RHEA MEDICAL CENTER
DAYTON, TENNESSEE

2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

APPROVED BY HOSPITAL BOARD OF DIRECTORS (MAY 28, 2013)

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

Rhea Medical Center (RMC) 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 RMC 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, RMC, are meeting our obligations to efficiently deliver medical services.

RMC 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
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EXECUTIVE SUMMARY
Executive Summary

Rhea Medical Center ("RMC" 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 RMC 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

RMC partnered with Quorum Health Resources (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

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

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

- 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 web site;
- 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\textsuperscript{5}.

• 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.

\textsuperscript{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:
  1) Summarizes, in general terms, the input provided and how and over what time period such input was provided;
  2) Provides the names of organizations providing input and summarizes the nature and extent of the organization’s input; and
  3) 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:

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 Rhea County compared to all TN counties</td>
<td>April 9, 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 Rhea County compared to its national set of “peer counties”</td>
<td>April 9, 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>April 9, 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>April 9, 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>April 9, 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>April 9, 2013</td>
<td>1989 through 2009</td>
</tr>
<tr>
<td><a href="http://www.dataplacce.org">www.dataplacce.org</a></td>
<td>To determine availability of specific health resources</td>
<td>April 9, 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>April 9, 2013</td>
<td>2007 to 2009</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>April 9, 2013</td>
<td>2003 to 2010</td>
</tr>
<tr>
<td><a href="http://www.datwarehouse.hrsa.gov">www.datwarehouse.hrsa.gov</a></td>
<td>To identify applicable manpower shortage designations</td>
<td>April 9, 2013</td>
<td>2013</td>
</tr>
</tbody>
</table>
• In addition, we deployed a CHNA “Round 1” survey to our local expert advisors to gain local 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 the Federal guidelines and regulations.

• We received community input from 19 local expert advisors. Survey responses started Wednesday, April 3, 2013 at 2:30 P.M. and ended with the last response on Friday, April 19, 2013 at 1:13 P.M.;

• Information analysis augmented by local opinions showed how Rhea 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.

When the analysis was complete, we put the information and summary conclusions before our local group of experts, who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional statements of need, and new needs did emerge from this exchange. Consultation with 16 local experts occurred again via an internet-based survey (explained below) during the period beginning Thursday, April 25, 2013 at 2:44 P.M. and ending Thursday, May 9, 2013 at 3:15 P.M.

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 RMC process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and challenge conclusions developed from

<table>
<thead>
<tr>
<th>Web Site or Data Source</th>
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<th>Date Accessed</th>
<th>Data Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.worldlifeexpectancy.com/usa-health-rankings">www.worldlifeexpectancy.com/usa-health-rankings</a></td>
<td>To determine relative importance among 15 top causes of death</td>
<td>April 9, 2013</td>
<td>2010 published 11/29/12</td>
</tr>
</tbody>
</table>

8 Response to Schedule H (Form 990) Part V B 1 h; complies with 501(e)(3)(B)(i)
9 Response to Schedule H (Form 990) Part V B 1 f
10 Response to Schedule H (Form 990) Part V B 3
11 Response to Schedule H (Form 990) Part V B 1 e
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.

We dichotomized the rank order into two groups: high priority needs and low priority needs. The determination of the break point - high as opposed to low - was a qualitative interpretation by QHR and the RMC executive team, where a reasonable break point in rank occurred, indicated by the amount of points each potential need received and the number of local experts allocating any points to the need. When presented to the RMC executive team, the divided need rank order identified which needs the Hospital considered high responsibility to respond vs. low responsibility to respond. The result provided a matrix of needs and guided the Hospital in developing its implementation response.12

The proposed regulations provide that, in order to assess the community it serves, a hospital facility must identify significant health needs of the community, prioritize them, and then identify potential measures and resources available to address them, such as programs, organizations, and facilities in the community.13 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.14 By definition, the high priority needs are deemed “significant” needs as defined by the regulations.

12 Response to Schedule H (Form 990) Part V Section B 6 g, h and Part V B 1 g
13 Draft regulations page 30
14 Draft regulations page 32
FINDINGS
Findings

Definition of Area Served by the Hospital Facility

RMC, in conjunction with QHR, defines its service area as Rhea County in Tennessee, which includes the following ZIP codes:

- 37321 – Dayton
- 37332 – Evensville
- 37381 – Spring City
- 37337 – Grandview
- 37338 – Graysville

In 2011, the Hospital received 86.2% of its patients from this area.

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15 Responds to IRS Form 990 (h) Part V B 1 a
16 Truven MEDPAR patient origin data for the hospital; Responds to IRS Form 990 (h) Part V B 1 a
Demographic of the Community\textsuperscript{17}

The 2012 population for Rhea County is estimated to be 35,308\textsuperscript{18} and is expected to increase at a rate of 4.1%. This is in contrast to the 3.9% national rate of growth and the Tennessee growth rate of 4.1%. Rhea County anticipates a population of 36,762 by 2017.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2012 median age for the county is 39.1 years, which is older than the State median age (37.6 years), and the national median age (36.8 years). The 2012 Median Household Income for the area is $34,842, which is lower than the State median income of $41,614 and the national median income of $49,559. Median Household Wealth value is below the National and the State values. The Median Home Values show the same pattern as Household Wealth. Rhea’s unemployment rate as of March, 2013 was 11.5\%\textsuperscript{19}, which is higher than the 7.8% statewide and the 7.6% national civilian unemployment rates.

The portion of the population in the county over 65 is 15.4%, slightly above the State average of 13.3%. The portion of the population of women of childbearing age is 18.8%, slightly below the Tennessee average of 20.1%. 1.8% of the population is Black non-Hispanic and 92.1% is White non-Hispanic. The Hispanic population comprises 3.9% of the total.

\textsuperscript{17} Responds to IRS Form 990 (h) Part V B 1 b
\textsuperscript{18} All population information, unless otherwise cited, sourced from Truven (formerly Thomson) Market Planner
\textsuperscript{19} http://research.stlouisfed.org/fred2/series/TNRHEA3URN; http://research.stlouisfed.org/fred2/series/UNRATE
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 Effected</th>
<th>Health Service Topic</th>
<th>Demand as % of National</th>
<th>% of Population Effected</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>114.3%</td>
<td>29.2%</td>
<td>Routine Screen: Cardiac Stress 2yr</td>
<td>94.7%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Vigorous Exercise</td>
<td>92.1%</td>
<td>46.7%</td>
<td>Chronic High Cholesterol</td>
<td>105.6%</td>
<td>23.5%</td>
</tr>
<tr>
<td>Chronic Diabetes</td>
<td>131.0%</td>
<td>13.0%</td>
<td>Routine Cholesterol Screening</td>
<td>69.6%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Healthy Eating Habits</td>
<td>67.6%</td>
<td>25.8%</td>
<td>Chronic High Blood Pressure</td>
<td>122.6%</td>
<td>32.3%</td>
</tr>
<tr>
<td>Very Unhealthy Eating Habits</td>
<td>120.5%</td>
<td>3.3%</td>
<td>Chronic Heart Disease</td>
<td>140.1%</td>
<td>11.7%</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>32.5%</td>
<td>FPIGP: 1+ Visit</td>
<td>103.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td>I Follow Treatment Recommendations</td>
<td>85.7%</td>
<td>34.6%</td>
<td>Used Midlevel in last 6 Months</td>
<td>101.7%</td>
<td>43.4%</td>
</tr>
<tr>
<td>I am Responsible for My Health</td>
<td>93.8%</td>
<td>53.0%</td>
<td>OB/Gyn 1+ Visit</td>
<td>85.6%</td>
<td>38.8%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td></td>
<td></td>
<td>Ambulatory Surgery last 12 Months</td>
<td>105.5%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Chronic COPD</td>
<td>139.6%</td>
<td>6.5%</td>
<td>Internet Usage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Use: Cigarettes</td>
<td>126.5%</td>
<td>32.9%</td>
<td>Use Internet to Talk to MD</td>
<td>76.8%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Chronic Allergies</td>
<td>112.8%</td>
<td>24.8%</td>
<td>Facebook Opinions</td>
<td>85.5%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td>Looked for Provider Rating</td>
<td>85.4%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Mammography in Past Yr</td>
<td>53.9%</td>
<td>42.6%</td>
<td>Misc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Screen: Colorectal 2 yr</td>
<td>92.1%</td>
<td>23.3%</td>
<td>Charitable Contrib: Hosp/Hosp Sys</td>
<td>90.5%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Cancer Screen: Pap/Cerv Test 2 yr</td>
<td>89.1%</td>
<td>53.7%</td>
<td>Charitable Contrib: Other Health Org</td>
<td>84.5%</td>
<td>33.0%</td>
</tr>
<tr>
<td>Routine Screen: Prostate 2 yr</td>
<td>95.5%</td>
<td>30.4%</td>
<td>HSA/FSA: Employer Offers</td>
<td>93.4%</td>
<td>47.1%</td>
</tr>
<tr>
<td>Orthopedic</td>
<td></td>
<td></td>
<td>Emergency Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Lower Back Pain</td>
<td>116.5%</td>
<td>26.7%</td>
<td>Emergency Room Use</td>
<td>107.5%</td>
<td>36.7%</td>
</tr>
<tr>
<td>Chronic Osteoporosis</td>
<td>125.8%</td>
<td>17.2%</td>
<td>Urgent Care Use</td>
<td>93.4%</td>
<td>22.0%</td>
</tr>
</tbody>
</table>
Leading Causes of Death

<table>
<thead>
<tr>
<th>TN Rank</th>
<th>Rhea Co. Rank</th>
<th>Condition</th>
<th>Rank among all counties in TN (#1 rank = worst in state)</th>
<th>Rate of Death per 100,000 age adjusted</th>
<th>TN</th>
<th>Rhea Co.</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Heart Disease</td>
<td>52 of 95</td>
<td>210.9</td>
<td>260.5</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Cancer</td>
<td>38 of 95</td>
<td>195.9</td>
<td>218.0</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>Stroke</td>
<td>70 of 95</td>
<td>47.2</td>
<td>52.4</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>11,17,24</td>
<td>4</td>
<td>Accidents</td>
<td>33 of 95</td>
<td>50.1</td>
<td>74.0</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Lung</td>
<td>7 of 95</td>
<td>32.0</td>
<td>79.0</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>Alzheimer's</td>
<td>13 of 95</td>
<td>33.6</td>
<td>41.1</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>7</td>
<td>Flu - Pneumonia</td>
<td>16 of 95</td>
<td>20.9</td>
<td>37.0</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>Diabetes</td>
<td>19 of 95</td>
<td>25.8</td>
<td>36.9</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>11</td>
<td>Hypertension</td>
<td>13 of 93</td>
<td>8.2</td>
<td>13.7</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>10</td>
<td>Suicide</td>
<td>55 of 95</td>
<td>14.6</td>
<td>14.2</td>
<td>As expected</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>9</td>
<td>Kidney</td>
<td>20 of 95</td>
<td>14.2</td>
<td>15.0</td>
<td>As expected</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>12</td>
<td>Blood Poisoning</td>
<td>28 of 95</td>
<td>10.1</td>
<td>11.9</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>13</td>
<td>Liver</td>
<td>34 of 95</td>
<td>9.9</td>
<td>11.7</td>
<td>As expected</td>
<td></td>
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<tr>
<td>26</td>
<td>15</td>
<td>Parkinson's</td>
<td>49 of 92</td>
<td>5.8</td>
<td>4.8</td>
<td>Lower than expected</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>14</td>
<td>Homicide</td>
<td>30 of 94</td>
<td>8.0</td>
<td>6.5</td>
<td>Lower than expected</td>
<td></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\(^\text{20}\).

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;

• 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:
  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 Asians were worse than Whites and staying the same:
  o Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and
  o 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:
  o Heart Disease – 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 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:
  - 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 Hispanics were worse than non-Hispanic Whites for the most recent year and getting better:
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;
  - 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
  - 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:
  - Cancer – Women age 40 and over who received a mammogram in the last 2 years; adults age 50 and over who ever received colorectal cancer screening;
  - Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
  - 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;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
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;

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

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. Specific opinions from the local expert advisors are summarized as follows:\(^\text{21}\):

\(^{21}\) All comments and the analytical framework behind developing this summary appear in Appendix A.
• Hispanic population has numerous health needs that are poorly addressed in part due to a lack of interpreters for the dialects spoken by these persons

• Uninsured and unemployed are often morbidly obese leading to high levels of Type II diabetes and coronary heart disease. These people must travel to another county for primary care. The local health department does not have a primary care clinic.

• Black death rate for heart disease exceeds the national rate

Statistical information about special populations follows:

**Access to Care: Rhea County, TN**

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured individuals (age under 65)¹</td>
<td>3,489</td>
</tr>
<tr>
<td>Medicare beneficiaries²</td>
<td></td>
</tr>
<tr>
<td>Elderly (Age 65+)</td>
<td>4,381</td>
</tr>
<tr>
<td>Disabled</td>
<td>1,265</td>
</tr>
<tr>
<td>Medicaid beneficiaries²</td>
<td>10,034</td>
</tr>
<tr>
<td>Primary care physicians per 100,000 pop²</td>
<td>32.5</td>
</tr>
<tr>
<td>Dentists per 100,000 pop²</td>
<td>26.0</td>
</tr>
<tr>
<td>Community/Migrant Health Centers³</td>
<td>Yes</td>
</tr>
<tr>
<td>Health Professional Shortage Area³</td>
<td>No</td>
</tr>
</tbody>
</table>

*nda No data available.*

² *HRSA. Area Resource File, 2008.*
³ *HRSA. Geospatial Data Warehouse, 2009.*
Findings

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

Conclusions from Public Input to Community Health Needs Assessment

- 17 area residents participated in a survey asking opinions about their perception of local healthcare needs. In descending order of opinion, five topics were identified as being of "Major Concern" or "Most Important Issue to Resolve":
  1. Lack of insurance – 76% listed as a major concern;
  2. Access to affordable care – 53% listed as a major concern;
  3. Lifestyle health education and practice – 47% listed as a major concern;
  4. Access to prenatal care – 47% listed as a major concern;
  5. Obesity – 41% listed as a major concern;
- Respondents noted the need for additional specialty care in the county for services including orthopedics, cardiology, geriatrics, and counselors for mental health and substance abuse;
Summary of Observations from Rhea County Compared to All Other State Counties, in Terms of Community Health Needs

- In general, Rhea County residents are at about average health for Tennessee.
- In a health status classification termed "Health Outcomes", Rhea County ranks number 67 among the 95 ranked counties in Tennessee (best being #1). None of the metrics show beneficial values. All metrics have values which are not statistically significantly higher than the Tennessee average but all are significantly higher than the desired national goals.
- In another health status classification "Health Factors", Rhea County ranks number 50 among the 95 ranked counties in Tennessee.
- Conditions where improvement is needed include:
  - Adult Smoking at about Tennessee average, an adverse finding.
  - Adult Obesity, seems high but is statistically at the Tennessee average, and exceeds the national benchmark, an adverse finding.
  - Sexually transmitted disease is about 67% of Tennessee rate; yet exceeds the national benchmark.
  - Motor Vehicle crash deaths are significantly above Tennessee and the national benchmark, an adverse finding.
  - Uninsured is about Tennessee average, exceeding national benchmark, an adverse finding.
  - Preventable hospital stays is about Tennessee average, exceeding national benchmark.
  - The dentist to population ratio is significantly above Tennessee and the national benchmark, an adverse finding.
  - Diabetic Screening is below the Tennessee average and significantly below the national benchmark, an adverse finding.
  - Mammography screening is below Tennessee and the national benchmark.
  - The percent of restaurants which are fast food is about the Tennessee average and above the national benchmark.
  - Teen Birth Rate is greater than the Tennessee average, exceeding national benchmark.
- Rhea County has good performance in:
Excess Drinking that is below Tennessee average and at about the national benchmark

Social and Economic metrics are near the Tennessee average, excepting lower performance in the percent of the population who have had some college;

Summary of Observations from Rhea 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 Rhea 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:

- Low Birth Wt. (<2500g)
- Very Low Birth Wt. (<1500g)
- Premature Births (<37 weeks)
- Births to Women under 18
- Infant Mortality
- White non Hispanic Infant Mortality
- Post-neonatal Infant Mortality
- Breast Cancer (Female)
- Colon Cancer
- Coronary Heart Disease
- Lung Cancer
- Motor Vehicle Injuries
- Stroke

SOMEWHER A CONCERN - observations because occurrence is EITHER above national average or above peer group average:

- Suicide
- Births to Unmarried Women
- Unintentional Injury

BETTER PERFORMANCE – better than peers and national rates:

- Births To Women Ages 40 to 54
- Neonatal infant mortality
Conclusions from the Demographic Analysis Comparing Rhea County to National Averages

Rhea County in 2012 was comprised of 35,308 residents. Since 2000 it has experienced population growth and anticipates continued growth through the next five years. The population is 92.1% non-Hispanic White. Non-Hispanic Blacks constitute 1.8% of the population, the largest minority population. 15.4% of the population is age 65 or older. This is a larger population segment than the elderly comprise compared to both the Tennessee and national averages. 18.8% of females are in the childbirth population segment. This segment is slightly lower than Tennessee and the national averages. The median income and median wealth of the population is below the state and national averages.

The following areas were identified comparing the county to national averages. Metrics impacting more than 25% of the population and that are statistically significantly different from the national average:

- Obtained a pap smear or cervix exam – impacting 53.7% of the population, 10.9% below average
- I am responsible for my health – impacting 53% of the population, 6.2% below average
- Engage in vigorous exercise – impacting 46.7% of the population, 7.9% below average
- Routine cholesterol screening – impacting 45.5% of the population, 10.4% below average
- Mammography in past year – 42.6% of population, 7.1% below average
- Visited an obstetrician or gynecologist in the past year – 39.8% of population, 15% below average
- Emergency room use – impacting 36.7% of population, 7.9% above average
- I will follow treatment recommendation – impacting 34.6% of population, 14.3% below average
- Tobacco use including cigarettes – impacting 32.9% of the population, 26.9% above average
- I will travel to obtain medical care – impacting 32.5%, 3.2% below average
- Chronic high blood pressure – impacting 32.3% of the population, 22.6% above average
- Obtained a prostate screening in past year – impacting 30.4% of population 5.5% below average
- Morbid obese body mass index – impacting 29.2% of the population, 14.3% above average
- Chronic low back pain – impacting 26.7% of the population, 18.5% above average
• Healthy Eating Habits – impacting 25.8% of the population, 13% below average

Metrics impacting more than 25% of the population and that are not statistically significantly different from the national average:

• Visited a family or general physician one or more times a year – 91% of population, 3% above average neither an adverse or beneficial finding
• Used a midlevel in the last 6 months – impacting 43.4% of the population, 1.7% above average, neither an adverse or beneficial finding
• Donate to a non-healthcare charitable organization – impacting 33% of the population, 5.5% below average, neither a beneficial or an adverse finding

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

• Made a charitable contribution to a health care organization – impacting 21.7% of the population, 9.1% below average
• Chronic diabetic – impacting 13.6% of the population, 31% above average
• Chronic osteoporosis – impacting 12.2% of the population, 25.9% above average
• Chronic heart disease – impacting 11.7% of the population, 40.1% above average
• Chronic COPD – impacting 6.5% of the population, 39% above average

Key Conclusions from Consideration of the Other Statistical Data Examinations

Additional observations of Rhea 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
• For Hospice one program, Hospice of Chattanooga exists in the in the county.

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

1. **Heart Disease** – Rhea ranks 52 of 95 TN counties (1 being best) with a death rate of 260.5 / 100,000 and this rate is higher than expected
2. **Cancer** – Rhea ranks 38 of 95 with a death rate of 218.0 / 100,000 and this rate is higher than expected
3 Lungs – Rhea ranks 7 of 95 with a death rate of 79.0 / 100,000 and this rate is higher than expected

4 Accidents – Rhea ranks 33 of 95 with a death rate of 74.0 / 100,000 and this is higher than expected

5 Stroke – Rhea ranks 70 of 95 with a death rate of 52.4 / 100,000 and this is higher than expected

6 Alzheimer’s – Rhea ranks 13 of 95 with a death rate of 41.1 / 100,000 and this is higher than expected

7 Flu / Pneumonia – Rhea ranks 16 of 95 with a death rate of 37.0 / 100,000 and this is higher than expected

8 Diabetes – Rhea ranks 19 of 95 with a death rate of 36.9 / 100,000 and this is higher than expected

9 Kidney Disease – Rhea ranks 20 of 95 with a death rate of 15.0 / 100,000 and this is as expected

10 Suicide – Rhea ranks 55 of 95 with a death rate of 14.2 / 100,000 and this is as expected

- Among other leading causes of death, Hypertension and Blood Poisoning are higher than expected; Parkinson’s and Homicide are lower than expected.
- Life expectancy for Men has increased during the period 1989 through 2009. Life expectancy for women has slightly decreased.
- Diabetes incidence places Rhea County in the fifth lowest national decile,
- Free or reduced lunch program enrolled 67.4% of students in Rhea County.
- 2009 heart disease and stroke were in the second lowest national quintile
- White non-Hispanic heart disease was in the second highest quintile.
- White non-Hispanic stroke incidence places it into the 3 highest quintile
- Rhea is has not designated a health professional shortage area.
EXISTING HEALTH CARE FACILITIES, RESOURCES AND IMPLEMENTATION PLAN\textsuperscript{22}

\textsuperscript{22} The following replies to Schedule H (Form 990) Part V B 6 a and V B 6 b.
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 Rhea Medical Center. 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 Rhea Medical Center current efforts responding to the need;
- Establishes the Implementation Plan programs and resources Rhea Medical Center will devote to attempt to achieve improvements;
- Documents the Leading Indicators Rhea Medical Center will use to measure progress;
- Presents the Lagging Indicators Rhea Medical Center 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, Rhea Medical Center is the major hospital in the service area. Rhea is a 25 bed, acute care medical facility located in Dayton, TN. The next closest facilities are outside the service area and include:

- Sky Ridge Medical Center – 185 bed hospital in Cleveland, TN; 29 miles from Dayton (39 minutes)
- Erlanger Bledsoe – a 25 bed critical access hospital in Pikeville, TN; 22 miles from Dayton (33 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 Rhea Medical Center 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 Indicators also must be within the ability of the hospital to influence and measure.

---

23 Response to IRS Form 990 h Part V B 1 c
Significant Needs

1. **Affordability / Access to Care:** – over 50% of local experts cite lack of insurance and access to care, particularly for specialties including cardiology and mental health, as the top health care issue in Rhea County

   **Problem Statement:** There is a lack of providers to care for patients covered by TNCare and there are patients with no insurance in Rhea County.

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

- Physician practice in Spring City which takes TNCare patients. This clinic provides financial assistance based on need
- RMC Emergency Department accepts TNCare patients
- Inpatients at RMC are charged a sliding scale based on financial need
- RMC assists patients who may be eligible for TNCare with applications for TNCare
- RMC assists patients with applications for financial aid for hospital services

**RMC Implementation Plan Programmatic Initiatives:**

- The RMC Strategic Plan includes plans to consider opening a clinic on the south side of the area which could accept TNCare and provide access to help for patients needing financial assistance.
- RMC provides community education on participation in Medicare Advantage through the hospital Foundation “Lunch and Learn” program
- Begin tracking number of applications for TNCare and charity care

**Anticipated Results from RMC Implementation Plan**

- These efforts will reduce the number of patients who are unable to access care due to their inability to pay

**Leading Indicators RMC Will Use to Measure Progress:**

- Number of applications for TNCare financial assistance
  - Compare numbers from each year as they are collected
- Number of patients applying for or qualifying for RMC charity care
  - Compare numbers from each year as they are collected

**Lagging Indicator RMC Will Use to Identify Improvement**

- Uninsured: Percentage of uninsured in Rhea county, 2012 value = 3,489
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 Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhea County Primary Care</td>
<td>423-775-1160, Dr. Philip Daugherty, 188 16th Avenue, Dayton, TN 37321</td>
</tr>
<tr>
<td>Rhea County Health Department</td>
<td>423-775-7819, Debbie Williams, RN, 334 Eagle Lane, Evensville, TN 37332</td>
</tr>
<tr>
<td>Women’s Care Center</td>
<td>423-775-0019, Lenita Sanders, 285 Main Street, Dayton, TN 37321</td>
</tr>
<tr>
<td>Volunteers in Medicine</td>
<td>423-775-0609, Sonya Franklin, PO BOX 514, Dayton, TN 37321</td>
</tr>
</tbody>
</table>

2. **Obesity / overweight:** – Obesity and overweight conditions are cited by the local experts as a significant concern; the Rhea County rate is well above the rate in Rhea’s peer group counties, the Tennessee state median, and the national goal. The physical activity level in Rhea County is below the state rate and national goal. Rhea County is over 10% below average for “healthy eating”, and reports 20% above average for “very unhealthy eating habit”.

**Problem Statement:** The percentage of overweight people in Rhea County exceeds the national rate.

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

- RMC has an integrated approach to obesity by coordinating its efforts with diabetic reduction efforts formulating a multi-component obesity prevention intervention initiative
- RMC wellness programs promote healthy diet and exercise
- RMC offers “Heart Healthy” and “Diabetic/Carb Counting” classes to the community
- RMC provides and staffs a booth at the annual Pumpkinfest event that offers only healthy foods to attendees versus candy provided by other businesses at the event

**RMC Implementation Plan Programmatic Initiatives:**

- Include “Heart Healthy” recipes in the Better Living quarterly magazine RMC distributes to residents in Rhea County
- Participate in “Healthy Kids” day in partnership with YMCA which includes sessions on exercise and nutrition
- Serve as a community example through healthy food service offerings in the hospital cafeteria
- Provide water to children as a healthy alternative to sugared drinks at the “Farm/City Day” event held at the local agricultural exposition center
- Track number of RMC employees who participate in RMC wellness programs

**Anticipated Results from RMC Implementation Plan**
Greater percentage of Rhea County residents will no longer be obese

**LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:**

- Percentage of RMC employees who participate in RMC wellness programs
  - Compare numbers from each year as they are collected

**LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT**

- Rhea County adult obesity rate, 2012 value = 34%

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>Rhea Family YMCA, 423-775-0821</td>
<td>Lamont Singleton, 232 4th Avenue, Dayton, TN 37321</td>
</tr>
<tr>
<td>Rhea County Health Department, 423-775-7819</td>
<td>Debbie Williams, RN, 334 Eagle Lane, Evensville, TN 37332</td>
</tr>
<tr>
<td>Rhea County Health Council, 423-775-5563</td>
<td>Christine Ralph, c/o Rhea County United Way, PO Box 669, Dayton, TN 37321</td>
</tr>
</tbody>
</table>

**3. Coronary heart disease:** Heart disease is the #1 cause of death in Rhea County; this is unfavorable to national averages; it is cited by local experts as a significant health concern; the rate of stress testing is below the national average; chronic heart conditions are 40% above the national average. This is compounded by high blood pressure and high cholesterol which are listed as top health concerns by local experts.

**Problem Statement:** Coronary heart disease is the #1 cause of death in Rhea County.

**RMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- The RMC employee wellness program provides a lipid panel and evaluation of heart disease risk
- RMC offers free blood pressure screening to community organizations
- RMC promotes exercise education in the Better Living quarterly magazine distributed to residents in Rhea County by RMC
- RMC provides Lunch and Learn education for Heart Healthy Living in the community
- Track number of employees who participate in annual health screenings provided by the hospital

**RMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- Increase blood pressure screenings made available to senior citizen groups
- Market wellness program to industries throughout Rhea County
• Include “Heart Healthy” recipes in the Better Living quarterly magazine distributed to residents in Rhea County by RMC
• Serve as community example through healthy food service offerings in hospital cafeteria

ANTICIPATED RESULTS FROM RMC IMPLEMENTATION PLAN

• Improved rate of death due to heart disease

LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:

• Percentage of employees who participate in annual health screenings provided by the hospital
  ○ Compare numbers from each year as they are collected

LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT

• Rhea County rate of death due to heart disease moves closer to the state rate; 2012 value = 190.6

<table>
<thead>
<tr>
<th>Other local resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhea Family YMCA, 423-775-0821, Lamont Singleton, 232 4th Avenue, Dayton, TN 37321</td>
</tr>
<tr>
<td>Rhea County Health Department, 423-775-7819, Debbie Williams, RN, 334 Eagle Lane, Evensville, TN 37332</td>
</tr>
<tr>
<td>Rhea County Health Council, 423-775-5563, Christine Ralph, c/o Rhea County United Way, PO Box 669, Dayton, TN 37321</td>
</tr>
<tr>
<td>UT Agricultural Extension Service, 423-775-7807, Anna Johnson, 334 Eagle Lane, Evensville, TN 37332</td>
</tr>
</tbody>
</table>

4. Cancer: is the #2 cause of death in Rhea County. It is cited by local experts as a concern, and is worse than the Tennessee state median

Problem Statement: There is a lack of providers to care for patients covered by TNCare and there are patients with no insurance in Rhea County.

RMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

• RMC provides a full range of diagnostic imaging services to support early diagnosis and treatment of cancer including digital mammography; stereotactic breast biopsy with sentinel node identification; nuclear imaging; and PET Scan capability
• RMC provides screening colonoscopy and endoscopy with surgical intervention if indicated
• RMC provides facilities for breast cancer survivors’ support group meetings
RMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Increase community outreach for mammography services.
- Collaborate with the Health Department to utilize available grants for breast and cervical cancer screening
- Track number of mammography examinations performed at RMC

ANTICIPATED RESULTS FROM RMC IMPLEMENTATION PLAN

- Increased utilization of diagnostic screening services for breast cancer via mammography

LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:

- Number of mammography examinations performed at RMC
  - Compare numbers from each year as they are collected

LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT

- Increased percentage of Rhea County women having mammograms; 2012 rate = 93.9% of the national average

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</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Cancer Society</td>
<td>Lisa Bishop</td>
<td>6221 Shallowford Road, Chattanooga, TN 37421</td>
</tr>
<tr>
<td>Rhea County Health Department</td>
<td>Debbie Williams, RN</td>
<td>334 Eagle Lane, Evensville, TN 37332</td>
</tr>
<tr>
<td>Volunteers in Medicine</td>
<td>Sonya Franklin</td>
<td>PO BOX 514, Dayton, TN 37321</td>
</tr>
</tbody>
</table>

5. Alcohol Abuse / Substance Abuse: is cited as a concern by over 50% of the local experts

Problem Statement: Alcohol and substance abuse resources need to increase.

RMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- None

RMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- None

RMC DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASONS:
Lack of expertise or competency – RMC does not have psychiatry facilities or providers available for patients
Lack of resources – RMC does not have facilities available to treat alcohol and substance abuse
Other local organizations, cited below, have expertise to address this need

LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:
None as RMC will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations shown below as resources

LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT
None

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>Alcoholics Anonymous, Chattanooga Central Office, 423-499-6003, Christie Jolley, 5611 Ringgold Road, Chattanooga, TN 37412</td>
<td></td>
</tr>
<tr>
<td>CADAS, 423-756-7644, John Fuchcar, 205 Minor Street, Chattanooga, TN 37405</td>
<td></td>
</tr>
<tr>
<td>Crisis response team, 866-791-9225, Judy Bomar, 413 Spring Street, Chattanooga, TN 37405</td>
<td></td>
</tr>
<tr>
<td>Tennessee Poison Control Center 800-222-1222, Dr. Donna Seger, 1161 21st Avenue S, Nashville, TN 37232</td>
<td></td>
</tr>
</tbody>
</table>

6. Smoking / Tobacco Use: – local experts cite smoking and tobacco use as a significant health concern in Rhea County where the smoking rate is more that 25% than the national average.

Problem Statement: The number of local residents who smoke or otherwise uses tobacco products needs to decline.

RMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- Patients are referred to the Tennessee Tobacco Quit Line and the on-line smoking cessation program at Freedom from Smoking online for smoking cessation assistance
- RMC provides a smoke-free campus

RMC DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASONS:
• Lack of effective interventions to address the need – RMC has attempted to provide smoking cessation classes and training in the past. The participation was small – under 10 participants – and all dropped out of the class before it was completed.

**ANTICIPATED RESULTS FROM RMC IMPLEMENTATION PLAN**

• None

**LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:**

• None as RMC will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations shown below as resources

**LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT**

• None

<table>
<thead>
<tr>
<th>Other local resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Cancer Society, 423-267-8613, Lisa Bishop, 6221 Shallowford Road, Chattanooga, TN 37421</td>
</tr>
<tr>
<td>State of Tennessee Tobacco Quit Line 1-800-QUIT-NOW, Tennessee Department of Health Commissioner John Dreyzehner, MD, MPH</td>
</tr>
<tr>
<td>American Lung Association 1-800-LUNGUSA, 1466 Riverside Drive, Chattanooga, TN 37406</td>
</tr>
</tbody>
</table>

**7. Maternal and Infant Issues:** – Rhea County ten birth rate, infant mortality, white non-Hispanic infant mortality, and post-neonatal infant mortality are all above national rates and well above national goals.

**Problem Statement:** Infant mortality rates and teen birth rates are above national targets in Rhea County.

**RMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

• Emergency department nurses and physicians are certified on Pediatric Advanced Life Support (“PALS”) as well as through the Sugar & Safe Care, Temperature, Airway, Blood Pressure, Lab Work, Emotional Support (“STABLE”) program through the American Heart Association.

**RMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

• Employees and hospital administration will continue to support March of Dimes with fundraising and contributions each year ($1,500 - $2,000)

• Pregnant patients are referred or transferred to birthing centers in Chattanooga, Tennessee
- Track number of patients transferred to prenatal and postnatal care

**ANTICIPATED RESULTS FROM RMC IMPLEMENTATION PLAN**

- Patients receive appropriate, timely care

**LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:**

- Number of patients transferred to appropriate prenatal and postnatal care
  - Compare numbers from each year as they are collected

**LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT**

- Rhea County infant mortality rates; 2012 = 9.4

<table>
<thead>
<tr>
<th>Other local resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Care Center 423-775-0019, Lenita Sanders, 285 Main Street, Dayton, TN 37321</td>
</tr>
<tr>
<td>WIC program, 800-342-5942, Robin Gibbey, 344 Eagle Lane Evansville, TN 37332</td>
</tr>
<tr>
<td>University Women’s Services, 423-756-4796, Dr. Michael Smith, 9400 Rhea County Highway, Dayton, TN 37321</td>
</tr>
</tbody>
</table>

8. **Compliance Behavior:** – Cited by over 30% of local experts, Rhea County residents are 10% below national rates on “healthy eating habits”, 15% below national rates on “following treatment recommendations”, and 7% below national rates on “I am responsible for my health”

**Problem Statement:** Rhea County residents report rates of compliance with physician instructions for treatment and take responsibility for their own health lower than the national average.

**RMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- RMC provides case managers who verify discharge plans prior to patients being discharged
- RMC provides written discharge instructions to inpatients, outpatients, and emergency department patients when they leave the hospital
- RMC makes follow-up calls to emergency department, inpatient, and outpatient surgery patients after their care to verify that they understand their instructions and are able to comply

**RMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- RMC will make discharge instructions for the top three conditions and surgical procedures available on the hospital website
• Track readmission rages for congestive heart failure patients

**ANTICIPATED RESULTS FROM RMC IMPLEMENTATION PLAN**

• Patients will be encouraged to be more compliant with homecare instructions

**LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:**

• Readmission rates for congestive heart failure patients
  ○ Compare numbers from each year as they are collected

**LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT**

• Patients who reported that YES, they were given information about what to do during their recovery at home, RMC 2012 = 87%

---

<table>
<thead>
<tr>
<th>Other local resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Care of East Tennessee</strong>, 423-570-0800, Tiffany Bower, 5740 Uptain Road, 6300 Bldg, Suite 6300, Chattanooga, TN 37411</td>
</tr>
<tr>
<td><strong>Amedisys Home Health</strong>, 423-775-5263, Daphne Chapman, 25 Cranwell Road, Pikeville, TN</td>
</tr>
</tbody>
</table>

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9. **Diabetes:** – Cited by local experts as a concern, diabetes as a cause of death in Rhea County is significantly higher than expected. It is the #8 cause of death, which is worse than the state median. The chronic rate of diabetes in Rhea County is over 30% above the national average.

**Problem Statement:** Rhea County residents’ rate of diabetic screening is below the national rate.

**RMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

• RMC provides diabetic screenings at health fairs, employee wellness programs, and with Home Health Care of East Tennessee, and at Senior Neighbor Centers
• RMC wellness programs promotes healthy diet and exercise
• RMC provides “Diabetic/Carb Counting” classes to the community

**RMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

• Include “Carb Conscious” recipes in the Better Living quarterly magazine distributed to residents in Rhea County by RMC
• Serve as a community example through health food service offerings in the hospital cafeteria
• RMC will establish a process to track and report the number of people screened for diabetes at health fairs
**ANTICIPATED RESULTS FROM RMC IMPLEMENTATION PLAN**

- Greater percentage of Rhea County residents will be screened for diabetes

**LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:**

- Number of people screened for diabetes at health fairs, 2012 = 0

**LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT**

- Rhea County diabetic screening rates will move closer to the national average; 2012 = 81%

<table>
<thead>
<tr>
<th>Other local resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhea County Health Council, 423-775-5563, Christine Ralph, c/o Rhea County United Way, PO Box 669, Dayton, TN 37321</td>
</tr>
<tr>
<td>American Diabetes Association, 865-524-7868, Nash M. Childs, PE</td>
</tr>
<tr>
<td>UT Agricultural Extension Services 423-775-7807, Anna Johnson, Knoxville, TN 37996</td>
</tr>
</tbody>
</table>

10. **Physicians:** – Cited by local experts as a concern; there is one primary care physician in Rhea County for every 2,275 people. The Tennessee rate is one primary care physician for every 1,409 people, and the national benchmark is one for every 1,067 people.

**Problem Statement:** There are too few physicians providing care for patients in Rhea County.

**RMC AREA SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- Opened physician practice in Spring City

**RMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- Strategic plan: Evaluate opportunities to recruit additional primary care physicians and mid-level providers to the community
- Strategic plan: Evaluate the ability of the community to support increase cardiology and other specialty providers
- RMC physician and mid-level recruitment
- RMC will review the success of its physician recruitment process and enter discussion with the medical staff about how to construct the most desirable practice environment

**ANTICIPATED RESULTS FROM RMC IMPLEMENTATION PLAN**

- Increased access to physicians and mid-level providers in Rhea County

**LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:**
- Number of physicians and mid-level providers in Rhea County accepting new patients

**LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT**
- Primary care physician to population ratio in Rhea County; 2012 = 2,275:1

<table>
<thead>
<tr>
<th>Other local resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhea County Primary Care, Dr. Philip Daugherty, 423-775-1160, 118 16th Avenue, Dayton, TN 37321</td>
</tr>
<tr>
<td>Volunteers in Medicine 423-775-0609, Sonya Franklin, PO BOX 514, Dayton, TN 37321</td>
</tr>
<tr>
<td>Physicians Care Dayton, 423-570-0252, William E. Meadows, III, MD, 455 Chickamauga Drive, Dayton, TN 37321</td>
</tr>
</tbody>
</table>

**11. Alzheimer's:** is the #6 cause of death in Rhea County, is higher than expected, and worse than the Tennessee median

**Problem Statement:** Rhea County has inadequate treatment capacity for Alzheimer’s.

**RMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**
- None

**RMC DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASONS:**
- Lack of expertise or competency – RMC does not have psychiatry facilities or providers available for Alzheimer’s patients
- Lack of resources – RMC does not have the special facilities needed to treat Alzheimer’s patients
- Other local organizations, cited below, have expertise to address this need

**LEADING INDICATORS RMC WILL USE TO MEASURE PROGRESS:**
- None as RMC will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations shown below as resources

**LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT**
- None

<table>
<thead>
<tr>
<th>Other local resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
</table>
### 12. Dental

Cited by local experts as a need, the availability of dental services in Rhea County is below Tennessee and national peer group levels

**Problem Statement:** Rhea County has an inadequate number of dentists.

**RMC Services Available to Respond to this Need Include:**

- None

**RMC Does Not Intend to Develop an Implementation Plan for This Need for the Following Reasons:**

- Lack of expertise or competency – RMC does not have dental providers
- Lack of resources – RMC does not have funding or facilities for routine dental care

**Leading Indicators RMC Will Use to Measure Progress:**

- None as RMC will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations shown below as resources

**Lagging Indicator RMC Will Use to Identify Improvement**

- None

---

<table>
<thead>
<tr>
<th>Other Local Resources Identified During the CHNA Process Which Are Believed Available to Respond to This Need Include the Following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteers in Medicine 423-775-0609, Sonya Franklin, PO BOX 514, Dayton, TN 37321</td>
</tr>
<tr>
<td>Remote Area Medical Clinic (“RAM” clinic), 1-877-5RAMUSA</td>
</tr>
<tr>
<td>Dr. Dennis Vanmeter, DMD, 423-775-1444</td>
</tr>
<tr>
<td>Dr. Teresa Browder, DDS, 423-775-8280</td>
</tr>
<tr>
<td>Dr. Linda Moore, DDS, 423-775-0009</td>
</tr>
<tr>
<td>Dr. Mike Allport, DDS, 423-775-9971</td>
</tr>
</tbody>
</table>

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### 13. Mental Health / Suicide

Mental health issues and a lack of available services in Rhea
County were cited as an issue by local experts; Suicide is the #10 cause of death in Rhea County; health survey respondents reported poor mental health days at above the state and national average

Problem Statement: Rhea County has an inadequate number of dentists.

RMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- None

RMC DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASONS:

- Lack of expertise or competency – RMC does not have psychiatry facilities or providers available for patients
- Lack of resources – RMC does not have funding or special resources needed to treat these patients
- Other local organizations, cited below, have expertise to address this need

LEADING INDICATOR RMC WILL USE TO MEASURE PROGRESS:

- None as RMC will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations shown below as resources

LAGGING INDICATOR RMC WILL USE TO IDENTIFY IMPROVEMENT

- None

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

<table>
<thead>
<tr>
<th>Other local resources</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast Tennessee Area Agency on Aging and Disability, 866-836-6678, Jim Shulman</td>
<td></td>
</tr>
<tr>
<td>Rhea County Mental Health, 423-570-0077, Carrie Tanzi, 7200 Rhea County Highway, Dayton, TN 37321</td>
<td></td>
</tr>
<tr>
<td>Tennessee Mental Health Consumers Organization, 423-775-3205, Troy Vaughn</td>
<td></td>
</tr>
</tbody>
</table>

Other Needs Identified During the CHNA Process

14. Blood Pressure (High) – While this is the #9 cause of death in Rhea County, local experts assigned very few points to this condition for attention; The implementation plans for coronary heart disease and obesity will contribute to addressing this need

Problem Statement: The health of Rhea County residents would be improved if fewer people suffered from high blood pressure
Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:

Rhea Family YMCA, 423-775-0821, Lamont Singleton, 232 4th Avenue, Dayton, TN 37321

Rhea County Health Council, 423-775-5563, Christine Ralph, c/o Rhea County United Way, PO Box 669, Dayton, TN 37321

15. Physical Environment – Daily fine particulate matter and drinking water safety are at levels worse than national benchmarks.

Problem Statement: The health of Rhea County residents would be improved if air quality is improved and fewer people are exposed to unsafe drinking water.

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

Rhea County Health Council, 423-775-5563, Christine Ralph, c/o Rhea County United Way, PO Box 669, Dayton, TN 37321

16. Chronic COPD / Lung disease / pulmonary issues – This is the #5 cause of death in Rhea County

Problem Statement: The health of Rhea County residents would be improved if fewer people suffered from lung disease

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

American Lung Association 1-800-LUNGUSA, 1466 Riverside Drive, Chattanooga, TN 37406

17. Stroke – This is the #3 cause of death in Rhea County; the implementation plans for coronary heart disease and obesity may impact the rate of strokes

Problem Statement: The health of Rhea County residents would be improved if fewer people suffered strokes

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

Rhea Family YMCA, 423-775-0821, Lamont Singleton, 232 4th Avenue, Dayton, TN 37321
18. Cholesterol (high) – Routine screening for high cholesterol in Rhea County is 10% below the national rate; the implementation plans for coronary heart disease and obesity may impact the rate of high cholesterol.

**Problem Statement:** The health of Rhea County residents would be improved if fewer people had high cholesterol.

<table>
<thead>
<tr>
<th>Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhea Family YMCA, 423-775-0821, Lamont Singleton, 232 4th Avenue, Dayton, TN 37321</td>
</tr>
</tbody>
</table>

**Overall Community Need Statement and Priority Ranking Score:**

**Significant Needs Where Hospital Has Implementation Responsibility**

1. Affordability and access to care;
2. Obesity / overweight;
3. Coronary heart disease;
4. Cancer;
5. Maternal and infant issues;
6. Compliance behavior;
7. Diabetes; and
8. Physicians.

**Significant Needs Where Hospital Did Not Develop an Implementation Plan**

5. Alcohol abuse / substance abuse;
6. Smoking / tobacco use;
13. Alzheimer’s;
14. Availability of Dental care; and
15. Mental Health services and suicide prevention.

**Other Identified Needs Where Hospital Did Not Develop Implementation Plan**

16. Blood pressure (high);
17. Physical environment;
18. Chronic COPD / Lung disease / pulmonary issues;
19. Stroke; and
20. Cholesterol (high).

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24 Schedule H (Form 990) Part V B 6 h
APPENDICES
Appendix A – Local Expert Advisor Opinion About Significant Needs

A total of 17 local expert advisors participated in an online survey offering opinions regarding their perceptions of community health needs. The following is an analysis of their responses:

The first question was open-ended. “What do you believe to be the most important health or medical issue confronting the residents of your County?” Answers were placed in a “Word Cloud” format for analysis and generated the following image:

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.

Specific verbatim comments received were as follows:

- Without question, the number one issue facing our community's residents is access to health care insurance coupled with the ability to pay premiums. This also presents hospitals with the very large problem of delivering quality health care to the citizenry with no financial compensation. I would venture to say that fully one half of our population does not presently pay for their own health coverage or chooses not to carry coverage or is uninsurable.

- Obesity resulting from poor diet and lack of exercise.
• Obesity and a society who perpetuates unhealthy choices leading to obesity.

• The one area that needs attention is that if anyone has heart problems or broken bones they must be transported approximately 40 miles away to find proper care. I think Rhea Medical has made great strides in getting updated equipment to attract Specialty Doctors. We need to continue this trend.

• Affordable health care and affordable insurance coverage. We seem to have the facilities in place and access to general medicine and many specialists but many are uninsured.

• Our community has a large population of older people. I hear a lot of worry about insurance cost and coverage.

• Old age assistance, juvenile issues and drug use (prescription and non-prescription drug use)

• Our elder people that do not drive long distances need a reliable place to get their emergency care and follow up tests with specialists without having to leave the community in which they feel comfortable.

• The lack of proper attention to preventative "medicine" as in proper diet, nutrition, regular checkups, exercise, and general education on healthy living. Too many people never think twice about their health until an illness occurs and then many times they are uninsured causing a double burden on the community.

• Community lifestyle health education and practice in this rural county.

• My response is based on the many phone calls we receive at the Health Department on a daily basis. The largest amount of phone calls are regarding adults ages 19-64 with no insurance - many with little to no income - who are facing what they believe to be non-emergent issues. Everyone realizes that many times the Emergency Room at the Hospital ends up with these residents -- which ends up being a much larger expense to be absorbed than if it was dealt with before it progressed. Our Health Department doesn't have an on-site Primary Care Clinic and the closest two Health Departments who do have a Primary Care Clinic are not taking any new patients.

• At one time, I would have answered by saying the overall quality of care. This is no longer the case as our community hospital has done an outstanding job recruiting high caliber medical professionals and our facilities are now second to none. Without question, the number one issue facing our community's residents is access to health care insurance coupled with the ability to pay premiums. This also presents hospitals with the very large problem of delivering quality health care to the citizenry with no financial compensation. I would venture to say that fully one half of our population does not presently pay for their own health coverage or chooses not to carry coverage or is uninsurable.

• Drug Addiction
• Good health education for the public. Informing the general public as to what the hospital has to offer. Consider the public\physician ratio.

• Healthcare reform. A key component is essential health benefits.

• Poor lifestyle choices of residents including tobacco and alcohol use, poor dietary habits, misuse of prescription drugs and lack of exercise.

• Access to medical and mental health services for low income families.

• The availability of specialized services was a need in this community when we first arrived in Rhea County. . . The hospital has come a long way and is my first choice in services if they are available without me even considering larger cities with bigger hospitals. In Rhea County we have had doctors move into our area that are very qualified in their fields and that has almost eliminated our need to travel to larger cities for medical care.

• The biggest issue that I see is the lack of insurance coverage for families. With TNCare most of the children can be covered if their parents would only follow through and apply for coverage and then the adults that are not offered coverage where they work or if they don't work then they go without coverage. If the adults need medical attention they use the emergency room and because they can't be turned away that is their form of medical care. These families readily tell everyone that they don't need coverage because they just go to the ER.

• We see way too many cases of illegal drug use, misuse of prescribed drugs, and the selling of the prescribed medications that are meant for people or their children.

• Families that have insurance coverage are more often than not healthier than the ones without any coverage and the healthier families can care for their children much better.

Our second question to the local experts was, “Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e. people with certain situations), which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what.”

The responses generated the following image:
Specific verbatim comments received were as follows:

- Our youth need education about food and exercise. They need role models. They need to learn to make healthy choices so that they can change their health destiny.

- We have many uninsured/unemployed residents in our area which are morbidly obese. The health diagnosis of the year is Type II Diabetes, Coronary Artery Disease, and Hypertension. With no local Primary Care for these individuals the situation increases constantly.

- We have a huge Hispanic population with numerous health needs that are not being taken care of because what little Health Care they have access to is not providing appropriate interpreters for their rural dialects!

- Lifestyle health from early age transcends into adult health issues. A greater education and ongoing public health programs may be needed.

- Perhaps more medical service availability to the middle-aged and senior residence. Such as wellness programs that some industries provide to employee and spouse.

- I believe that most low income and undereducated members of our community participate in activities which worsen the health care delivery system. Folks who smoke, drink and refuse to exercise are typically obese and are on government subsidies of some type. Those of us who actually pay our premiums are not only subsidizing their health care costs but their overall lifestyle choices as well.
• We do have a growing minority population and as mentioned earlier, uninsured and low income people.

• Lack of prenatal care for all groups. Limited resources for those living in our community. Low-income and uninsured experience hardship when required to drive to another county to receive services. Need to increase the number of doctors providing prenatal care in Rhea County. Next issue would be to get those needing the assistance to actually use the services.

• Mental Health Services. Although the services might be available for those living in our community, many are not able to seek out the services they need. Especially the low-income or uninsured find it difficult to get the help they need and there are many times they are not in a place to even understand what services to ask for. Having an advocate assigned to help on their behalf would be beneficial.

• Counseling Services. Those in our community suffer from many situations or brokenness that could benefit from counseling. There is a lack of counselors in our community and a lack of those accepting insurance. Counseling would be most beneficial for facing many health issues or life issues, however, most will never receive the counseling. A need for additional counselors in Rhea County exists. It would be beneficial if the low-income or uninsured persons could receive this service.
# Appendix B – Process to Identify and Prioritize Community Need

<table>
<thead>
<tr>
<th>Potential Need Topic</th>
<th>Total Votes by Need</th>
<th>Experts Casting Votes</th>
<th>Cumulative Votes Cast</th>
<th>Cumulative %</th>
<th>Point Difference from Previous</th>
<th>Priority Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. AFFORDABILITY/ACCESS TO CARE</td>
<td>187</td>
<td>6</td>
<td>187</td>
<td>13.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. OBESITY/OVERWEIGHT</td>
<td>124</td>
<td>14</td>
<td>311</td>
<td>22.2%</td>
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</tr>
<tr>
<td>3. CORONARY HEART DISEASE</td>
<td>103</td>
<td>10</td>
<td>414</td>
<td>29.6%</td>
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<td></td>
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<tr>
<td>4. CANCER</td>
<td>101</td>
<td>9</td>
<td>515</td>
<td>36.8%</td>
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</tr>
<tr>
<td>5. ALCOHOL ABUSE/SUBSTANCE ABUSE</td>
<td>83</td>
<td>9</td>
<td>598</td>
<td>42.7%</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>6. SMOKING / TOBACCO USE</td>
<td>73</td>
<td>11</td>
<td>671</td>
<td>47.9%</td>
<td>10</td>
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</tr>
<tr>
<td>7. MATERNAL AND INFANT MEASURES</td>
<td>70</td>
<td>8</td>
<td>741</td>
<td>52.9%</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>8. COMPLIANCE BEHAVIOR</td>
<td>70</td>
<td>7</td>
<td>811</td>
<td>57.9%</td>
<td>0</td>
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<tr>
<td>9. DIABETES</td>
<td>66</td>
<td>6</td>
<td>877</td>
<td>62.6%</td>
<td>4</td>
<td></td>
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<tr>
<td>10. PHYSICIANS</td>
<td>64</td>
<td>10</td>
<td>941</td>
<td>67.2%</td>
<td>2</td>
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</tr>
<tr>
<td>11. ALZHEIMER’S</td>
<td>58</td>
<td>11</td>
<td>999</td>
<td>71.4%</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>12. DENTAL</td>
<td>53</td>
<td>9</td>
<td>1052</td>
<td>75.1%</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>13. MENTAL HEALTH / SUICIDE</td>
<td>51</td>
<td>11</td>
<td>1103</td>
<td>78.8%</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>14. BLOOD PRESSURE (High)</td>
<td>44</td>
<td>6</td>
<td>1147</td>
<td>81.9%</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>15. PHYSICAL ENVIRONMENT</td>
<td>33</td>
<td>7</td>
<td>1180</td>
<td>84.3%</td>
<td>11</td>
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</tr>
<tr>
<td>16. CHRONIC COPD / LUNG DISEASE / PULMONARY</td>
<td>32</td>
<td>5</td>
<td>1212</td>
<td>86.6%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>17. STROKE</td>
<td>30</td>
<td>10</td>
<td>1242</td>
<td>88.7%</td>
<td>2</td>
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</tr>
<tr>
<td>18. CHOLESTEROL (HIGH)</td>
<td>22</td>
<td>10</td>
<td>1264</td>
<td>90.3%</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>19. ACCIDENTS</td>
<td>21</td>
<td>12</td>
<td>1285</td>
<td>91.8%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>20. SEXUALLY TRANSMITTED DISEASE</td>
<td>20</td>
<td>7</td>
<td>1305</td>
<td>93.2%</td>
<td>1</td>
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<tr>
<td>21. CHRONIC OSTEOPOROSIS</td>
<td>15</td>
<td>8</td>
<td>1320</td>
<td>94.3%</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>22. FLU</td>
<td>12</td>
<td>10</td>
<td>1332</td>
<td>95.1%</td>
<td>3</td>
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<tr>
<td>23. PRIORITY POPULATION</td>
<td>12</td>
<td>7</td>
<td>1344</td>
<td>96.0%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>24. PALLIATIVE CARE &amp; HOSPICE</td>
<td>11</td>
<td>9</td>
<td>1355</td>
<td>96.8%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>27. WELLNESS AND LIFESTYLE EDUCATION</td>
<td>10</td>
<td>1</td>
<td>1365</td>
<td>97.5%</td>
<td>1</td>
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<tr>
<td>28. LONG TERM HEALTH CARE FOR AGING</td>
<td>10</td>
<td>1</td>
<td>1375</td>
<td>98.2%</td>
<td>0</td>
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</tr>
<tr>
<td>25. KIDNEY</td>
<td>9</td>
<td>11</td>
<td>1384</td>
<td>98.9%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>26. LOW BACK PAIN (Chronic)</td>
<td>6</td>
<td>7</td>
<td>1390</td>
<td>99.3%</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>29. HEALTHCARE COST AND IMPROVE THE QUALITY OF CARE</td>
<td>5</td>
<td>1</td>
<td>1395</td>
<td>99.6%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>30. COMMUNITY EDUCATION PROGRAMS</td>
<td>5</td>
<td>1</td>
<td>1400</td>
<td>100.0%</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Individuals Participating as Local Expert Advisors

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25 Responds to IRS Schedule H (990) Part V B 1 g and V B 1 h.
<table>
<thead>
<tr>
<th>Company or Organization</th>
<th>Title or Position</th>
<th>Area of Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dayton Housing Authority</td>
<td>Executive Director</td>
<td>Community Leader</td>
</tr>
<tr>
<td>State of Tennessee Department of Health</td>
<td>Community Health Council Coordinator</td>
<td>Public Health Education</td>
</tr>
<tr>
<td>Community National Bank</td>
<td>Vice President</td>
<td>Broad Community Interest</td>
</tr>
<tr>
<td>Robinson Manufacturing Company</td>
<td>Retired</td>
<td>Long time community resident</td>
</tr>
<tr>
<td>We Care Social Services Agency, Inc.</td>
<td>President</td>
<td>Public Health</td>
</tr>
<tr>
<td>NAPA Auto Parts/Dayton-Pikeville</td>
<td>President</td>
<td>Long-term resident / businessman</td>
</tr>
<tr>
<td>Rhea County Health Department</td>
<td>Nursing Supervisor</td>
<td>Public Health</td>
</tr>
<tr>
<td>SouthEast Bank</td>
<td>Vice President</td>
<td>Community Leader</td>
</tr>
<tr>
<td>Past Hospital Board Member</td>
<td>Retired</td>
<td>Leader</td>
</tr>
<tr>
<td>Suburban Manufacturing Company (Retired)</td>
<td>President</td>
<td>Leader</td>
</tr>
</tbody>
</table>
Company or Organization: Dayton Chamber of Commerce
Title or Position: Board of Directors
Area of Expertise: Broad Community Interest

Company or Organization: Rotary Club of Dayton
Title or Position: President
Area of Expertise: Broad Community Interest

Company or Organization: City of Dayton
Title or Position: Building Inspector
Area of Expertise: Health & welfare of the citizens of City of Dayton

Company or Organization: City of Dayton
Title or Position: Mayor
Area of Expertise: Representative of populations

Company or Organization: Bryan College
Title or Position: Director of Gift and Estate Design
Area of Expertise: Broad Community Interest

Company or Organization: Women’s Care Center
Title or Position: Executive Director
Area of Expertise: Public Health, Pregnancy resource

Advice Received from Local Experts

Q. Do you agree with the observations formed about the comparison of Rhea County to all other State counties?
Clarifying reasons for opinions and additional needs which reported by local experts:

- Also, a recent community needs assessment showed "bullying" as the number one need for help in the county.

- Since I am not experienced in the Drinking Water numbers I am surprised by this statement. I would have thought a larger majority of our population had access to city water resources. Our environmentalist does agree that of those who still use only well water, most test positive for E.coli.

- It has been my observation we have adequate access to Primary Care and Dentists for those insured residents. It's the uninsured who have this huge need.

- Our industry does not affect air pollution.

- Excellent access to recreational facilities.

- Healthy foods readily available.

- Agree with percentage of fast food.

- Drinking water safety not an issue.

Q. Do you agree with the observations formed about the comparison of Rhea County to its peer counties?
Clarifying reasons for opinions and additional needs reported by local experts:

- Am not able to make a determination without more information.

- Within the daily conversation of community activities and printed publications I don't hear of suicides or infant mortalities, only as a rarity of incidents or events. I do hear of many of the other noted titles such as births to single and very young women, etc.

- Additional training needs to be available to teenagers about negative results of sexual and drug usage.

- I very strongly disagree on the unfavorable observations. Rhea County has a very good Health & Wellness program provided by a number of agencies, including Rhea Medical Center.

Q. Do you agree with the observations formed about the population characteristics of Rhea County?
Clarifying reasons for opinions and additional needs reported by local experts:

- I would disagree that healthy eating habits data is correct. Our obesity rates, number of fast food restaurants, and other chronic conditions lead me to doubt those findings. I think it is much worse.
- Lack of knowledge and cost of Insurance creates these numbers.
- This does not compare with the findings in Rhea County in our Health & Wellness Program.

Q. Do you agree with the observations formed about the opinions from local residents?
Clarifying reasons for opinions and additional needs reported by local experts:

- Lack of health care insurance that is affordable along with high percentage of elders that cannot afford the available health care.

Q. Do you agree with the observations formed about the additional data analyzed about Rhea County?

Do you agree with the summary of other data analyzed?

- I agree with the above observations: 88%
- I disagree with some or all of the observations: 13%

Clarifying reasons for opinions and additional needs reported by local experts:

- G. [Rhea is not designated as a Health Provider Shortage Area] By the numbers this may be true but as is true in most rural areas the real issue is a quality health professional shortage. There is also tremendous pressure on good providers to spend less time with their patients.
- H. [Percentage of residents that live in poverty] This figure should be the same as the percentage on Medicaid which I believe to be higher than 12.4%.

- No doubt the individual completing the Survey was only relaying information they had been given, but, how can I [1 Primary Care Physician for every 2,275 people in Rhea County] and J [1 Dentist for every 3,641 people in Rhea County] be true and G [Rhea is not designated as a Health Provider Shortage Area] at the same time. If all this data is concrete we have more issues to deal with than we had originally thought.
- In my opinion, the government standard for free lunch program is too high.
- My first survey taken sighted on Wellness Education which focuses on the youth to be educated and through to the home and parents. I find that 67% of students are enrolled in
free and reduced lunch programs to be "unbelievable". I guess I don't understand the rule/regulations concerning this program!!!!!!
Appendix C – Illustrative Schedule H (Form 990) Part V B Potential Response

Illustrative IRS Schedule H Part V Section B (form 990)26

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 #15 (page 11) & #16 (page 11)
1. b. – See Footnote #17 (page 12)
1. c. – See Footnote #23 (page 28)
1. d. – See Footnote #7 (page 6)
1. e. – See Footnote #11 (page 8)
1. f. – See Footnote #9 (page 8)

26 Questions are drawn from 2012 f990sh.pdf Forms and may change when the hospital is to make its 990 h filing
1. g. – See Footnotes #12 (page 9) & #25 (page 50)
1. h. – See Footnotes #8 (page 8) & #25 (page 50)
1. i. – See Footnote #6 (page 6)
1. j. – No response needed

2. **Indicate the tax year the hospital facility last conducted a CHNA: 20_ _**

   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 Footnote #10 (page 8)

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, b, f, g, and h.

6. a. – See footnote #22 (page 27)
6. b. – See footnote #22 (page 27)
6. g. – See footnotes #12 (page 9)
6. h. – See footnote #24 (page 43)

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

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 Form4720 for all of its hospital facilities?

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