Significant Need Candidate	Total Votes for Need	Point Break from Higher Ranked Need	Number of 13 Local Experts Voting for Need	Percent of votes cast	Cummulative votes cast	Determination
CANCER - 2012 SIGNIFICANT NEED	212		12	16.31%	16.31%	Significant Need
HEART DISEASE - 2012 SIGNIFICANT NEED	145	67	12	11.15%	27.46%	
MENTAL ISSUES - Including Substance Abuse	131	14	8	10.08%	37.54%	
HEALTHY LIFESTYLE PROMOTION AND EDUCATION	113	18	10	8.69%	46.23%	
DIABETES - 2012 SIGNIFICANT NEED	105	8	10	8.08%	54.31%	
OBESITY	104	1	9	8.00%	62.31%	
COST	61	43	4	4.69%	67.00%	Other Identified Need
POVERTY	55	6	6	4.23%	71.23%	
ALZHEIMER'S	53	2	6	4.08%	75.31%	
SMOKING	51	2	7	3.92%	79.23%	
MATERNAL AND CHILD ISSUES - including preventing Teen pregnancy	38	13	5	2.92%	82.15%	
DENTIST	35	3	4	2.69%	84.85%	
PRIMARY CARE PHYSICIANS	29	6	4	2.23%	87.08%	
PREVENTION	26	3	5	2.00%	89.08%	
PHYSICIANS - including after hours/weekend availability	26	0	4	2.00%	91.08%	
ACCIDENTS	25	1	3	1.92%	93.00%	
HYPERTENSION	25	0	3	1.92%	94.92%	
PRIORITY POPULATIONS - including children with developmental delays	20	5	2	1.54%	96.46%	
EDUCATIONAL ATTAINMENT	13	7	3	1.00%	97.46%	
Fraud and Abuse Programs for Seniors	10	3	1	0.77%	98.23%	
COMPLIANCE	6	4	2	0.46%	98.69%	
PALLIATIVE / HOSPICE	6	0	2	0.46%	99.15%	
LUNG	5	1	1	0.38%	99.54%	
STROKE	5	0	1	0.38%	99.92%	
CHRONIC LOWER BACK PAIN	1	4	1	0.08%	100.00%	

Individuals Participating as Local Expert Advisors[33]

Local Expert Qualification	Yes Applies to Me	No Does Not Apply to Me	No Response	Total Response
(1) Public Health - Persons with special knowledge of or expertise in public health	4	7	5	16
(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	6	6	4	16
(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.	6	6	4	16
(4) Chronic Disease Groups - Representative of or member of Chronic Disease Group or Organization, including mental and oral health.	3	8	5	16
(5) Represents the Broad Interest of the Community - Individuals, volunteers, civic leaders, medical personnel and others to fulfill the spirit of broad input required by the federal regulations.	12	2	2	16
Other (please specify)				
Senior Citizens center				
I am a concerned citizen who is grateful for our local hospital.				
FQHC				
Healthcare provider				

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

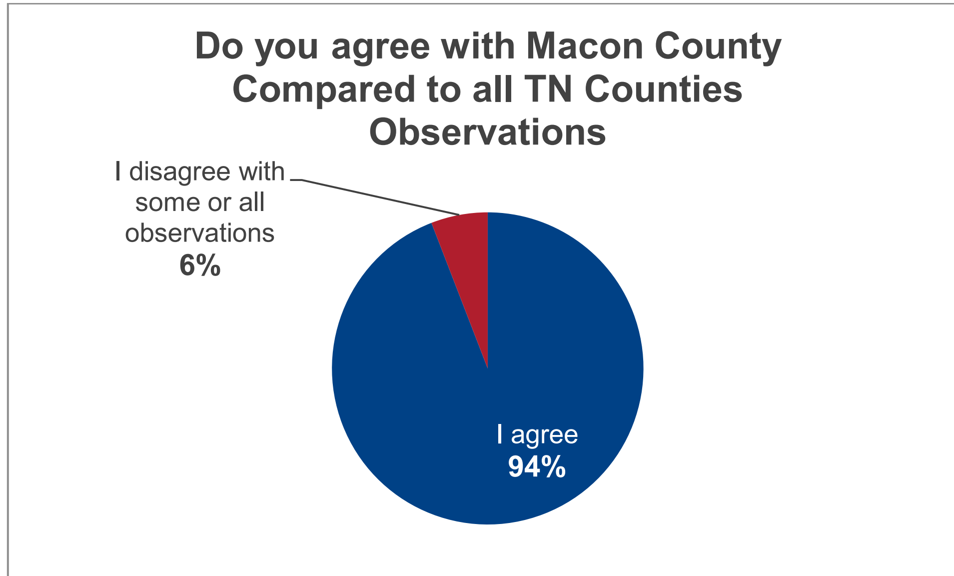
Appendix C – Advice Received from Local Expert Advisors

Question: *Within the County, do you perceive the local Priority Populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.*

Comments:

- There is a High population of 13-25 year olds who have issues with knowing their sexual orientation. Because of this I feel it is the underlying factor of WHY this age group has a high rate of drug and alcohol use as well as being bullied by their peers. The peer pressure on this group is the WHY as to why teen pregnancy and misuse of drugs is utilized. The schools are NOT doing enough to identify this and deal with it appropriately hense, thge numbing of drugs and suicide options..
- Priority in our county needs to be geared to the pre teen and teen aged groups on bullying and education of drugs. The schools need to do a better job in identifying these needs
- Educational programs to address causes and treatment of obesity, diabetes and cancer. Assistance with implementation is necessary. Must become priorities with county leadership, school system, healthcare professionals and the community at large.
- No
- No unique needs known.
- I feel that our local hospital provides very adequate care to the county's population.
- Hispanic population-Diabetes Rural area, low income population-Adult Mental Health Services Needed Lack of medical providers in Macon County-in all medical disciplines, Dental, OB, etc.
- Yes, given the rural area we live in, such populations lack the support needed such as support groups and/or groups or organizations that one may feel welcomed or a part of. Since we do live in such a rural area, getting the needed services, transportation and/or insurance and limited to no income plays a tremendous role in the accessible services.
- low income group; end of life care
- Dental needs aren't always being met.
- According to this survey, I am not a "Priority Population" so I do not wish to comment on that which I know nothing about. I personally find the definition set forth by Congress to be discriminatory and offensive.

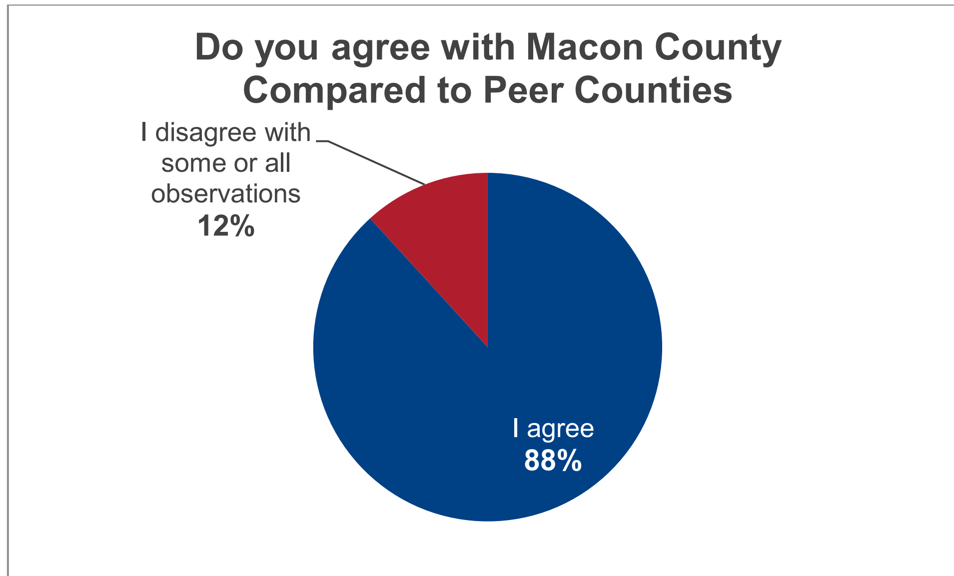
Question: Do you agree with the observations formed about the comparison of Macon to all other Tennessee counties?



Comments:

- I did not look up the exact percentages you cited on the most recent census and DOH surveys, but from my experience and previous research these numbers feel reasonable. Just make sure they have been updated to the most recent available.
- I am aware of how they classify the clinical care statistics in the county health rankings. I feel this is unfair and inaccurate in relation to the population to primary care physician. A large majority of primary care in the county is delivered by nurse practitioners. A measure of this needs to be considered.
- A particular area of need as it relates to my profession is services for youth with mental health concerns and family supports/services for children with intellectual/developmental delays, such as Autism.

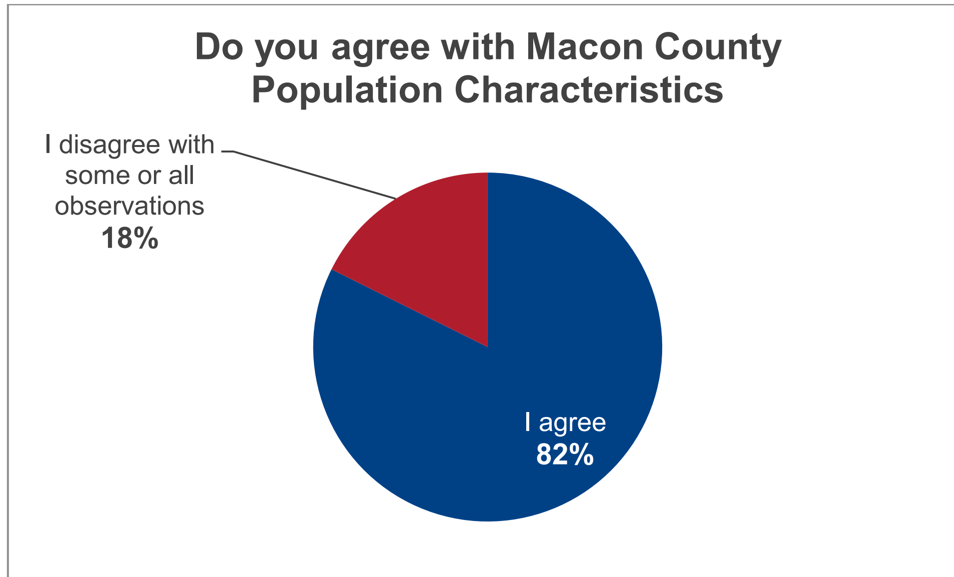
Question: *Do you agree with the observations formed about the comparison of Macon to its peer counties?*



Comments:

- You might re-check the health care access and quality stats. Are those numbers several years old? I am not sure where those statistics were pulled from, but it does seem high. HOPE has been in the county offering a sliding fee scale with office visits for as low as $30 and payment plans available for 10 years, but has seen a dramatic increase in patient visits (uninsured as well as insured) over the past two years. I am hoping that has had an impact on the percent of adults not visiting a doctor due to cost. If not, we at HOPE# must re-double our efforts.
- Additional needs that should be concerned is access to youth mental health services, including but not limited to local access mobile crisis units, programs proactively addressing suicidal behaviors in youth, and quality youth mental health care providers specializing in self-destructive behaviors, such as drug and alcohol use, teen pregnancy,and self-injurious behaviors. The CDC estimates that 1 in 68 children are on the Autism spectrum; however, resources are limited for families to have access to service providers trained in assessment and program planning for that vulnerable population. Families rely heavily on the school system as this time; however, the school system does not have the capacity (individuals trained in screening, diagnosing, implementing Applied Behavior Analysis, and supporting families through support groups) to meet the comprehensive needs of the families.

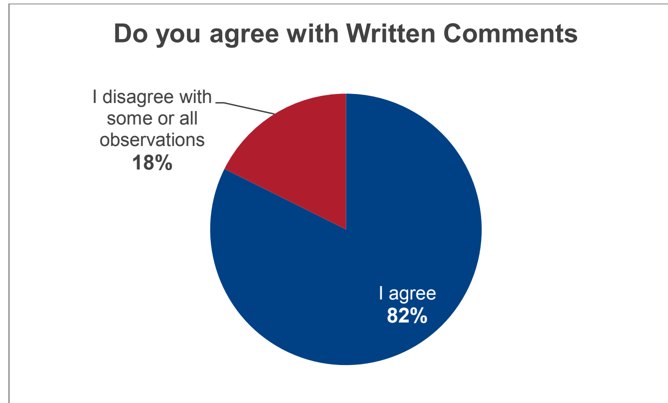
Question: *Do you agree with the observations formed about the population characteristics of Macon County?*



Comments:

- US census statistics for 2010 have pop at 22,000 figure, not 19. These stats probably just need cleaned up.
- The lack of economic opportunity within the county limits population growth.
- Lack of employers in area contributes to slower growth rate of population.
- I feel the population is higher than 22,248.
- I do not agree with the alcohol. I'm sure it is more than that!

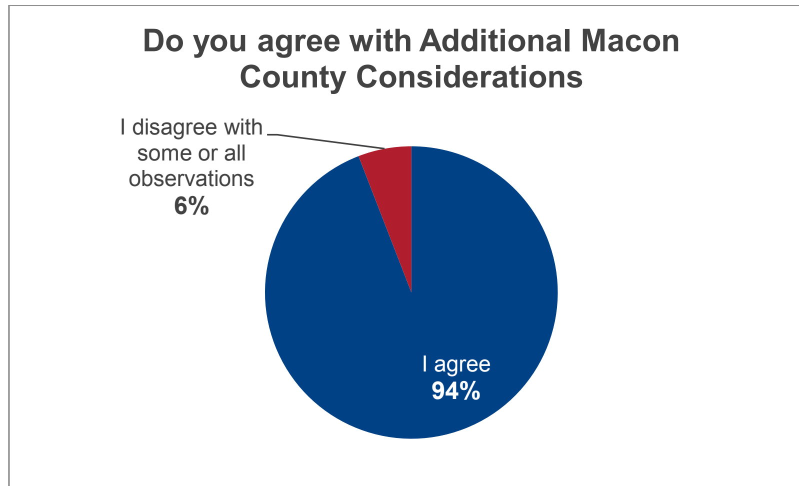
Question: *Do you agree with the observations formed about the opinions from local residents?*



Comments:

- In addition to heart, cancer and diabetes, I believe that substance use disorder (addiction) is a big issue which impacts health negatively. We need to work harder to identify patients who suffer from this disorder and refer for treatment, as well as educate the public about its dangers in a non-judging and non-stigmatizing way. . Behavioral health care is also a huge need. We do have more resources now than we did before, but the public needs to be educated about the importance of treating mental health problems and seeking this type of care needs to be normalized and affirmed rather than stigmatized. I also agree with those who stress the importance of healthy diet, exercise, and weight management. The hospital cannot do all these things, and already does a good job of working with other community providers to address them. However, there is always room for improvement and growth.
- I agree with most statements but several specific answers seem to draw from personal opinion instead of facts or statistics. The 'small town community' feel in the county is great to raise a family but lacks some key elements. Also, as one comment stated, the reason behind the stats needs to be addressed. The lack of jobs in the community is huge underlying cause of many things but has to be addressed by community leaders. The stigma associated with mental health treatment must be addressed in order for persons to obtain treatment. Lastly, additional programs or 'out of the box' approaches need to be explored to address alcohol & drugs abuse about teens/young adults as well as suicide prevention. The current approaches are not working according to statistics.
- I agree with most answers but several answers sounded very opinionated with little factual base to support the answers. Thoughts I think everyone shares are that the underlying causes of these statistics is where to start addressing the problems. The county has a great 'small town' environment, but several major 'big picture' problems exist. The lack of economic opportunities is a huge problem needing to be addressed by leaders of community. The stigma associated with receiving mental health treatment needs to be addressed to the community as well. Also 'outside the box' approaches to talking to youth about alcohol & drug abuse & suicide should be addressed. The current approach is NOT WORKING according to the stats.
- QUALITY mental health services for youth !!!!!! If possible, the hospital should work with community leaders to secure grants for youth in our community. While the hospital itself may not have the capacity to do it all, their backing, support, and collaboration could help others with a similar cause implement services.

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



Comments:

- Not sure about the Kidney related death stats....
- I do agree that self-destructive behaviors, such as alcohol and drug use and suicide, are a means to "escape". With that said, in a research study I conducted using logistic regression analyses of the Youth Risk Behavior Survey (YRBS) data, surveying over 15,000 students nationwide, hopelessness (depression) was the primary predictor of suicidal behaviors in US high school students. Adolescents who reported feeling sad or hopeless for two consecutive weeks or more were almost 6 times more likely to report having made a suicide plan as opposed the 1.5 times more likely of those reporting being bullied. Many factors beyond sexual orientation lead to depressive behaviors in youth. Our community has limited resources to help diverse populations have access to options, supports, and opportunities that build the capacity to see hope in their future. The issue extends well beyond the LGBT population as many of the suicidal attempts/and completions in MC are not from that population of youth. Also, there is a misconception in general media that there is a 1:1 positive correlation between suicide and bullying. While bullying has been identified in research as a predictor, not all youth who are bullied will commit suicide and many youth who do commit suicide have not been bullied. Yes, we should continually address bullying behaviors, particularly bullying on social media, as the 2011 YRBS indicated electronic bullying was more of a predictor that traditional bullying; however, a common thread among most suicidal behaviors is mental health. Services must be put in place to address mental health concerns and build protective factors against depression and self-destructive behaviors. Self-injurious behaviors, such as cutting and burning oneself, is another means to numb emotional pain with physical pain for a moment. Again, this is also addressed through QUALITY mental health providers. Pisani (2012) examined help-seeking behaviors among adolescents who had seriously considered suicide. The study found that the greater belief the students had in the availability and capability of adults to respond to students with help, the more likely students were to reach out to others for help when experiencing suicidal thoughts.

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

Illustrative IRS Schedule h Part V Section B (Form 990)[34]

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?**

   Suggested Answer – 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**

   Suggested Answer – 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**

      Suggested Answer – see footnotes 16 and 18 on page 13

   b. **Demographics of the community**

      Suggested Answer – see footnote 19 on page 13

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

      Suggested Answer – see footnotes 28 and 29 on pages 40 and 41

   d. **How data was obtained**

      Suggested Answer – see footnote 10 on page 9

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

      Suggested Answer – see footnote 26 on page 38

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

      Suggested Answer – see footnote 11 on page 10

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

      Suggested Answer – see footnote 33 on page 60

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

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

Suggested Answer – see footnotes 7 and 8 on pages 8 and 9

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

Suggested Answer – see footnotes 9, 12, 13 and 24 on pages 9, 11 and 18

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

Suggested Answer – No additional descriptions

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

Suggested Answer – see footnote on cover page

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

Suggested Answer – see footnotes 14 and 32 on pages 11 and 54

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**

Suggested Answer – see footnotes 3 and 6 on pages 4 and 8

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

Suggested Answer – No

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

Suggested Answer – Yes

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

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

Suggested Answer – http://www.mcgh.net/

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

Suggested Answer – No other website

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

Suggested Answer – Yes

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

Suggested Answer – No other efforts

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

   Suggested Answer – see footnotes 30 and 31 on pages 51 and 52

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

   Suggested Answer – 2012

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

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

       Suggested Answer – Yes

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

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

    Suggested Answer – see footnote 29 on page 41

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

    Suggested Answer – None incurred

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

    Suggested Answer – 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?

    Suggested Answer – Nothing to report