Daviess Community Hospital
Washington, IN

2013 Community Health Needs Assessment and Implementation Plan

Adopted by Board Resolution December 5, 2013

1 Response to Schedule H (Form 990) Part V B 2 and section 501(r)1
Dear Community Resident:

Daviess Community Hospital (DCH) welcomes you to review this document as we strive to meet the health and medical needs in our community. All not-for-profit hospitals are required to develop this report in compliance with the Affordable Care Act.

The “2013 Community Health Needs Assessment” identifies local health and medical needs and provides a plan to indicate how DCH 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, DCH, are meeting our obligations to efficiently deliver medical services.

DCH will conduct this effort at least once every three years. As you review this plan, please see if, in your opinion, we have identified the primary needs and if our intended response should make appropriate needed improvements.

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

The report is a response to a federal requirement of not-for-profit hospitals to identify the community benefit it provides in responding to documented community need. Footnotes are provided to answer specific tax form questions. For most purposes, they may be ignored. Of greater importance, however, is the potential for this report to guide our actions and the efforts of others to make needed health and medical improvements.

Please think about how to help us improve the health and medical services our area needs. I invite your response to this report. We all live and work in this community together and our collective efforts can make living here more enjoyable and healthier.

Thank You,

David Bixler
Chief Executive Officer
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EXECUTIVE SUMMARY
Executive Summary

Daviess Community Hospital ("DCH" or the "Hospital") is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of “Community Benefit” under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA assures DCH 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. 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; and
- 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.

Project Objectives

DCH partnered with Quorum Health Resources, LLC (QHR) for the following:

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

Brief 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 without means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

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3 As of the date of this report Notice of proposed rulemaking was published 6/26/2012 and available at http://federalregister.gov/a/2012-15537
4 Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice
In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- Emergency room open to all, regardless of ability to pay;
- Surplus funds used to improve patient care, expand facilities, train, etc.;
- Controlled by independent civic leaders; and
- All available and qualified physicians are privileged.

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 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 ideally downloadable from the hospital website;
- Failure to complete a CHNA in any applicable three-year period results in a penalty 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); and
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.  

This report was developed under the guidance of IRS/Treasury 2011-52 as modified by the Draft Federal Regulations published in the April 5, 2013 Federal Register.

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5 Section 6652
APPROACH
Approach

To complete a CHNA, the hospital must:

- Describe the processes and methods used to conduct the assessment;
  - Sources of data and dates retrieved;
  - Analytical methods applied;
  - Information gaps impacting ability to assess the needs; and
  - Identification of with whom the hospital collaborated.
- The proposed regulations provide that a hospital facility’s CHNA report will be considered to describe how the hospital facility took into account input if the CHNA report:
  - Summarizes, in general terms, the input provided and how and over what time period such input was provided;
  - Provides the names of organizations providing input and summarizes the nature and extent of the organization’s input; and
  - Describes the medically underserved, low income, or minority populations being represented by organizations or individuals providing input.
- Describe the process and criteria used in prioritizing health needs;
- Describe existing resources available to meet the community health needs; and
- Identify the programs and resources the hospital facility plans to commit to meeting each identified need, and the anticipated impact of those programs and resources on the health need.

QHR takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with local survey data, and resolve any data inconsistency or discrepancies from 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 to exist in their portion of the county.

Most data used in the analysis is available from public internet sources. Critical data needed to address specific regulations or developed by the individuals cooperating with us in this study is displayed in the report of the appendix. Data sources include:

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6 Response to Schedule H (Form 990) Part V B 1 i
7 Response to Schedule H (Form 990) Part V B 1 d
<table>
<thead>
<tr>
<th>Web Site or Data Source</th>
<th>Data Element</th>
<th>Date Accessed</th>
<th>Data Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.countyhealthrankings.org">www.countyhealthrankings.org</a></td>
<td>Assessment of health needs of Daviess County compared to all IN counties</td>
<td>May 23, 2013</td>
<td>2002 to 2010</td>
</tr>
<tr>
<td><a href="http://www.communityhealth.hhs.gov">www.communityhealth.hhs.gov</a></td>
<td>Assessment of health needs of Daviess County compared to its national set of “peer counties”</td>
<td>May 23, 2013</td>
<td>1996 to 2009</td>
</tr>
<tr>
<td>Truven (formerly known as Thomson) Market Planner</td>
<td>Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the contribution each group makes to the entire area; and, to access population size, trends, and socio-economic characteristics</td>
<td>May 23, 2013</td>
<td>2012</td>
</tr>
<tr>
<td><a href="http://www.capc.org">www.capc.org</a> and <a href="http://www.getpalliativecare.org">www.getpalliativecare.org</a></td>
<td>To identify the availability of Palliative Care programs and services in the area</td>
<td>May 23, 2013</td>
<td>2012</td>
</tr>
<tr>
<td><a href="http://www.caringinfo.org">www.caringinfo.org</a> and iweb.nhpco.org</td>
<td>To identify the availability of hospice programs in the county</td>
<td>May 23, 2013</td>
<td>2012</td>
</tr>
<tr>
<td><a href="http://www.healthmetricsandevaluation.org">www.healthmetricsandevaluation.org</a></td>
<td>To examine the prevalence of diabetic conditions and change in life expectancy</td>
<td>May 23, 2013</td>
<td>1989 through 2009</td>
</tr>
<tr>
<td><a href="http://www.dataplace.org">www.dataplace.org</a></td>
<td>To determine availability of specific health resources</td>
<td>May 23, 2013</td>
<td>2005</td>
</tr>
<tr>
<td><a href="http://www.cdc.gov">www.cdc.gov</a></td>
<td>To examine area trends for heart disease and stroke</td>
<td>May 23, 2013</td>
<td>2008 to 2010</td>
</tr>
<tr>
<td><a href="http://www.CHNA.org">www.CHNA.org</a></td>
<td>To identify potential needs among a variety of resource and health need metrics</td>
<td>May 23, 2013</td>
<td>2003 to 2010</td>
</tr>
<tr>
<td><a href="http://www.datawarehouse.hrsa.gov">www.datawarehouse.hrsa.gov</a></td>
<td>To identify applicable manpower shortage designations</td>
<td>May 23, 2013</td>
<td>2013</td>
</tr>
</tbody>
</table>
• We deployed a CHNA survey to local expert advisors to gain input as to local health needs and the needs of priority populations. Local expert advisors were local individuals selected to conform to the input required by Federal guidelines and regulations\(^8\).

• Information analysis augmented by local opinions from the community health needs survey showed how Daviess 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 if they believe certain population groups (or people with certain situations) need help to improve their condition, and if so, who needs to do what\(^9\).

• We received community input from 14 local expert advisors. Survey responses started Monday, May 22, 2013 and ended with the last response on June 11, 2013.

With the prior steps identifying potential community needs, the local experts participated in a structured communication technique called a Delphi method, originally developed as a systematic, interactive forecasting method that relies on a panel of experts. Experts answer questionnaires in a series of rounds. We contemplated and implemented one round as referenced during the above dates. After each round, we provided an anonymous summary of the experts’ forecasts from the previous round, as well as reasons provided for their judgments. The process encouraged experts to revise their earlier answers in light of the replies of other members of their panel. Typically, this process decreases the range of answers and moves the expert opinions toward a consensus "correct" answer. The process stops when we identify the most pressing, highest priority, community needs.

In the DCH process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and challenge conclusions developed from the data analysis. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

The proposed regulations clarify a CHNA need only identify significant health needs, and need only prioritize, and otherwise assess, those significant identified health needs. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. The determination of the break point, Significant Need as opposed to Other Need, was a qualitative interpretation by QHR and the DCH executive team where a reasonable break point in the descending rank order of votes occurred, indicated by the weight

\(^8\) Response to Schedule H (Form 990) Part V B 1 h; complies with 501(r)(3)(B)(i)

\(^9\) Response to Schedule H (Form 990) Part V B 1 f
amount of points each potential need received and the number of local experts allocating any points to the need. Our criteria included the Significant Needs had to represent a majority of all cast votes. The Significant Needs also needed a plurality of Local Expert participation. When presented to the DCH executive team, the dichotomized need rank order (Significant vs. Other) identified which needs the hospital needed to focus upon in determining where and how it was to develop an implementation response.¹⁰

¹⁰ Response to Schedule H (Form 990) Part V Section B 6 g, h and Part V B 1 g
FINDINGS
Findings

Definition of Area Served by the Hospital Facility\textsuperscript{11}

DCH, in conjunction with QHR, defines its service area as Daviess County in Indiana, which includes the following ZIP codes:

\begin{itemize}
  \item 47501 Washington
  \item 47519 Cannelburg
  \item 47529 Elnora
  \item 47558 Montgomery
  \item 47562 Odon
  \item 47568 Plainville
\end{itemize}

In 2011, the hospital received 64\% of its patients from this area\textsuperscript{12}.

\textsuperscript{11} Responds to IRS Form 990 (h) Part V B 1 a
\textsuperscript{12} Truven MEDPAR patient origin data for the hospital; Responds to IRS Form 990 (h) Part V B 1 a
Demographic of the Community

The 2013 population for Daviess County is estimated to be 31,466 and expected to increase at a rate of 3.3%. This is higher than the 1.7% projected IN growth, but on pace with the 3.3% national growth. Daviess County anticipates a population of 32,500 by 2018.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2013 median age for the county is 33.2 years, which is younger than the state median age (39.3 years), and the national median age (41 years). The 2013 median household income for the area is $47,177 which is higher than the state median income of $44,914, but lower than the national median income of $48,374. Median household wealth value is above both the national and the state values. The median home values for the area is $111,418 which is lower than the national and state values. Daviess County’s unemployment rate as of March, 2013 was 6.5%, which is better than the 8.7% statewide and 7.6% national civilian unemployment rates.

The portion of the population in the county over 65 is 14.8%, above the state average. The portion of the population of women of childbearing age is 17.7%, below the state average of 19.6% and national average of 19.8%. 0.6% of the population is Black non-Hispanic and 93% is White non-Hispanic. The Hispanic population comprises 4.8% of the total.

13 Responds to IRS Form 990 (h) Part V B 1 b
14 All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
15http://research.stlouisfed.org/fred2/graph/?g=iVY
The population also was 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 discern the following table of probable lifestyle and medical conditions present in the population. Items with red text are viewed as statistically important, potentially adverse findings. Items with blue text are viewed as statistically important, potential beneficial findings. Items with black text are viewed as either not statistically different from the national normal situation, or not considered either favorable or unfavorable in our use of the information.
<table>
<thead>
<tr>
<th>Health Service Topic</th>
<th>Demand as % of National</th>
<th>% of Population Affected</th>
<th>Health Service Topic</th>
<th>Demand as % of National</th>
<th>% of Population Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight / Lifestyle</td>
<td></td>
<td></td>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI: Morbid/Obese</td>
<td>112.1%</td>
<td>26.6%</td>
<td>Routine Screen: Cardiac Stress 2yr</td>
<td>89.3%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Vigorous Exercise</td>
<td>95.7%</td>
<td>46.6%</td>
<td>Chronic High Cholesterol</td>
<td>96.4%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Chronic Diabetes</td>
<td>113.4%</td>
<td>11.6%</td>
<td>Routine Cholesterol Screening</td>
<td>92.0%</td>
<td>46.7%</td>
</tr>
<tr>
<td>Healthy Eating Habits</td>
<td>88.8%</td>
<td>26.3%</td>
<td>Chronic High Blood Pressure</td>
<td>107.8%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Very Unhealthy Eating Habits</td>
<td>116.0%</td>
<td>3.2%</td>
<td>Chronic Heart Disease</td>
<td>114.4%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Behavior</td>
<td></td>
<td></td>
<td>Routine Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Will Travel to Obtain Medical Care</td>
<td>96.8%</td>
<td>28.8%</td>
<td>FP/GP: 1+ Visit</td>
<td>103.6%</td>
<td>91.5%</td>
</tr>
<tr>
<td>I Follow Treatment Recommendations</td>
<td>92.7%</td>
<td>37.3%</td>
<td>Used Midlevel in last 6 Months</td>
<td>104.5%</td>
<td>43.7%</td>
</tr>
<tr>
<td>I Am Responsible for My Health</td>
<td>95.5%</td>
<td>61.3%</td>
<td>OB/Gyn 1+ Visit</td>
<td>88.1%</td>
<td>49.9%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td></td>
<td></td>
<td>Ambulatory Surgery last 12 Months</td>
<td>104.2%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td>Internet Usage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic COPD</td>
<td>107.6%</td>
<td>4.6%</td>
<td>Tobacco Use: Cigarettes</td>
<td>110.2%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Chronic Allergies</td>
<td>105.0%</td>
<td>24.6%</td>
<td>Used Internet to Talk to MD</td>
<td>74.0%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td>Facebook Opinions</td>
<td>87.4%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Mammography in Past Yr</td>
<td>95.2%</td>
<td>43.2%</td>
<td>Looked for Provider Rating</td>
<td>87.5%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Cancer Screen: Colorectal 2 yr</td>
<td>91.6%</td>
<td>22.8%</td>
<td>Misc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Screen: Pap/Cerv Test 2 yr</td>
<td>91.4%</td>
<td>55.0%</td>
<td>Charitable Contrib: Hosp/Hosp Sys</td>
<td>92.7%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Routine Screen: Prostate 2 yr</td>
<td>97.7%</td>
<td>31.2%</td>
<td>Charitable Contrib: Other Health Org</td>
<td>89.3%</td>
<td>34.8%</td>
</tr>
<tr>
<td>Orthopedic</td>
<td></td>
<td></td>
<td>Emergency Room Use</td>
<td>102.7%</td>
<td>34.0%</td>
</tr>
<tr>
<td>Chronic Lower Back Pain</td>
<td>100.3%</td>
<td>24.7%</td>
<td>Urgent Care Use</td>
<td>98.6%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Chronic Osteoporosis</td>
<td>106.0%</td>
<td>10.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Leading Causes of Death

<table>
<thead>
<tr>
<th>IN Rank</th>
<th>Daviess Co. Rank</th>
<th>Condition</th>
<th>Rank among all counties in IN (#1 rank = worst in state)</th>
<th>Rate of Death per 100,000 age adjusted</th>
<th>IN</th>
<th>Daviess Co.</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Heart Disease</td>
<td>30 of 92</td>
<td>195.0</td>
<td></td>
<td>237.4</td>
<td>As expected</td>
</tr>
<tr>
<td>2,10,12,15,23,26, 28,29,30,32,35, 36,38,41</td>
<td>2</td>
<td>Cancer</td>
<td>90 of 92</td>
<td>190.8</td>
<td></td>
<td>169.2</td>
<td>As expected</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>Stroke</td>
<td>3 of 92</td>
<td>43.5</td>
<td></td>
<td>75.7</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>18, 22, 27</td>
<td>4</td>
<td>Accidents</td>
<td>36 of 92</td>
<td>39.3</td>
<td></td>
<td>47.2</td>
<td>As expected</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>Diabetes</td>
<td>2 of 92</td>
<td>24.0</td>
<td></td>
<td>46.6</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>Lung</td>
<td>69 of 92</td>
<td>55.3</td>
<td></td>
<td>45.8</td>
<td>As expected</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>Kidney</td>
<td>5 of 92</td>
<td>21.0</td>
<td></td>
<td>29.3</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>Alzheimer's</td>
<td>80 of 92</td>
<td>26.8</td>
<td></td>
<td>15.9</td>
<td>Lower than expected</td>
</tr>
<tr>
<td>9</td>
<td>9</td>
<td>Flu - Pneumonia</td>
<td>69 of 92</td>
<td>17.1</td>
<td></td>
<td>15.4</td>
<td>Lower than expected</td>
</tr>
<tr>
<td>14</td>
<td>10</td>
<td>Blood Poisoning</td>
<td>38 of 92</td>
<td>12.1</td>
<td></td>
<td>11.8</td>
<td>As expected</td>
</tr>
<tr>
<td>11</td>
<td>11</td>
<td>Hypertension</td>
<td>11 of 92</td>
<td>6.6</td>
<td></td>
<td>10.4</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>13</td>
<td>12</td>
<td>Suicides</td>
<td>79 of 92</td>
<td>12.8</td>
<td></td>
<td>9.0</td>
<td>As expected</td>
</tr>
<tr>
<td>21</td>
<td>13</td>
<td>Liver</td>
<td>53 of 91</td>
<td>7.9</td>
<td></td>
<td>6.6</td>
<td>Lower than expected</td>
</tr>
<tr>
<td>24</td>
<td>14</td>
<td>Parkinson's</td>
<td>73 of 92</td>
<td>7.1</td>
<td></td>
<td>5.0</td>
<td>As expected</td>
</tr>
<tr>
<td>31</td>
<td>15</td>
<td>Homicide</td>
<td>70 of 86</td>
<td>5.4</td>
<td></td>
<td>1.4</td>
<td>Lower than expected</td>
</tr>
</tbody>
</table>
Primary and Chronic Disease Needs and Health Issues of Uninsured Persons, Low-Income Persons, and Minority Groups

Some information is available to describe the size and composition of various uninsured persons, low income persons, minority groups, and other vulnerable population segments. Specific studies identifying needs of such groups, distinct from the general population at a county unit of analysis, are not readily available from secondary sources.

The National Healthcare Disparities Report results from a Congressional directive to the Agency for Healthcare Research and Quality (AHRQ). This production is an annual report to track disparities related to "racial factors and socioeconomic factors in priority populations." The emphasis is on disparities related to race, ethnicity, and socioeconomic status. The directive includes a charge to examine disparities in "priority populations," which are groups with unique healthcare needs or issues that require special attention\(^{16}\).

Nationally, this report observes the following trends:

- Measures for which Blacks were worse than Whites and are getting better:
  - Diabetes – Hospital admissions for short-term complications of diabetes per 100,000 population;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over; and
  - Functional Status Preservation and Rehabilitation. Female Medicare beneficiaries age 65 and over, who reported ever being screened for osteoporosis with a bone mass or bone density measurement.

- Measures for which Blacks were worse than Whites and staying the same:
  - Cancer – Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over; breast cancer deaths per 100,000 female population per year; adults age 50 and over who ever received colorectal cancer screening; colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over; colorectal cancer deaths per 100,000 population per year;
  - Diabetes – Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes;
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year; Children ages 19-35 months who received all recommended vaccines;
  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months; people age 12 and over treated for substance abuse who completed treatment course;

\(^{16}\) http://www.ahrq.gov/qual/nhdr10/Chap10.htm 2010
Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;

Supportive and Palliative Care – High-risk long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;

Timeliness – Adults who needed immediate care for an illness, injury, or condition in the last 12 months, who received care as soon as they wanted; emergency department visits where patients left without being seen; and

Access – People with a usual primary care provider; people with a specific source of ongoing care.

Measures for which Asians were worse than Whites and getting better:

Cancer – Adults age 50 and over who ever received colorectal cancer screening; and

Patient Safety – Adult surgery patients who received appropriate timing of antibiotics.

Measures for which Asians were worse than Whites and staying the same:

Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and

Access – People with a usual primary care provider.

Measures for which American Indians and Alaska Natives were worse than Whites for the most recent year and staying the same:

Heart Disease – Hospital patients with heart failure who received recommended hospital care;

HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;

Respiratory Diseases – Hospital patients with pneumonia who received recommended hospital care;

Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement;

Supportive and Palliative Care – Hospice patients who received the right amount of medicine for pain; high-risk, long-stay nursing home residents with pressure sores; adult home healthcare patients who were admitted to the hospital; and
• Access – People under age 65 with health insurance.

• Measures for which American Indians and Alaska Natives were worse than Whites for the most recent year and getting worse:
  o Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  o Patient safety – Adult surgery patients who received appropriate timing of antibiotics.

• Measures for which Hispanics were worse than non-Hispanic Whites for the most recent year and getting better:
  o Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;
  o Lifestyle Modification – Adult current smokers with a checkup in the last 12 months who received advice to quit smoking; adults with obesity who ever received advice from a health provider about healthy eating; and
  o Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.

• Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and staying the same:
  o Cancer – Women age 40 and over who received a mammogram in the last two years; adults age 50 and over who ever received colorectal cancer screening;
  o Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
  o Heart Disease – Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge; hospital patients with heart failure who received recommended hospital care;
  o HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  o Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months;
  o Respiratory Disease – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
  o Lifestyle Modification – Adults with obesity who ever received advice from a health provider to exercise more;
- Supportive and Palliative Care – Long-stay nursing home residents with physical restraints; high-risk, long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
- Patient Safety – Adult surgery patients who received appropriate timing of antibiotics;
- Timeliness – Adults who needed care right away for an illness, injury, or condition in the last 12 months and got care as soon as wanted;
- Patient Centeredness – Adults with ambulatory visits who reported poor communication with health providers; children with ambulatory visits who reported poor communication with health providers; and
- Access – People under age 65 with health insurance; people under age 65 who were uninsured all year; people with a specific source of ongoing care; people with a usual primary care provider; people unable to get or delayed in getting needed care due to financial or insurance reasons.

- Measures for which Hispanics were worse than non-Hispanic Whites for the most recent year and getting worse:
  - Maternal and Child Health – Children ages 3-6 who ever had their vision checked by a health provider.

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 to identify unique population needs to which we should respond. The expert panel of advisors agreed that there were special need populations summarized as follows:\footnote{All comments and the analytical framework behind developing this summary appear in Appendix A. Responds to IRS Schedule H (form 990) Part V B 1.}

- Children living in poverty (39.5)
- Affordability is a barrier to care access, especially for children and access to dental care
Statistical information about special populations follows:

**Access to Care: Daviess County, IN**

In addition to use of services, access to care may be characterized by medical care coverage and service availability.

- **Uninsured individuals (age under 65)**\(^1\) 4,420
- **Medicare beneficiaries**\(^2\)
  - **Elderly (Age 65+)** 3,995
  - **Disabled** 791
- **Medicaid beneficiaries**\(^2\) 5,261
- **Primary care physicians per 100,000 pop**\(^2\) 29.9
- **Dentists per 100,000 pop**\(^2\) 19.9
- **Community/Migrant Health Centers**\(^3\) No
- **Health Professional Shortage Area**\(^3\) No

*nda No data available.*

\(^2\) HRSA. Area Resource File, 2008.
\(^3\) HRSA. Geospatial Data Warehouse, 2009.

**Vulnerable Populations: Daviess County, IN**

Vulnerable populations may face unique health risks and barriers to care, requiring enhanced services and targeted strategies for outreach and case management.

**Vulnerable Populations Include People Who**\(^1\)

- Have no high school diploma (among adults age 25 and older) 5,447
- Are unemployed 577
- Are severely work disabled 733
- Have major depression 1,919
- Are recent drug users (within past month) 2,020

*nda No data available.*

\(^1\) The most current estimates of prevalence, obtained from various sources (see the Data Sources, Definitions, and Notes for details), were applied to 2008 mid-year county population figures.
Findings

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

Conclusions from Public Input to Community Health Needs Assessment

- The hospital conducted a Community Health Needs Survey in 2013 inviting Daviess County and Surrounding Areas to participate. 484 individuals responded. 31.2% were Males and 68.8% were females. The age breakdown was: under 55, 54.5%, 55-64, 27.1% and 65+, 18.6%. Survey participants gave their opinion about medical and mental health issues in the community. The following were identified as major issues:
  - Teen birth rates/teen pregnancy, 259 individuals, 54.4% of respondents;
  - Mental health issues such as depression, anxiety, grief, stress with divorce and custody issues and bipolar disorder 266 individuals, 55.6% of respondents;
  - People making unhealthy food choices, 285 individuals, 59.9% those responding;
  - Not having health insurance, 299 individuals, 62.7% of those responding;
  - Heart disease, 248 individuals, 52.2% of those responding;
  - Diabetes, 242 individuals, 50.8%; and
  - Cancer, 305, 63.8% of those responding.
- The respondents identified the following as Moderate issues:
  - Childhood vaccination;
  - Sexually transmitted disease;
  - Suicide deaths;
  - Eating disorders; and
  - Flu/Pneumonia.

Summary of Observations from Daviess County Compared to All Other State Counties, in Terms of Community Health Needs

- In general, Daviess County residents are about average health for state;
- In a health status classification termed “Health Outcomes,” the County ranks 58th among 92 counties (best being #1). On measures of morbidity and mortality, Daviess County performs better than state averages, but worse than national benchmarks for premature death (Death before age 75) and low birth weight. Daviess County performs worse than the state averages for poor or fair health, poor physical health days, and poor mental health days.
• In another health status classification "Health Factors," Daviess County fares slightly better, ranking 45th among the 92 counties. Clinical care measures on the supply of primary care physicians and dentists, preventable hospital stays, diabetic screening, and mammography screening are below the State average and National benchmarks. Conditions where improvement remains to achieving state average rates and then national goals include:
  o Adult smoking;
  o Adult obesity;
  o Uninsured;
  o Some college attainment; and
  o Daily fine particulate matter.

Summary of Observations from Daviess County 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 Daviess County is compared to its national set of peer counties and compared to national rates make the following observations:

UNFAVORABLE – observations occurring at rates worse than national AND worse than among peers:
  • No Care in First Trimester;
  • Infant Mortality;
  • White non Hispanic Infant Mortality;
  • Neonatal Infant Mortality;
  • Post-neonatal Infant Mortality; and
  • Stroke.

SOMEWHAT A CONCERN – observations because occurrence is EITHER above national average or above peer group average:
  • Breast Cancer (Female);
  • Lung Cancer;
  • Motor Vehicle Injuries;
  • Low Birth Weight (<2500 g);
  • Premature Births (<37 weeks); and
  • Unintentional Injury.
BETTER PERFORMANCE – better than peers and national rates:

- Very Low Birth Weight (<1500 g);
- Births to Women under 18;
- Births to Women age 40-54;
- Births to Unmarried Women;
- Colon Cancer;
- Coronary Heart Disease; and
- Suicide.
Conclusions from the Demographic Analysis Comparing Daviess County to National Averages

Daviess County in 2013 comprises 31,466 residents. During the next five years, it is expected to see a population increase of 3.3% to achieve 32,500 residents. This is higher than the anticipated state growth (1.7%), but on pace with the national growth (3.3%). The population is younger and has a higher median income than the state, but lower than the national comparisons. 14.8% of the population is age 65 or older, higher than IN. 0.6% are non-Hispanic White, Asian, and Pacific Island origin; Hispanics constitute 4.8% of the population; Blacks comprise 0.6% of the population; Whites 93%. Females ages 15 to 44 comprise 17.7% of the population, less than the percentage in Indiana (19.6%) or the nation (19.8).

The following areas were identified comparing the county to national averages. Metrics impacting more than 30% of the population and that are statistically significantly different from the national average:

- Pap/Cervix Screening was 8.6% below average, impacting 55% – an adverse finding;
- Routine Cholesterol Screening was 8% below average, impacting 46.7% – an adverse finding;
- OB/GYN 1+ Visit was 11.9% below average, impacting 40.9% – an adverse finding;
- Compliance with Treatment Recommendation was 7.3% below average, impacting 37.3% – an adverse finding; and
- Tobacco Use: Cigarettes was 19.2% above average, impacting 30.9% – an adverse finding.

Situations and conditions statistically significantly different from the national average, but impacting less than 30% of the population include:

- BMI: Morbid/Obese was 12.1% above average, impacting 28.6% – an adverse finding;
- Chronic High Blood Pressure was 7.8% above average, impacting 28.3% – an adverse finding;
- Healthy Eating Habits was 11.2% below average, impacting 26.3% – an adverse finding;
- Chronic Lower Back Pain was 9.3% above average, impacting 24.7% – an adverse finding;
- Chronic Allergies was 5.9% above average, impacting 24.5% – an adverse finding;
- Cancer Screen: Colorectal 2 year was 8.2% below average, impacting 22.8% – an adverse finding;
- Routine Screen: Cardiac Stress 2 years was 10.7% below average, impacting 13.9% – an adverse finding;
- Chronic Diabetes was 13.4% above average, impacting 11.8% – an adverse finding;
- Chronic Osteoporosis was 5.9% above average, impacting 10.3% – an adverse finding;
- Chronic Heart Disease was 14.4% above average, impacting 9.5% – an adverse finding;
- Chronic COPD was 7.6% above average, impacting 4.6% – an adverse finding; and
- Very Unhealthy Eating Habits was 16% above average, impacting 3.2% – an adverse finding.

**Key Conclusions from Consideration of the Other Statistical Data Examinations**

Additional observations of Daviess County found:

- Palliative Care programs (programs focused not on curative actions but designed to relieve disease symptoms pain and stress arising from serious illness) do not exist in the county; and
- Hospice: three programs exist in the county.

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

- Heart Disease #1 cause of death statewide and in County – 237.4/100,000 ranking #30 among 92 IN Counties;
- Cancer #2 cause of death statewide and in County – 169.2/100,000 ranking #90 IN County;
- Stroke #3 cause of death in County, statewide #4 – 75.7/100,000 ranking #3 IN County - significantly higher than expected;
- Accidents #4 cause of death in County, statewide #18 – 47.2/100,000 ranking #36 IN County;
- Diabetes #5 cause of death in County, statewide #7 – 46.6/100,000 ranking #2 IN County – significantly higher than expected;
- Lung Disease #6 cause of death in County, statewide #3 – 45.8/100,000 ranking #69 IN County;
- Kidney Disease #7 cause of death in County, statewide #8 – 29.3/100,000 ranking #5 IN County - significantly higher than expected;
- Alzheimer's #8 cause of death in County, statewide #6 – 15.9/100,000 ranking #80 IN County – significantly lower than expected;
- Flu-Pneumonia #9 cause of death statewide and in County – 15.4/100,000 ranking #69 IN County – significantly lower than expected;
- Blood Poisoning #10 cause of death in County, statewide #14 – 11.8/100,000 ranking #38 IN County; and
- Among other leading causes of death, Hypertension is significantly higher than expected.
Liver Disease and Homicide are lower than expected.
The incident of Heart Disease death is above national averages, but below state averages. The incident of Stroke deaths is well above both state and national averages. Diabetes is above state average.

- Life expectancy for Daviess County males in 1989 was 71.3 years, 3.1 years behind the top counties, improving in 2009 to 74.4 years, 4.8 years behind the top counties; and
- Life expectancy for Daviess County females in 1989 was 79.1 years, 1.1 years behind the top counties, improving in 2009 to 77.6 years, 3.3 years behind the top counties.
EXISTING HEALTH CARE FACILITIES, RESOURCES AND IMPLEMENTATION PLAN
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 Daviess Community Hospital\(^{18}\). The following list includes:

- 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 DCH current efforts responding to the need;
- Establishes the Implementation Plan programs and resources DCH will devote to attempt to achieve improvements;
- Documents the Leading Indicators DCH will use to measure progress;
- Presents the Lagging Indicators DCH 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, DCH is the major hospital in the service area. DCH is a 37 bed, acute care medical facility located in Washington, IN. The next closest facilities are outside the service area and include:

- Good Samaritan Hospital – 172 bed acute care medical facility in Vincennes, IN; 23.9 miles away from Washington (33 minutes);
- Memorial Hospital and Health Care Center – 85 bed acute care medical facility in Jasper, IN; 26.4 miles away from Washington, IN (36 minutes); and
- Greene County General Hospital – 20 bed critical access hospital in Linton, IN; 38.1 miles away from Washington, IN (51 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 DCH Implementation Plan utilizes “Leading Indicators”. Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading

\(^{18}\) Response to IRS Form 990 h Part V B 1 c
Indicators also must be within the ability of the hospital to influence and measure.

**Significant Needs**

1. **Sexual/Reproductive Health/Child Health** – Teen birth rate higher than Indiana as a whole, identified by Community Survey Participants as a major concern. The teen birth rate for Daviess County is 47 Teen births/1,000 females ages 15-19. This is higher than the State of Indiana (41) and the National Benchmark 21 /1,000. Prenatal care in the first trimester of pregnancy is 22% below average.

   **Problem Statement:** The teen birth rate should be decreased.

   **DCH Services Available to Respond to this Need Include:**
   
   - The hospital has an active Obstetrical Service and the OB provider staff actively participates in the hospitals OB committee.

   **DCH Implementation Plan Programmatic Initiatives:**
   
   - The hospital will be the catalyst for and with Community Health Partners develop a program similar to the “Baby Think It Over” program; and
   - Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how DCH services can benefit their initiatives. DCH will initiate efforts by contacting each organization through the Health Partners Advisory Group for effort collaboration.

   **Anticipated Results from DCH Implementation Plan**
   
   - The teen birth rate will decline.

   **Leading Indicator DCH Will Use to Measure Progress:**
   
   - Numbers participating in the program. Currently 0.

   **Lagging Indicators DCH Will Use to Identify Improvement**
   
   - The teen pregnancy rate which is currently 47/1,000 female population ages 15 to 19.

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**Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy Care Center</td>
<td>705 Troy Rd, Washington, IN 47501, Ph: (812) 257-1041</td>
</tr>
<tr>
<td>Washington Community Schools</td>
<td>301 East South Street, Washington, IN 47501, Ph: (812) 254-5536</td>
</tr>
<tr>
<td>Washington Catholic Schools</td>
<td>201 N.E. Second Street, Washington, IN 47501, Ph: (812) 254-2050</td>
</tr>
</tbody>
</table>

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19 The services listed as currently available and the programmatic initiatives are presented in priority order corresponding to each Significant need and respond to IRS Form 990 h Part V B 6 h
2. Physicians – There is a shortage of providers in the community.

Problem Statement: The physician provider ratio to population is lower than Indiana and National rates. Daviess County primary care ratio per population is 1 to 2,884 population, Indiana 1 to 1,577 population and the U.S. benchmark is 1 to 1,067 ratio. The community survey identified access to dental care, especially for poor children, as a concern. The county is a designated health professions shortage area.

DCH Services available to respond to this need include:

- The hospital undertook a Medical Staff Development Plan in 2012 to determine what specialty and how many providers are required to provide access to care and has an ongoing recruitment effort.

DCH Implementation Plan programmatic initiatives:

- Recruitment of needed providers;
- Work with dental providers and the Community Health Partners Advisory Group to investigate having dental screening at the Bethel Mall Fair; and
- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how DCH services can benefit their initiatives. DCH will initiate efforts by contacting each organization for effort collaboration.

Anticipated results from DCH implementation plan:

- The number of providers will increase and provide increased access to care.

Leading Indicator DCH will use to measure progress:

- Number of Providers interviewed or who have a site visit.
LAGGING INDICATORS DCH WILL USE TO IDENTIFY IMPROVEMENT

- The primary care physician provider population ratio will increase. It is currently 1 primary care provider per 2,884 population.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:

| Economic Development Corporation, 219 E Main Street, PO Box 191, Washington, IN 47501, Ph: (812) 254-1500 |
| Washington Community Schools, 301 East South Street, Washington, IN 47501, Ph: (812) 254-5536 |
| Daviess Community Hospital Medical Staff, Addresses and Phone numbers available at: http://www.dchosp.com |

3. Drug Use – Drug Abuse was cited as a problem by the Community Survey. Heavy drinkers are a higher percentage of the population than state and national rates.

Problem Statement: Drug and substance abuse should be reduced.

DCH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- The hospital treats drug and substance abuse patients in the emergency department. Patients are admitted for detoxification and referral to treatment facilities and programs.

DCH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- The hospital will implement the “New Visions” drug and alcohol treatment program; and
- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how DCH services can benefit their initiatives. DCH will initiate efforts by contacting each organization through the Health Partners Advisory Group for effort collaboration.

ANTICIPATED RESULTS FROM DCH IMPLEMENTATION PLAN

- Drug and substance abuse will decrease.

LEADING INDICATOR DCH WILL USE TO MEASURE PROGRESS:

- Numbers of patients referred to the “New Visions” treatment program. Currently zero (0).

LAGGING INDICATORS DCH WILL USE TO IDENTIFY IMPROVEMENT

- The number of Daviess County individuals needing alcohol and or drug treatment in the past year (7%); and
- The number in Daviess County who have abused drugs in the past year (6%).

Source: Indiana Adult Household Survey: Daviess County
Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Address/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Medical Staff Offices</td>
<td>Available at: <a href="http://www.dchosp.com">http://www.dchosp.com</a></td>
</tr>
<tr>
<td>Purdue University Cooperative Extension Service, Daviess County Office</td>
<td>214 N.E. Third St., Washington, IN Ph: (812) 254-8668</td>
</tr>
<tr>
<td>First Steps 4 Rivers Resources</td>
<td>2212 East National Highway, Washington, IN 47501, Ph: (812) 254-4471</td>
</tr>
<tr>
<td>United Way Mailing Address</td>
<td>P.O. Box 224, Washington, IN 47501, Physical Address: 200 East Van Trees, Washington, IN 47501, Ph: (812) 254-1038</td>
</tr>
<tr>
<td>Daviess County Family YMCA</td>
<td>405 NE 3rd Street, Washington, IN 47501, Ph: (812) 254-4481</td>
</tr>
<tr>
<td>Lighthouse Recovery Center</td>
<td>1276 E. 250 N. Washington, IN 47501, Ph: (812) 254-0113.</td>
</tr>
<tr>
<td>Daviess Community Hospital Medical Staff Addresses and Phone numbers</td>
<td>available at: <a href="http://www.dchosp.com">http://www.dchosp.com</a></td>
</tr>
<tr>
<td>Daviess County Sheriff’s Department</td>
<td>101 NE 4th St., Washington, IN 47501, Ph: (812) 687-7200</td>
</tr>
<tr>
<td>Washington Police Department</td>
<td>101 NE 3rd St., Washington, IN 47501, Ph: (812) 254-4410</td>
</tr>
<tr>
<td>Southwest Indiana Methamphetamine Alliance</td>
<td>11660 N, 700 E., Odon IN 47562, Ph: (812) 787-1668</td>
</tr>
<tr>
<td>Washington Community Schools</td>
<td>301 East South Street, Washington, IN 47501, Ph: (812) 254-5536</td>
</tr>
</tbody>
</table>

### 4. Obesity/Overweight

Obesity was cited as a major problem in the Community Survey. The rate of obesity is 10% above the national average; healthy eating habits 22% below average.

**Problem Statement:** Obesity should be reduced.

**DCH Services Available to Respond to This Need Include:**

- The hospital dietician provides consultation to promote healthy eating habits and diabetic programs that are open to the public.
- Casey Persohn, DCH’s registered dietitian, spearheaded a campaign to help hospital employees find better health and improved wellness. Her search for a dynamic, entertaining and effective employee wellness program led her to a program called DIET FREE. A ten-week video seminar program that focuses on nutrition, fitness, and healthy lifestyle changes; and
- DCH sponsored a session of DIET FREE at a community-wide program on Thursday, September 6, 2013, at the Washington High School Auditorium.
DCH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- The hospital will investigate the POSE surgical procedure for weight loss;
- The hospital will implement the “Healthy Choices” healthy eating habits and lifestyle program in cooperation with Purdue Extension and the schools; and
- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how DCH services can benefit their initiatives. DCH will initiate efforts by contacting each organization through the Health Partners Advisory Group for effort collaboration.

ANTICIPATED RESULTS FROM DCH IMPLEMENTATION PLAN

- A reduction in the percentage of the population that is obese.

LEADING INDICATOR DCH WILL USE TO MEASURE PROGRESS:

- The number of participants in the “Healthy Choices” program. Currently zero (0).

LAGGING INDICATORS DCH WILL USE TO IDENTIFY IMPROVEMENT

- The percentage of obese in the Daviess County Population health indicator, measured by BMI: Morbid/Obese was 12.1% above the national average. Source:
  
  http://assessment.communitycommons.org

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington Community Schools</td>
<td>301 East South Street Washington, IN 47501</td>
<td>(812) 254-5536</td>
</tr>
<tr>
<td>Physician Medical Staff Offices</td>
<td>Available at: <a href="http://www.dchosp.com">http://www.dchosp.com</a></td>
<td></td>
</tr>
<tr>
<td>Purdue University Cooperative Extension Service</td>
<td>Daviess County Office, 214 N.E. Third St., Washington, IN</td>
<td>(812) 254-8668</td>
</tr>
<tr>
<td>United Way Mailing Address</td>
<td>P.O. Box 224, Washington, IN 47501, Washington, IN</td>
<td>(812) 254-1038</td>
</tr>
<tr>
<td>Daviess County Family YMCA</td>
<td>405 NE 3rd Street, Washington, IN 47501</td>
<td>(812) 254-4481</td>
</tr>
<tr>
<td>Anytime Fitness</td>
<td>16 Cherry Tree Plaza, Washington, IN 47501</td>
<td>(812) 254-2200</td>
</tr>
<tr>
<td>Dr. Linda Callaghan</td>
<td>2108 State Street, Washington, IN 47501</td>
<td>(812) 254-8886</td>
</tr>
<tr>
<td>Senior &amp; Family Services, Inc. “Fitness For You”</td>
<td>211 E. Main St., Washington, IN 47501</td>
<td>(812) 254-1881</td>
</tr>
</tbody>
</table>

5. Affordability – Cited as a major concern in the community health needs survey.
**Problem Statement:** Affordability of healthcare is a problem.

**DCH services available to respond to this need include:**

- DCH charges are low when price comparison with other hospitals is done;
- DCH negotiates with the Amish Community for hospital services; and
- The hospital financial assistance practice works with individual patients to identify need and provides for discounted or free care. Individuals are identified who qualify for Medicaid coverage and assistance in obtaining coverage is provided.

**DCH Implementation Plan programmatic initiatives:**

- The Affordable Care Act will increase the number of insured in the country. Indiana will utilize the Federal Exchange Program and will not participate in the Medicaid Expansion Program;
- The public will need assistance with signing up for exchanges and some of those who do not have internet access will use the library resources for internet access. The hospital will partner with the library for education regarding exchanges and the exchange insurance application program. An information system will be established to determine the number of individuals seeking information about affordability issues; and
- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how DCH services can benefit their initiatives. DCH will initiate efforts by contacting each organization for effort collaboration.

**Anticipated results from DCH Implementation Plan**

- Increased community awareness of the Affordable Care Act requirement for individuals and families to purchase health insurance on the exchange and how to go about it, focusing on the general population and in particular those who do not have internet access.

**Leading indicator DCH will use to measure progress:**

- The number of individuals who receive educational information in collaboration with the library.
  - 2012 individuals receiving health education = zero (0) (future values to be tracked)

**Lagging indicators DCH will use to identify improvement**

- A reduction in the number of uninsured in Daviess County. Access to care current number = 5,261 individuals in Daviess County.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
6. Stroke – Stroke is the 3rd leading cause of death in Daviess County. Higher than expected. It is the 4th leading cause of death in Indiana. Stroke death in Daviess County is the 3rd worse of 93 counties in the state. 75.7 deaths per 100,000 population compared to 43.5 for the state as a whole.

Problem Statement: Death from stroke should be reduced.

DCH services available to respond to this need include:

- The hospital treats stroke patients; inpatient, outpatient, and in the emergency department;
- The hospital rehabilitation department treats stroke patients during recovery;
- The hospital is actively recruiting for a neurologist; and
- The hospital has a blood pressure screening program.

DCH implementation plan programmatic initiatives:

- The hospital will increase community awareness of the symptoms of stroke with a program similar to the FAST program (Face, Arms, Speech and Time) to raise patient and care giver awareness of the signs of stroke at health fairs and educational programs;
- The hospital will increase its blood pressure screening program. Managing high blood pressure is the most important thing that can be done to lessen the risk for stroke. Patient education and blood pressure screening can increase treatment for hypertension and lessen the risk of stroke; and
- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how DCH services can benefit their initiatives. DCH will initiate efforts by contacting each organization.

Anticipated results from DCH implementation plan

- Blood pressure screening can increase awareness of hypertension leading to earlier treatment and ultimately lessen the risk of stroke.

Leading indicator DCH will use to measure progress:

- An increase in the number of individuals screened for hypertension.
  - In the most recent 12 month period, 1,460 individuals were screened.

Lagging indicators DCH will use to identify improvement
• The stroke death rate for Daviess County which is 75.7 deaths per 100,000 population.

Source:
www.countyhealthrankings.org

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:

<table>
<thead>
<tr>
<th>Physician  Medical Staff Offices: Available at: <a href="http://www.dchosp.com">http://www.dchosp.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Daviess County Health Department, 303 E Hefron St., Washington, IN 47501, Ph: (812) 254-8666</td>
</tr>
<tr>
<td>Daviess County Family YMCA, 405 NE 3rd Street, Washington, IN 47501, Ph: (812) 254-4481</td>
</tr>
<tr>
<td>Anytime Fitness, 16 Cherry Tree Plaza, Washington, IN 47501, Ph: (812) 254-2200</td>
</tr>
<tr>
<td>Senior &amp; Family Services, Inc. “Fitness For You”, 211 E. Main St., Washington, IN 47501, Ph: (812) 254-1881</td>
</tr>
</tbody>
</table>

Other Needs Identified During the CHNA Process

7. Smoking;
8. Cancer;
9. Alcohol abuse;
10. Coronary heart disease;
11. Diabetes;
12. Healthy food;
13. Accidents;
14. Mental health/suicide;
15. Chronic COPD/lung disease/pulmonary;
16. Blood pressure (High);
17. Cholesterol (High);
18. Kidney;
19. Compliance behavior;
20. Flu/pneumonia;
21. Alzheimer’s; and
22. Chronic allergies.

Overall Community Need Statement and Priority Ranking Score:
Significant Needs Where Hospital Has Implementation Responsibility\textsuperscript{20}

1. Sexual/reproductive health/child health;
2. Physician;
3. Drug use;
4. Obesity/overweight;
5. Affordability; and

Significant Needs Where Hospital Did Not Develop Implementation Plan\textsuperscript{21}

None

Other Needs Where Hospital Developed Implementation Plan

None

Other Identified Needs Where Hospital Did Not Develop Implementation Plan

7. Smoking;
8. Cancer;
9. Alcohol abuse;
10. Coronary heart disease;
11. Diabetes;
12. Healthy food;
13. Accidents;
14. Mental health/suicide;
15. Chronic COPD/(lung disease)/pulmonary;
16. Blood pressure (High);
17. Cholesterol (High);
18. Kidney;
19. Compliance behavior;
20. Flu/pneumonia;
21. Alzheimer’s; and

\textsuperscript{20} \textit{Responds to IRS Schedule H (form 990) Part V B 1. e. and 6. a.}
\textsuperscript{21} \textit{Responds to IRS Schedule H (form 990) Part V B 7.}
22. Chronic allergies.
APPENDICES
Appendix A: Local Expert Advisor Opinion about Significant Needs

484 Community Responses to Community Health Need Survey Questions

What is your opinion about the following health and mental health issues in your community?

Interpretation – We asked survey participants to offer free text responses to several questions and interpreted the responses by developing “Word Clouds.” Word Clouds are analytical tools which give greater visual prominence to words appearing more frequently in the source text. This information visualization establishes a portrait of the aggregate responses, presenting the more frequently used terms with greater text size and distinction in the visual depiction. Common article word (i.e., “a,” “the,” etc.), non-contextual verbs (i.e., “is,” “are,” etc.) and similar words used when writing sentences are suppressed by this application.

In the above visualization, survey participants responded to the question: “What is the most important health or medical issue”? Answers initially focused on health care insurance, cost/affordability, obesity, and cancer. A second set of issues focused attention on hospitals, doctors and heart issues.

After the open question, we posed two multiple choice questions. Listed were potential health needs with the question: “What is your opinion about the following medical and mental health issues in your community?”

---

22 Responds to IRS Schedule H (form 990) V. B. 3
In descending order, seven needs identified by respondents as a “Major Issue” were:

1. Cancer – a major problem by 63% of respondents;
2. No health insurance – major problem by 62%;
3. Obesity/unhealthy food choices – major problem by 59%;
4. Mental health issues – major problem by 55%;
5. Teen birth rate/teen pregnancy – major problem by 54%;
6. Heart disease – major problem by 51%; and
7. Diabetes – major problem by 50%.

The next response was to a continued list of potential needs.
In descending order, five needs identified by respondents as a “Major Issue” were:

1. Youth drug abuse/use = 75%;
2. Adult substance abuse = 66%;
3. Prescription drug abuse = 57%;
4. Alcohol use among youth = 55%; and
5. Tobacco use/smoking = 52%.

In a listing of other potential issues, less than half of respondents cited a major problem with the following:

- Poverty;
- Low education levels;
- Motor vehicle accidents;
- Availability of exercise resources or fitness opportunities;
- Domestic violence;
- Sexual violence;
- Bullying in schools;
- Presence of radon;
- Littering;
- Water pollution; and
- Air pollution.

We explored potential for perceived problems in any of seven public health areas and received the opinion problems existed in three of the seven areas. 60% reported major concerns with healthy living, 58% reported major concerns with individual and family health concerns, and, 53% reported major concerns with healthcare availability. We received 113 specific comments as presented in the following word bubble:

From this we surmise the dominant issue is availability/accessibility of health care.

We asked if they or any household resident member left the county during the last two years in search of medical care. 56% reported yes they had left the county. We asked why they left the county, and in reply from 198 participants received the information, people were seeking a variety of physician services:
Respondents cited an average rating of 7.35 on a personal scale of viewing their health along a ten point continuum (ten representing the best possible health). 21% reported having problems three or more times accessing health care due to cost issues.

67% of responses were city of Daviess residents. Typical responses came from two person families. Where the participant was a 35-54 age, married, non-Hispanic female. Almost 75% of participants had post high school education. Only 2% of responses indicated they were currently unemployed.
Appendix B – Process to Identify and Prioritize Community Need

<table>
<thead>
<tr>
<th>Need Candidate</th>
<th>Total Points Allocated</th>
<th>Cumulative Percentage of Response</th>
<th>Number of Local Experts Voting for Need</th>
<th>Point Break from Higher need</th>
<th>Need Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SEXUAL/REPRODUCTIVE HEALTH/CHILD HEALTH</td>
<td>176</td>
<td>12.6%</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. PHYSICIANS</td>
<td>139</td>
<td>22.5%</td>
<td>6</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>3. DRUG USE</td>
<td>132</td>
<td>31.9%</td>
<td>9</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>4. OBESITY/OVERWEIGHT</td>
<td>126</td>
<td>41.1%</td>
<td>10</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5. AFFORDABILITY</td>
<td>114</td>
<td>49.2%</td>
<td>7</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>6. STROKE</td>
<td>114</td>
<td>57.4%</td>
<td>8</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>7. SMOKING</td>
<td>89</td>
<td>63.7%</td>
<td>9</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>8. CANCER</td>
<td>78</td>
<td>69.3%</td>
<td>7</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>9. ALCOHOL ABUSE</td>
<td>66</td>
<td>73.9%</td>
<td>5</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>10. CORONARY HEART DISEASE</td>
<td>58</td>
<td>76.0%</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11. DIABETES</td>
<td>56</td>
<td>80.0%</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>12. HEALTHY FOOD</td>
<td>55</td>
<td>86.9%</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. ACCIDENTS</td>
<td>48</td>
<td>89.4%</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>14. MENTAL HEALTH / SUICIDE</td>
<td>39</td>
<td>92.1%</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>15. CHRONIC COPD (LUNG DISEASE) PULMONARY</td>
<td>33</td>
<td>94.5%</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>16. BLOOD PRESSURE (High)</td>
<td>24</td>
<td>96.2%</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>17. CHOLESTEROL (High)</td>
<td>16</td>
<td>97.4%</td>
<td>3</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>18. KIDNEY</td>
<td>15</td>
<td>98.4%</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>19. COMPLIANCE BEHAVIOR</td>
<td>9</td>
<td>99.1%</td>
<td>2</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>20. FLU / PNEUMONIA</td>
<td>6</td>
<td>99.5%</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>21. ALZHEIMER'S</td>
<td>4</td>
<td>99.8%</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>22. CHRONIC ALLERGIES</td>
<td>3</td>
<td>100.0%</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Total: 1,400 14

Individuals Participating as Local Expert Advisors

<table>
<thead>
<tr>
<th>Organization</th>
<th>Position</th>
<th>Area of Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCH Health Department</td>
<td>Public Health Nurse</td>
<td>Public Health</td>
</tr>
<tr>
<td>Senior Community / Rotary</td>
<td>Retired</td>
<td>Community relationships</td>
</tr>
<tr>
<td>Daviess Family Medicine</td>
<td>Owner</td>
<td>Medicine / Physician / long term resident</td>
</tr>
<tr>
<td>Health Department</td>
<td>Public Health Nurse</td>
<td>Public Health</td>
</tr>
<tr>
<td>Daviess Community Hospital</td>
<td>CEO</td>
<td>Hospital and Healthcare Management</td>
</tr>
<tr>
<td>Washington Catholic High School</td>
<td>High School Junior</td>
<td>Representative of students</td>
</tr>
<tr>
<td>DCH Board</td>
<td>Board Member</td>
<td>Long term community resident</td>
</tr>
<tr>
<td>Daviess Community Hospital</td>
<td>Board of Governors</td>
<td>Long term resident</td>
</tr>
<tr>
<td>United Way of Daviess County</td>
<td>Executive Director</td>
<td>Social Service / 25 year com. Rel.</td>
</tr>
<tr>
<td>Healthy Families/Four Rivers</td>
<td>Family Support Specialist</td>
<td>Maps of poor population / new mothers</td>
</tr>
<tr>
<td>Purdue Extension</td>
<td>Economic &amp; Community Development</td>
<td></td>
</tr>
<tr>
<td>Daviess County Community Foundation</td>
<td>Director</td>
<td>Director of the county’s 3.5 million endowment. In addition to working with prospects to establish funds, the Foundation oversees administration of annual grants to benefit the community in areas like arts, human services, education, and community development. The foundation grants over $300,000 in awards and scholarships annually for Daviess County programs and students</td>
</tr>
<tr>
<td>Daviess Community Hospital</td>
<td>Surgical Services Director</td>
<td>Surgical Care</td>
</tr>
<tr>
<td>Washington Community Schools</td>
<td>Licensed Clinical Social Worker</td>
<td>Provide school social work services in academic public setting and am actively involved in local mental health services for children, adults and families</td>
</tr>
</tbody>
</table>

23 Responds to IRS Schedule H (form 990) Part V B 1. g. and V B 1. h.
24 Responds to IRS Schedule H (form 990) Part V 3
Advice Received from Local Experts

Q. Do you agree with the observations formed about the comparison of Daviess County to all other State counties?

- Don't believe these are current statistics.
- I agree with all the above statements except for sexually transmitted disease/infections. I believe this is under ranked because our population who is uninsured is higher than national average and thus we don't have accurate statistics on one of the sections of population that is at higher risk for SDI's. Poor/uninsured people probably have not been adequately measured in that statistic.
Q. Do you agree with the observations formed about the comparison of Daviess County to its peer counties?

- Childhood obesity higher than state average.
- I believe teen pregnancy is higher than National and Peer Counties, Along with births to unmarried women and colon cancer.
- Helpline calls from single mothers. Teen Pregnancy numbers esp. 13-16.
- We have a majority population who seeks prenatal care in first trimester. Premature birth is in the middle. It is not shown as much because a large portion of local residents deliver at hospitals outside this county. Agree high rate of births to unmarried women, but not sure if it's higher than other counties.
- Amish population practices may be influencing this?
Q. Do you agree with the observations formed about the population characteristics of Daviess County?

- In my professional opinion Daviess County residents make very poor food choices. The above observation is likely skewed by self reported bias. Letter B should be in the first group of issues.
- STDs are a growing concern in certain areas of the population.
Q. Do you agree with the observations formed about the opinions from local residents?

- I believe STDs and Eating disorders should be major issues.
- I believe that sexually transmitted diseases and the suicide rate have a greater issue than the survey showed.
- Have we surveyed school health nurses? Is asthma (childhood) an issue? Menopausal women -hormone testing - underlying cause of mental health issues?
Q. Do you agree with the observations formed about the additional data analyzed about Daviess County?

- B3 and D do not correlate.
- J seems too high.
- Stroke should be ranked lower, Accidents and lung should be above it.
Appendix C – Illustrative Schedule H (Form 990) Part V B Potential Response

Illustrative IRS Schedule H Part V Section B (form 990)

Community Health Needs Assessment Answers

1. During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9

Illustrative Answer – Yes

If “Yes,” indicate what the Needs Assessment describes (check all that apply):

a. A definition of the community served by the hospital facility
b. Demographics of the community
c. Existing healthcare facilities and resources within the community that are available to respond to the health needs of the community
d. How the data was obtained
e. The health needs of the community
f. Primary and chronic disease needs and health issues of uninsured persons, low-income persons, and minority groups
g. The process for identifying and prioritizing community health needs and services to meet the community health needs
h. The process for consulting with persons representing the community’s interests
i. Information gaps that limit the hospital facility’s ability to assess the community’s health needs
j. Other (describe in Part VI)

Illustrative Answer – check a. through i. Answers available in this report are found as follows:

1. a. – See Footnotes #11 (page 10) & #12 (page 10)
1. b. – See Footnotes #13 (page 11)
1. c. – See Footnote #18 (page 27)
1. d. – See Footnotes #7 (page 5)
1. e. – See Footnotes #20 (page 35)
1. f. – See Footnotes #9 (page 7) & #17 (page 18)

Questions are drawn from 2012 f 990sh.pdf Forms and may change when the hospital is to make its 990 h filing
1. g. – See Footnote #10 (page 8)
1. h. – See Footnote #8 (page 7) & #23 (page 43)
1. i. – See Footnote #6 (page 5) & #23 (page 43)
1. j. – No response needed

2. Indicate the tax year the hospital facility last conducted a CHNA: 2013

Illustrative Answer – 2013
See Footnote #1 (Title page)

3. In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If “Yes,” describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted

Illustrative Answer – Yes
See Footnotes #22 (page 38), #24 (page 43)

4. Was the hospital facility’s Need Assessment conducted with one or more other hospital facilities? If “Yes,” list the other hospital facilities in Part VI.

Illustrative Answer – No

5. Did the hospital facility make its CHNA widely available to the public? If “Yes,” indicate how the Needs Assessment was made widely available (check all that apply)

   a. Hospital facility’s website
   b. Available upon request from the hospital facility
   c. Other (describe in Part VI)

Illustrative Answer – check a. and b.

The hospital will need to obtain Board approval of this report, document the date of approval, and then take action to make the report available as a download from its web site. It may also be prudent to place a notice in a paper of general circulation within the service area noting the report is available free upon request.

6. If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):

   a. Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA
   b. Execution of an implementation strategy
   c. Participation in the development of a community-wide plan
   d. Participation in the execution of a community-wide plan
e. Inclusion of a community benefit section in operational plans
f. Adoption of a budget for provision of services that address the needs identified in the CHNA
g. Prioritization of health needs in its community
h. Prioritization of services that the hospital facility will undertake to meet health needs in its community
i. Other (describe in Part VI)

Illustrative Answer – check a, g, and h.

6. a. – See footnote #20 (page 35)
6. g. – See footnote #10 (page 8)
6. h. – See footnote #10 (page 8) & #19 (page 28)

7. Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If “No,” explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs?

Illustrative Answer – Yes
Part VI suggested documentation – See Footnote #21 (page 36)

8. 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)?
b. If “Yes” to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?
c. If “Yes” to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities?

Illustrative Answers – 8. a, 8 b, 8 c – No