# Gritman Medical Center

*Moscow, Idaho*

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution December 11th, 2019[1]

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

Gritman
MEDICAL CENTER

Dear Community Member:

At Gritman Medical Center (GMC), we have spent more than 100 years providing high-quality compassionate healthcare to the greater Moscow community. The "2019 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how GMC will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

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

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

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

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

Thank You,

Kara Besst
Chief Executive Officer
Gritman Medical Center

# TABLE OF CONTENTS

# EXECUTIVE SUMMARY

# EXECUTIVE SUMMARY

Gritman Medical Center ("GMC" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community.

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

The 2019 Significant Health Needs identified for Latah County are:

1. Mental Health/Suicide – 2016 Significant Need
2. Affordability/Accessibility – 2016 Significant Need
3. Physicians – 2016 Significant Need
4. Substance Abuse – 2016 Significant Need
5. Education/Prevention
6. Chronic Pain Management

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

# APPROACH

# APPROACH

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

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

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

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

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

## Project Objectives

GMC partnered with Quorum Health Resources (Quorum) to:[4]

- Complete a CHNA report, compliant with Treasury – IRS
- Provide the Hospital with information required to complete the IRS – Schedule H (Form 990)
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

## Overview of Community Health Needs Assessment

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

---

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

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

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

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

Specifically, the IRS requires:

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

## Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

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

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Other** (please specify)

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

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

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

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

existed in their portion of the county.[10]

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

Data sources include:[11]

| Website or Data Source | Data Element | Date Accessed | Data Date |
|---|---|---|---|
| www.countyhealthrankings.org | Assessment of health needs of Latah County compared to all Idaho counties | August 7, 2019 | 2012-2018 |
| IBM Watson Health (formerly known as Truven Health Analytics) | Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics | August 9, 2019 | 2019 |
| http://svi.cdc.gov | To identify the Social Vulnerability Index value | August 8, 2019 | 2012-2016 |
| http://www.healthdata.org/us-county-profiles | To look at trends of key health metrics over time | August 7, 2019 | 2014 |
| www.worldlifeexpectancy.com/usa-health-rankings | To determine relative importance among 15 top causes of death | August 8, 2019 | 2017 |

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

- A CHNA survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the

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

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

needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 31 Local Expert Advisors was received. Survey responses started September 15th, 2019 and ended on October 20th, 2019.

- Information analysis augmented by local opinions showed how Latah County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12] [13]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
    - The top three priority populations in the area are residents of rural areas, low-income groups, and older adults
    - There should be a focus on providing affordable and accessible care to the community
        - Issues with transportation
        - Shortage of services related to mental health and substance abuse

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

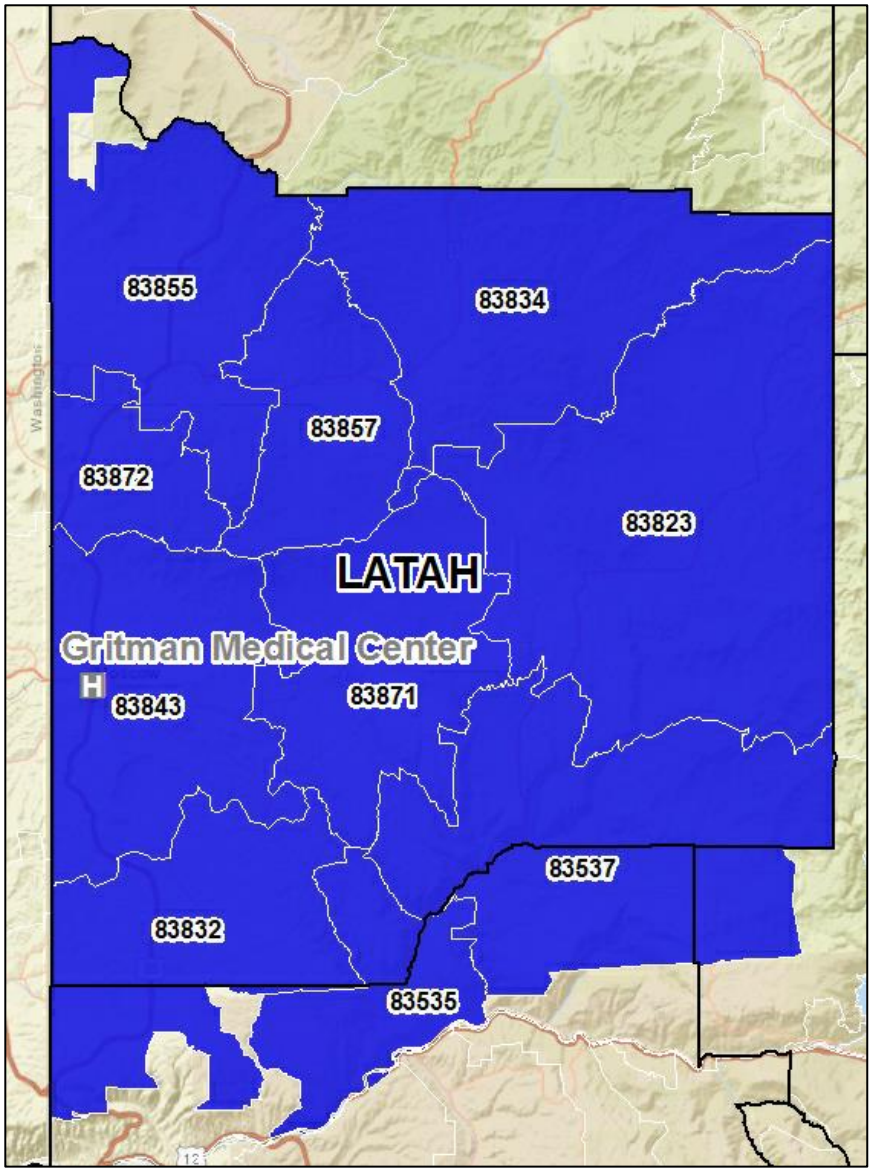
In the GMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list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

The ranked needs were divided into two groups: "Significant" and "Other Identified Needs." The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least sixty percent (60%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable break point in rank order occurred.[15]

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

# COMMUNITY CHARACTERISTICS

## Definition of Area Served by the Hospital[16]




For the purposes of this study, Gritman Medical Center defines its service area as Latah County in Idaho, which includes the following ZIP codes:[17]

| | | | | |
|---|---|---|---|---|
| 83535 – Juliaetta | 83537 – Kendrick | 83823 – Deary | 83832 – Genesee | 83834 – Harvard |
| 83843 – Moscow | 83855 – Potlatch | 83857 – Princeton | 83871 – Troy | 83872 – Viola |

During 2018, the Hospital received 80.5% of its Medicare inpatients from this area.[18]

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

## Demographics of the Community[19] [20]

| Variable | Latah County 2019 | Latah County 2024 | Latah County %Change | Idaho 2019 | Idaho 2024 | Idaho %Change | United States 2019 | United States 2024 | United States %Change |
|---|---|---|---|---|---|---|---|---|---|
| **DEMOGRAPHIC CHARACTERISTICS** | | | | | | | | | |
| Total Population | 40,776 | 42,583 | 4.4% | 1,758,469 | 1,868,439 | 6.3% | 329,236,175 | 340,950,067 | 3.6% |
| Total Male Population | 20,882 | 21,768 | 4.2% | 879,909 | 933,784 | 6.1% | 162,097,263 | 167,921,866 | 3.6% |
| Total Female Population | 19,894 | 20,815 | 4.6% | 878,560 | 934,655 | 6.4% | 167,138,912 | 173,028,201 | 3.5% |
| Females, Child Bearing Age (15-44) | 9,616 | 9,856 | 2.5% | 338,270 | 358,706 | 6.0% | 64,251,309 | 65,231,610 | 1.5% |
| Average Household Income | $62,828 | | | $74,015 | | | $89,646 | | |
| **POPULATION DISTRIBUTION** | | | | | | | | | |
| *Age Distribution* | | | | | | | | | |
| 0-14 | 6,542 | 6,964 | 6.5% | 371,714 | 380,007 | 2.2% | 61,258,096 | 61,645,382 | 0.6% |
| 15-17 | 1,378 | 1,401 | 1.7% | 76,567 | 82,449 | 7.7% | 12,813,020 | 13,319,388 | 4.0% |
| 18-24 | 8,781 | 7,958 | -9.4% | 172,501 | 191,878 | 11.2% | 31,474,821 | 32,296,411 | 2.6% |
| 25-34 | 6,032 | 6,480 | 7.4% | 222,613 | 226,502 | 1.7% | 44,370,805 | 43,645,423 | -1.6% |
| 35-54 | 8,101 | 9,028 | 11.4% | 419,993 | 441,922 | 5.2% | 83,304,733 | 84,255,193 | 1.1% |
| 55-64 | 4,234 | 4,028 | -4.9% | 212,956 | 213,225 | 0.1% | 42,525,512 | 43,333,585 | 1.9% |
| 65+ | 5,708 | 6,724 | 17.8% | 282,125 | 332,456 | 17.8% | 53,489,188 | 62,454,685 | 16.8% |
| **HOUSEHOLD INCOME DISTRIBUTION** | | | | | | | | | |
| Total Households | 16,570 | 17,500 | 5.6% | 654,886 | 698,357 | 6.6% | 125,018,838 | 129,683,911 | 3.7% |
| *2019 Household Income* | | | | | | | | | |
| <$15K | 2,991 | | | 71,843 | | | 13,139,420 | | |
| $15-25K | 1,696 | | | 62,820 | | | 11,333,086 | | |
| $25-50K | 4,107 | | | 161,169 | | | 26,888,001 | | |
| $50-75K | 2,871 | | | 127,072 | | | 21,157,116 | | |
| $75-100K | 1,720 | | | 84,382 | | | 15,409,735 | | |
| Over $100K | 3,185 | | | 147,600 | | | 37,091,480 | | |
| **EDUCATION LEVEL** | | | | | | | | | |
| Pop Age 25+ | 24,075 | | | 1,137,687 | | | 223,690,238 | | |
| *2019 Adult Education Level Distribution* | | | | | | | | | |
| Less than High School | 311 | | | 38,323 | | | 12,173,720 | | |
| Some High School | 670 | | | 71,864 | | | 16,245,471 | | |
| High School Degree | 4,982 | | | 316,858 | | | 61,068,735 | | |
| Some College/Assoc. Degree | 7,225 | | | 404,257 | | | 64,945,355 | | |
| Bachelor's Degree or Greater | 10,887 | | | 306,385 | | | 69,256,957 | | |
| **RACE/ETHNICITY** | | | | | | | | | |
| *2019 Race/Ethnicity Distribution* | | | | | | | | | |
| White Non-Hispanic | 35,908 | | | 1,432,389 | | | 197,594,684 | | |
| Black Non-Hispanic | 447 | | | 12,794 | | | 40,877,627 | | |
| Hispanic | 1,906 | | | 226,311 | | | 60,675,779 | | |
| Asian & Pacific Is. Non-Hispanic | 958 | | | 28,353 | | | 19,327,168 | | |
| All Others | 1,557 | | | 58,622 | | | 10,760,917 | | |

[19] Responds to IRS Schedule H (Form 990) Part V B 3 b
[20] Claritas (accessed through IBM Watson Health)

## Consumer Health Service Behavior[21]

Key health services topics for the service area population are presented in the table below. In the second column of the chart, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

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

| Health Service Topic | Demand as % of National | % of Population Affected |
|---|---|---|
| **Weight / Lifestyle** | | |
| BMI: Morbid/Obese | 97.0% | 29.6% |
| Vigorous Exercise | 94.9% | 54.2% |
| Chronic Diabetes | 98.8% | 15.5% |
| Healthy Eating Habits | 88.4% | 20.6% |
| Ate Breakfast Yesterday | 98.3% | 77.8% |
| Slept Less Than 6 Hours | 115.2% | 15.7% |
| Consumed Alcohol in the Past 30 Days | 94.4% | 50.8% |
| Consumed 3+ Drinks Per Session | 114.4% | 32.2% |
| **Behavior** | | |
| Search for Pricing Info | 98.5% | 26.5% |
| I am Responsible for My Health | 99.2% | 89.8% |
| I Follow Treatment Recommendations | 96.6% | 74.4% |
| **Pulmonary** | | |
| Chronic COPD | 96.6% | 5.2% |
| Chronic Asthma | 129.2% | 15.2% |
| **Heart** | | |
| Chronic High Cholesterol | 84.2% | 20.6% |
| Routine Cholesterol Screening | 94.9% | 42.1% |
| Chronic Heart Failure | 99.9% | 4.0% |

| Health Service Topic | Demand as % of National | % of Population Affected |
|---|---|---|
| **Cancer** | | |
| Cancer Screen: Skin 2 yr | 64.6% | 6.9% |
| Cancer Screen: Colorectal 2 yr | 76.8% | 15.8% |
| Cancer Screen: Pap/Cerv Test 2 yr | 100.7% | 48.5% |
| Routine Screen: Prostate 2 yr | 77.4% | 22.0% |
| **Orthopedic** | | |
| Chronic Lower Back Pain | 107.3% | 33.1% |
| Chronic Osteoporosis | 75.1% | 7.6% |
| **Routine Services** | | |
| FP/GP: 1+ Visit | 101.2% | 82.4% |
| NP/PA Last 6 Months | 94.3% | 39.1% |
| OB/Gyn 1+ Visit | 111.7% | 42.8% |
| Medication: Received Prescription | 105.2% | 57.7% |
| **Internet Usage** | | |
| Use Internet to Look for Provider Info | 108.2% | 43.2% |
| Facebook Opinions | 94.3% | 9.5% |
| Looked for Provider Rating | 76.1% | 17.8% |
| **Emergency Services** | | |
| Emergency Room Use | 112.8% | 39.2% |
| Urgent Care Use | 107.8% | 35.5% |

[21] Claritas (accessed through IBM Watson Health)

## Conclusions from Demographic Analysis Compared to National Averages

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

- 5.1% less likely to **Vigorously Exercise**, affecting 54.2%
- 14.4% more likely to **Consume 3+ Drinks per Session**, affecting 32.2%
- 5.1% less likely to receive **Routine Cholesterol Screenings**, affecting 42.1%
- 7.3% more likely have **Chronic Lower Back Pain**, affecting 33.1%
- 5.7% less likely to receive **Routine NP/PA Visit in the Last 6 Months**, affecting 39.1%
- 12.8% more likely to **Visit the Emergency Room (for non-emergent issues)**, affecting 39.2%

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

- 5.6% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 50.8%
- 11.7% more likely to receive **Routine OB/Gyn Visit**, affecting 42.8%

## Leading Causes of Death[22]

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

| Cause of Death | | | Rank among all counties in ID (#1 rank = worst in state) | Rate of Death per 100,000 age adjusted | | Observation (Latah County Compared to U.S.) |
|---|---|---|---|---|---|---|
| ID Rank | Latah Rank | Condition | | ID | Latah | |
| 2 | 1 | Cancer | 27 of 43 | 153.2 | 150.9 | As expected |
| 1 | 2 | Heart Disease | 38 of 43 | 162.4 | 147.8 | Lower than expected |
| 5 | 3 | Stroke | 23 of 43 | 38.5 | 46.6 | Higher than expected |
| 4 | 4 | Accidents | 35 of 43 | 49.7 | 46.1 | As expected |
| 3 | 5 | Lung | 35 of 43 | 47.2 | 37.0 | As expected |
| 6 | 6 | Alzheimer's | 12 of 43 | 36.6 | 26.2 | As expected |
| 7 | 7 | Diabetes | 38 of 43 | 20.2 | 15.3 | Lower than expected |
| 8 | 8 | Suicide | 39 of 43 | 23.1 | 13.9 | As expected |
| 9 | 9 | Flu - Pneumonia | 32 of 43 | 13.7 | 12.9 | As expected |
| 10 | 10 | Parkinson's | 1 of 43 | 11.1 | 11.6 | As expected |
| 11 | 11 | Liver | 34 of 42 | 10.2 | 6.9 | As expected |
| 14 | 12 | Hypertension | 22 of 42 | 4.9 | 5.5 | As expected |
| 12 | 13 | Kidney | 42 of 43 | 8.9 | 5.0 | Lower than expected |
| 13 | 14 | Blood Poisoning | 33 of 42 | 6.2 | 3.5 | Lower than expected |
| 15 | 15 | Homicide | 28 of 40 | 3.0 | 2.1 | As expected |

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

## Priority Populations[23]

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

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

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[24]

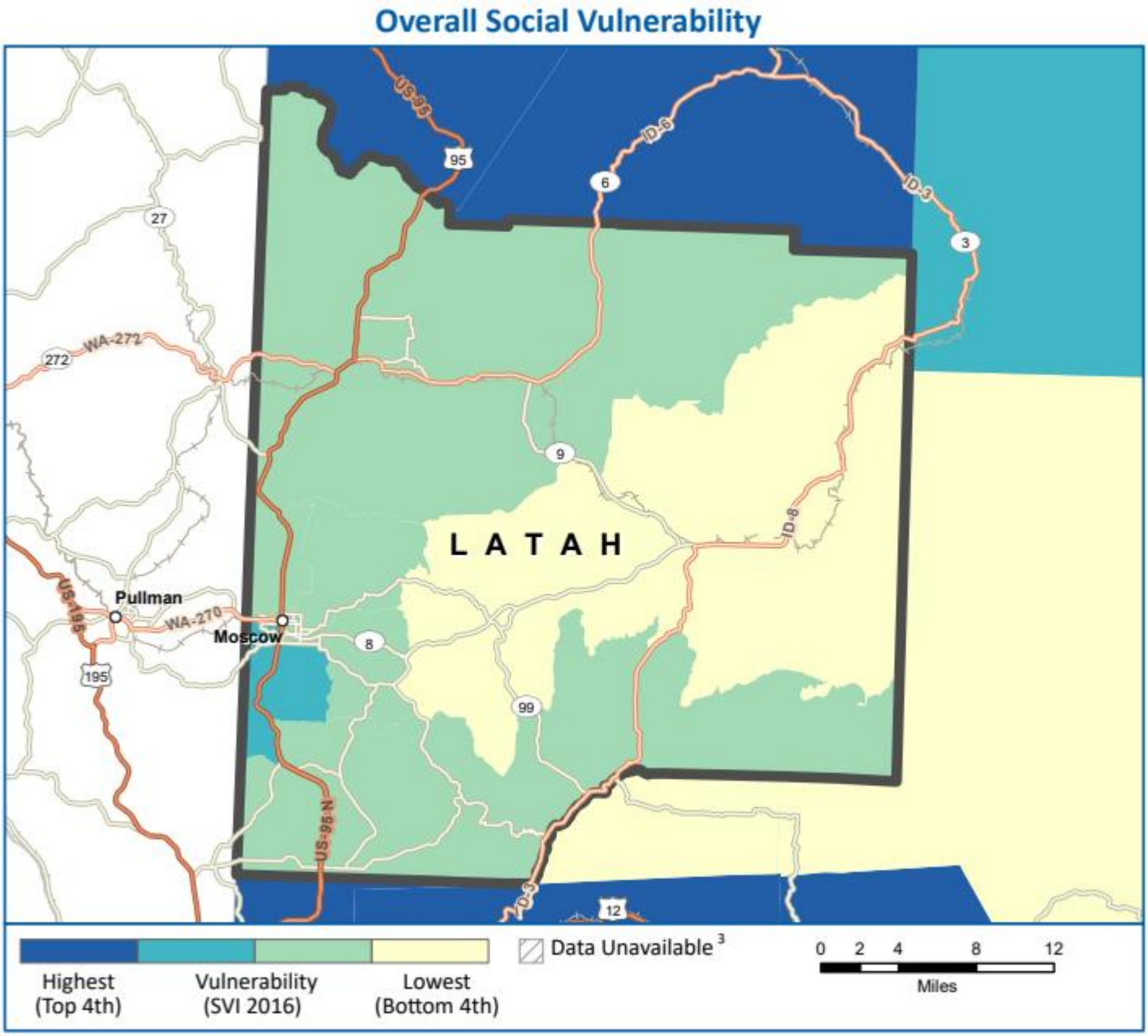
- The top three priority populations in the area are residents of rural areas, low-income groups, and older adults
- There should be a focus on providing affordable and accessible care to the community
    - Issues with transportation
    - Shortage of services related to mental health and substance abuse

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

## Social Vulnerability[25]

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

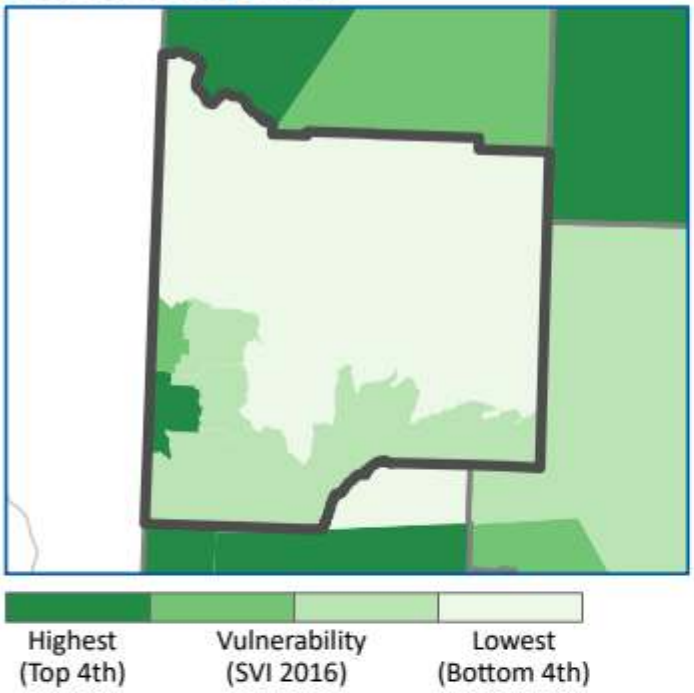
Based on the overall social vulnerability map, Latah County falls into the three of the four quartiles of social vulnerability. The majority of the county falls into the lowest quartile (light yellow) and the second lowest quartile (light green), making the county less vulnerable. The lower the social vulnerability the better.



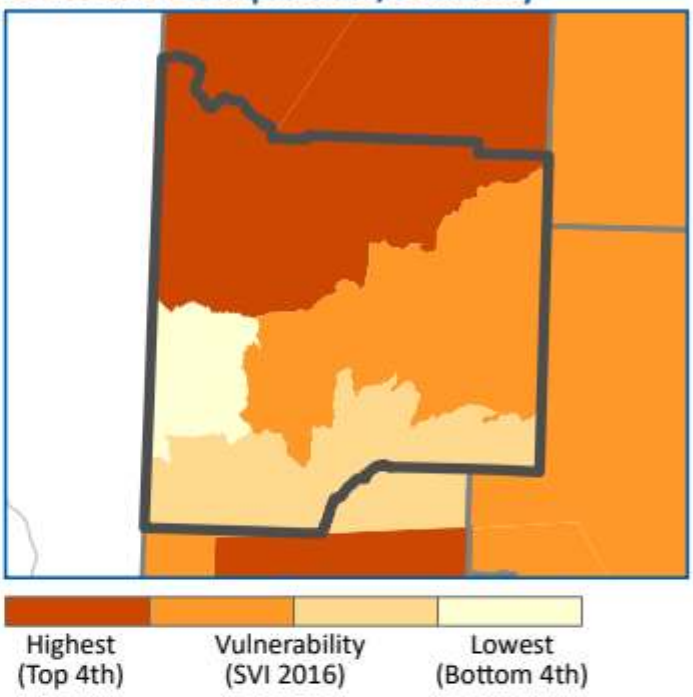

[25] http://svi.cdc.gov

## SVI Themes

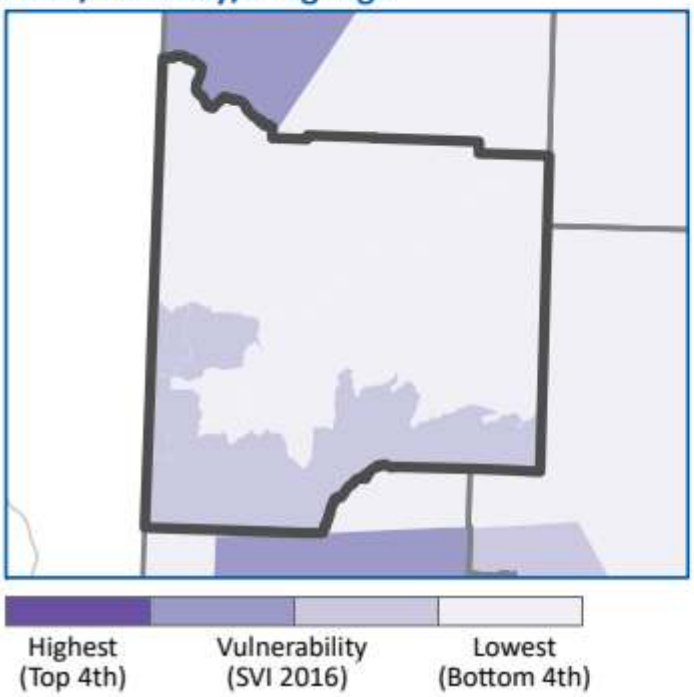
### Socioeconomic Status



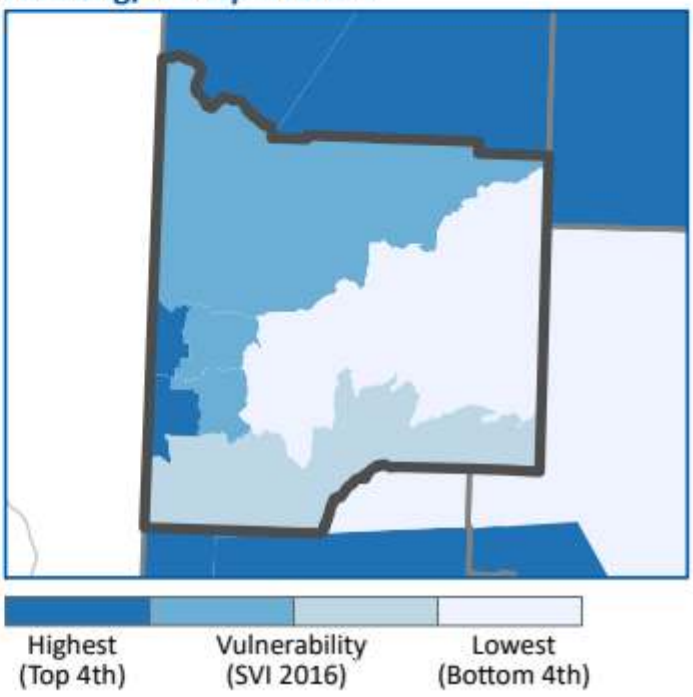

### Household Composition/Disability




### Race/Ethnicity/Language




### Housing/Transportation



## Comparison to Other State Counties[26]

To better understand the community, Latah County has been compared to all 42 counties in the state of Idaho across six areas: Length of Life, Quality of Life, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment.

In the chart below, the county's rank compared to all counties is listed along with measures in each area compared to the state average and U.S. Median.

| | Latah | Idaho | U.S. Median |
|---|---|---|---|
| **Length of Life** | | | |
| Overall Rank *(best being #1)* | **4/42** | | |
| - Premature Death* | 4,900 | 6,300 | 8,100 |
| **Quality of Life** | | | |
| Overall Rank *(best being #1)* | **5/42** | | |
| - Poor or Fair Health | 14% | 15% | 17% |
| - Poor Physical Health Days Reported in Past 30 Days (average) | 3.7 | 3.7 | 3.9 |
| - Poor Mental Health Days Reported in Past 30 Days (average) | 3.9 | 3.7 | 3.9 |
| - Low Birthweight | 5% | 7% | 8% |
| **Health Behaviors** | | | |
| Overall Rank *(best being #1)* | **8/42** | | |
| - Adult Smoking | 14% | 14% | 17% |
| - Adult Obesity | 22% | 28% | 32% |
| - Physical Inactivity | 15% | 19% | 26% |
| - Access to Exercise Opportunities | 82% | 78% | 66% |
| - Excessive Drinking | 20% | 17% | 17% |
| - Alcohol-Impaired Driving Deaths | 39% | 31% | 28% |
| - Sexually Transmitted Infections* | 358.5 | 356.3 | 321.7 |
| - Teen Births *(per 1,000 female population ages 15-19)* | 9 | 24 | 31 |
| **Clinical Care** | | | |
| Overall Rank *(best being #1)* | **3/42** | | |
| - Uninsured | 10% | 12% | 10% |
| - Population to Primary Care Provider Ratio | 1,120:1 | 1,550:1 | 2,050:1 |
| - Population to Dentist Ratio | 2,460:1 | 1,550:1 | 2,450:1 |
| - Population to Mental Health Provider Ratio | 690:1 | 510:1 | 970:1 |
| - Preventable Hospital Stays | 2,655 | 2,696 | 4,648 |
| - Mammography Screening | 47% | 39% | 40% |
| - Flu vaccinations | 43% | 39% | 42% |
| **Social & Economic Factors** | | | |
| Overall Rank *(best being #1)* | **5/42** | | |
| - Unemployment | 2.7% | 3.2% | 4.4% |
| - Children in Poverty | 12% | 15% | 21% |
| - Income Inequality** | 6.0 | 4.3 | 4.4 |
| - Children in Single-Parent Households | 22% | 25% | 32% |
| - Violent Crime* | 105 | 221 | 205 |
| - Injury Deaths* | 65 | 73 | 82 |
| **Physical Environment** | | | |
| Overall Rank *(best being #1)* | **28/42** | | |
| - Air Pollution - Particulate Matter | 9.3 µg/m³ | 7.4 µg/m³ | 9.2 µg/m³ |
| - Severe Housing Problems*** | 19% | 16% | 14% |

***Per 100,000 Population***

****Ratio of household income at the 80th percentile to income at the 20th percentile***

*****Severe housing problems = overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities***

[26] www.countyhealthrankings.org

## Conclusions from Other Statistical Data[27]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Latah County statistics to the U.S. average, as well as the trend in each measure over a 34-year span.

| Latah County | Current Statistic (2014) | Percent Change (1980-2014) |
|---|---|---|
| **UNFAVORABLE** Latah County measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change | | |
| N/A | | |
| **UNFAVORABLE** Latah County measures that are **WORSE** than the U.S. average and had a **FAVORABLE** change | | |
| - Female Stroke* | 51.3 | -49.4% |
| - Male Stroke* | 52.9 | -41.8% |
| - Female Transport Injuries Related Deaths* | 10.8 | -24.1% |
| **DESIRABLE** Latah County measures that are **BETTER** than the US average and had an **UNFAVORABLE** change | | |
| - Female Tracheal, Bronchus, and Lung Cancer* | 31.2 | 14.0% |
| - Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths* | 39.0 | 48.9% |
| - Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths* | 45.4 | 25.3% |
| - Male Self-Harm and Interpersonal Violence Related Deaths* | 27.1 | 4.0% |
| - Female Mental and Substance Use Related Deaths* | 4.9 | 205.0% |
| - Male Mental and Substance Use Related Deaths* | 12.5 | 173.7% |
| - Male Liver Disease Related Deaths* | 15.5 | 15.8% |
| **DESIRABLE** Latah County measures that are **BETTER** than the US average and had a **FAVORABLE** change | | |
| - Female Life Expectancy | 82.9 | 5.1% |
| - Male Life Expectancy | 79.2 | 6.6% |
| - Female Heart Disease* | 83.9 | -60.0% |
| - Male Heart Disease* | 151.0 | -58.1% |
| - Male Tracheal, Bronchus, and Lung Cancer* | 40.2 | -40.6% |
| - Female Self-Harm and Interpersonal Violence Related Deaths* | 7.1 | -13.6% |
| **AVERAGE** Latah County measures that are **EQUAL** to the US average and had an **UNFAVORABLE** change | | |
| - Female Skin Cancer* | 2.2 | 5.5% |
| - Male Skin Cancer* | 5.1 | 51.5% |
| - Female Liver Disease Related Deaths* | 12.2 | 12.4% |
| **AVERAGE** Latah County measures that are **EQUAL** to the US average and had a **FAVORABLE** change | | |
| - Female Breast Cancer* | 24.5 | -29.6% |
| - Male Breast Cancer* | 0.3 | -5.6% |
| - Male Transport Injuries Related Deaths* | 19.8 | -35.9% |

*rate per 100,000 population, age-standardized

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

## Community Benefit

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

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

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

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

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

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

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

Activities reported by the Hospital in its implementation efforts and/or its prior year tax reporting (FY2018) included:

Net Benefit of Community Benefit Activities (From Schedule H, Part I, Question 7k, column E) $5,953,888

Activities Included:

- Financial Assistance to the Community
- Subsided health services, including clinics in our rural communities
- Mentoring and Education to Health Professions
- Donating space to Community groups
- Involvement in Health Fairs
- SANE Exams in our Emergency Room
- Lactation Counseling in Family Birth
- Tabaco Cessation Counseling
- Support groups for Diabetes, Motherhood Connections, Parkinson's
- Fit and Fall Proof Classes

# IMPLEMENTATION STRATEGY

## Significant Health Needs

The methodology used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by GMC.[28] 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 GMC current efforts responding to the need including any written comments received regarding prior GMC implementation actions
- Establishes the Implementation Strategy programs and resources GMC will devote to attempt to achieve improvements
- Documents the Leading Indicators GMC will use to measure progress
- Presents the Lagging Indicators GMC 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, GMC is the major hospital in the service area. GMC is a 25-bed, acute care medical facility located in Moscow, Idaho. The next closest facilities are outside the service area and include:

- Pullman Regional Hospital, Pullman, WA, 9 miles (17 minutes)
- Whitman Hospital & Medical Center, Colfax, WA, 25 miles (37 minutes)
- St. Joseph Regional Medical Center, Lewiston, ID, 32 miles (29 minutes)
- Tri-State Memorial Hospital, Clarkston, WA, 36 miles (42 minutes)

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

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

1. **MENTAL HEALTH/SUICIDE –** 2016 Significant Need; Latah County's poor mental health days reported in the past 30 days is slightly above the state average; Population to mental health provider ratio is worse than the state average; Suicide is the #8 leading cause of death in Latah County; Latah County's mental and substance use related deaths increased from 1980-2014 (Female death rate increased 205.0%; Male death rate increased 173.7%)

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

- *See Appendix A for full list of comments*

**GMC services, programs, and resources available to respond to this need include:**[29]

- Safe room available in ED for patients presenting with mental health issues
- Employee Assistance Program available to GMC employees and family members that includes four free visits to mental health professionals per topic per year
- GMC hosts and is represented on multi-agency Community Behavioral Health Team that helps expedite care, facilitate placement, and organize community-wide plans and solutions
- GMC works with Latah Recovery Center, which provides resources, classes, and coaching to help people recover
- GMC supports a local organization that provides services and resources to help the homeless population become sustainable
- Participating in multi-hospital focus group to research additional facilities and services for patients awaiting transfer to acute care
- Intake form includes screening questions regarding mental health and substance abuse; following positive screening, provider will address and connect patient to needed resources
- Moscow ED physicians (contracted with GMC) are paid for an anti-bullying program in the Potlatch school district for 2019
- Offering adult and adolescent training programs aimed at identifying individuals at risk of suicide and future community member training opportunities could be an area of focus
- Crisis intervention training occurs yearly for first responders (EMS/police)
- Provide "safe sitter' and "safe at home" training for children and teens
- Case manager, counselors and psychiatrist work together to assist patients in crisis

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

- Explore additional opportunities with local police department on assisting with patient transfers to facilities
- Explore partnerships with local crisis center to develop plans for follow-up care, including potential connection

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

with GMC psychiatrists/mental health providers

- GMC discussing potential mental health relationship (partnering or purchase) with two physician groups
- Exploring collaboration opportunities with the University of Idaho following replacement of university psychiatrist with nurse practitioner

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

- Remodeled safe room in the emergency department
- Working with local police department to help assist with transfers to other facilities
- Recruited 2 psychiatrists (1 full time, 1 visits twice/month and specializes in children < 12)
- State-funded crisis center now open in community and some partnerships are forming between crisis center and Latah Recovery Center (crisis center is 24-hour)
- Added counselor in outpatient clinic setting in collaboration with local school district; program started in Potlatch, looking to expand to at least 2 other schools
- CHAS (Community Health Association of Spokane) includes a pharmacy and counseling and works with GMC to connect unattached patients with PCP in the GMC network

**Anticipated results from GMC Implementation Strategy**

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

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

- Number of psychiatric visits

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

- Suicide death rate
- Prevalence of depression/anxiety

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

| Organization | Contact Information |
|---|---|
| Behavioral Health Team | |
| Family Promise of the Palouse | 510 W Palouse River Dr, Moscow, ID 83843 (208) 882-0165<br>https://familypromisepalouse.org |
| Business Psychology Associates | https://www.bpahealth.com |
| Latah Recovery Center | 531 S Main St, Moscow, ID 83843<br>(208) 883-1045<br>https://latahrecoverycenter.org/ |
| Moscow Police Department | 18 E 4th St, Moscow, ID 83843<br>(208) 882-2677<br>https://www.ci.moscow.id.us/police |
| Potlatch School District | |
| University of Idaho – Psychiatry | |

**Other local resources identified during the CHNA process that are believed available to respond to this need:[30]**

| Organization | Contact Information |
|---|---|
| University of Idaho Counseling and Testing Center | 1210 Blake Ave, Moscow, ID 83844<br>(208) 885-6716<br>https://www.uidaho.edu/current-students/ctc |
| Idaho Region II Behavioral Health Crisis Line | (866) 449-3815 |
| Idaho Department of Health & Welfare | (208) 882-2433<br>www.healthandwelfare.idaho.gov |
| Mental Health & Alcohol Services | 626 8th Ave SE, Olympia, WA<br>(888) 713-6010 |

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

| Organization | Contact Information |
|---|---|
| Palouse River Counseling | 340 NE Maple, Pullman, WA<br>(509) 334-1133 |

2. **AFFORDABILITY/ACCESSIBILITY – 2016 Significant Need;** Latah County's population to mental health provider ratio is worse that the state average

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

- *See Appendix A for full list of comments*

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

- Actively recruiting for psychiatrist, pediatrician, ENT, oncologist, family practice, orthopedic surgeons, pain management, nurse practitioners
- WWAMI rural medicine scholarship program provided through hospital foundation to encourage new medical graduates to practice in the area
- Palouse Surgeons and Palouse Specialties – partnerships with Pullman Regional Hospital and Whitman Hospital and Medical Group to employ specialty physicians to provide coverage in Latah and Whitman counties
- Traveling specialties available – pediatrics, cardiology, nephrology, asthma/allergy, and neurosurgeon
- CME Program provides additional training and education to providers
- Telestroke technology, in partnership with Providence Sacred Heart Medical Center, allows local care team to collaborate with specialists at Sacred Heart to quickly diagnose and treat stroke patients
- Helped get local pharmacies to participate in 340b program
- Bosom Buddies program provides free mammograms to anyone in need
- Participate in health fairs providing health and wellness information as well as free screenings for blood pressure, wound care assessments, and massage
- Provide discounted wellness labs
- Diabetes Wellness classes and cooking classes hosted on site and free to public; free Fit & Fall Proof class; discounted osteoporosis fitness group; Motherhood Connections (new mother support group); cancer resource center
- Gritman Van Service – provides free transportation for health and wellness classes and for appointments
- Gritman Family Clinics in Kendrick, Troy, and Potlatch
    - Services include: Wellness Checks, Infant to senior care, Chronic Disease Management, Immunizations, Pregnancy and reproductive health testing, Care for coughs, colds, minor cuts and injuries, DOT & preemployment physicals, Women's Health, Dermatology, Sports Physicals
- Financial Assistance Program with sliding fee scale available for imaging and CHAS Clinic
- Cardiac Rehab and Martin Wellness Center scholarships
- Established cancer care fund to assist with cancer-related care and services

- Space provided to Family Promise Program
- Free blood pressure checks available at clinics and in the ED
- Financial Counselors available to help patients apply for insurance programs
- Opened internal medicine clinic
- Echocardiograms available in hospital
- Care Coordinator available to help patients manage chronic conditions and get appointments and services
- Offer a massage program
- Local EMS personnel rotate through GMC for training
- Offer both on-site and home-based sleep studies
- Offer Rocksteady Boxing program at Wellness Center to assist Parkinson's patients
- EMS integration with trauma services and training
- Offer DisABILITY program for disabled children (Enabling Explorers with Disability)
- Wound clinic has two barometric chambers, which draw patients from outside the local area
- Employee Assistance Program available to GMC employees and family members that includes four free visits to mental health professionals per topic per year

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

- Increasing imaging hours for women's imaging center, Ultrasound, MRI, and CT
- Explore additional opportunities for partnership with Palouse Surgeons and Palouse Specialties
- Expanding hours for PT services

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

- Expansion of 340 b program to assist local pharmacies with enrollment
- Recruited psychiatrists, pediatrics, oncologist, ENT, five family medicine, one orthopedic surgeon, neurologist, pulmonologist, three nurse practitioners, surgicalist, board-certified emergency provider
- Implemented an interventional pain clinic
- Doubled square footage of cardiac rehab space and expanded ability to see patients through increased appointment slots
- Lab is now offering home blood draws for patients
- Created new, fully-mobile website, which provides features for patients such as: online appointment scheduling (not all services), patient bill pay, online education center and health resources, including embedded content on service-specific pages

- Clinics and hospitals are national health service corp facilities, which helps with recruitment and retention of physicians and nurses (including family medicine clinics)
- CHAS (Community Health Association of Spokane) includes a pharmacy and counseling and works with GMC to connect unattached patients with PCP in the GMC network
- Added Oncology and Neurology via partnership with Palouse Specialties
- GMC is now integrated with Moscow Family Medicine, which has significantly reduced wait times for family medicine and urgent care (4 family practice clinics and one quick care facility now owned by GMC)
- CME program is the only accredited program among 5 hospitals within a 35-mile radius; GMC Is a participant in the University of Washington stewardship program, which provides education and training on infection prevention and infectious diseases
- Women's health services available in clinics
- Hosted health fairs on-site
- Launched Men's Health Program that provides financial assistance for PHI testing
- Opened Bengal Pharmacy

**Anticipated results from GMC Implementation Strategy**

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

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

- Dollars expended through Financial Assistance Policy (Note that given Medicaid expansion next year in Idaho, FAP dollars are likely to decrease)

- Number of discounted lab test provided
    - Value of discounted lab tests
- Number of primary care clinic visits

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

- Population to primary care ratio
- Physician supply and demand (will be analyzing as part of 2020 Strategic Plan work)

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

| Organization | Contact Information |
|---|---|
| Family Promise of the Palouse | 510 W Palouse River Dr, Moscow, ID 83843<br>(208) 882-0165<br>https://familypromisepalouse.org |
| CHAS Latah Community Heath (FQHC) | 719 S Main St, Moscow, ID 83843<br>(208) 848-8300<br>chas.org/locations/latah-community-health |
| SMART Transit | 1006 Railroad St, Moscow, ID 83843<br>(208) 883-7747<br>www.smarttransit.org |
| Providence Telestroke Network | |
| University of Washington | |

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

| Organization | Contact Information |
|---|---|
| Other local physicians | |
| Public Health – Idaho North Central District (2) | 215 10th St, Lewiston, ID 83501<br>(208) 799-3100<br>http://idahopublichealth.com/ |

3. **PHYSICIANS – 2016 Significant Need;** Latah County's population to mental health provider ratio is worse that the state average

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

- *See Appendix A for full list of comments*

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

- WWAMI rural medicine scholarship program provided through hospital foundation to encourage new medical graduates to practice in the area
- Palouse Surgeons and Palouse Specialties – partnerships with Pullman Regional Hospital and Whitman Hospital and Medical Group to employ specialty physicians to provide coverage in Latah and Whitman counties
- Work with local practices to recruit physicians to the area
- Traveling specialties available – pediatrics, cardiology, nephrology, asthma/allergy, and neurosurgeon
- CME Program provides additional training and education to providers
- Providing specialized training for pediatric hospitalists including neonatal resuscitation, STABLE, ACLS, PALS, and NRP
- Scholarships for local students interested in pursuing a medical/healthcare degree and practicing in the area (Janet Chisholm Martin Healthcare Scholarship, L. Clay Boyd Memorial Healthcare Scholarship, Chanda Morris Scholarship, Maurine Cherrington Scholarship, The Besst Family Scholarship, Midge Presol Scholarship)
- Clinical and simulation lab experience opportunities for first-year medical students
- Provided a special event for physicians to discuss preventing physician burnout
- Established Physician Engagement Team to address physician needs
- Specialized site visits for physicians being recruited
- Recruited two internal medicine physicians, pediatric/internal medicine/ED, wound care/internal medicine, ENT, urologist, family practice
- Worked with local practice to recruit eight family practice physicians and a pathologist

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

- Continuing to formalize CMO physician rounding process; developing different tasks for identifying physician needs and how to facilitate issues
- CMO working with elected medical staff leadership to best assist physicians and create seamless interactions between hospital and medical staff
- Further develop intervention process to address results of physician satisfaction survey

- Cross-border relationships with Dr. Gerald Early at Pullman - further standardize how physicians that practice at both locations are evaluated and how to meet their needs
- Identify physicians in crisis and facility early intervention (e.g., through observation of patterns of behavior, such as negative interactions with staff/patients and increasing conflicts)
- Opportunity to develop physician mentoring program where new providers are matched with existing community providers

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

- Recruited psychiatrists, pediatrics, oncologist, ENT, five family medicine, one orthopedic surgeon, neurologist, pulmonologist, three nurse practitioners, surgicalist, board-certified emergency provider
- Clinics and hospitals are national health service corp facilities, which helps with recruitment and retention of physicians and nurses (including family medicine clinics)
- CHAS (Community Health Association of Spokane) includes a pharmacy and counseling and works with GMC to connect unattached patients with PCP in the GMC network
- Added Oncology and Neurology via partnership with Palouse Specialties
- GMC is now integrated with Moscow Family Medicine, which has significantly reduced wait times for family medicine and urgent care (4 family practice clinics and one quick care facility now owned by GMC)
- Established pain clinic staffed by CRNA
- Conduct physician satisfaction survey and have developed protocols for intervention
- CMO recruited and rounding on physicians to identify needs and issues
- GMC worked with Idaho state hospital association to expand language around J-1 visas to include other medical specialties beyond original limit of 5; resulted in recruitment of Oncologist

**Anticipated results from GMC Implementation Strategy**

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

| Community Benefit Attribute Element | Yes, Implementation Strategy Addresses | Implementation Strategy Does Not Address |
|---|---|---|
| 5. Improves ability to withstand public health emergency | X | |
| 6. Otherwise would become responsibility of government or another tax-exempt organization | X | |
| 7. Increases knowledge; then benefits the public | | X |

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

- Number of physicians recruited

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

- Population to Primary Care Physician ratio

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

| Organization | Contact Information |
|---|---|
| Moscow Family Medicine | 623 S Main Street, Moscow, ID 83843<br>(208) 882-2011<br>moscowfamilymedicine.com |
| Moscow Medical | 213 N Main Street, Moscow, ID 83843<br>(208) 882-7565<br>www.moscowmedical.com |
| CHAS Latah Community Health (FQHC) | 719 S. Main St, Moscow, ID 83843<br>(208) 848-8300<br>chas.org/locations/latah-community-health |
| Inland Orthopedic Surgery | 2500 W A St Ste 201, Moscow, ID<br>(208) 883-2828<br>www.inlandortho.net |
| Palouse Surgeons | 2300 West A St, Moscow, ID 83843<br>(208) 883-1500<br>palousesurgeons.com |
| Palouse Medical | 825 SE Bishop Blvd, Ste 200, Pullman, WA 99163<br>(509) 332-2517<br>www.palousemedical.com |

| Organization | Contact Information |
|---|---|
| Palouse Specialties | www.pullmanregional.org/specialty-clinics |
| Catalyst Medical Group | http://www.valleymedicalcenter.com/events/catalyst-medical-group/ |
| Cancer Care Northwest | 1440 E Mullan Ave, Post Falls, ID 83854<br>(208) 754-3100<br>www.cancercarenorthwest.com |
| Idaho State Hospital Association | 615 N 7th St, Boise, ID 83702<br>(208) 338-5100<br>https://teamiha.org/ |

4. **SUBSTANCE ABUSE – 2016 Significant Need;** Latah County's mental and substance use related deaths increased from 1980-2014 (Female death rate increased 205.0%; Male death rate increased 173.7%)

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

- *See Appendix A for full list of comments*

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

- Employee Assistance Program available to GMC employees and family members that includes four free visits to mental health professionals per topic per year
- GMC works with Latah Recovery Center, which provides resources, classes, and coaching to help people recover
- In-house resource available to provide materials and education and resources for substance abuse issues

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

- Police speak with fraternities and sororities regarding substance abuse; this could be an opportunity to have a GMC representative involved in collaborating with university on behavioral health/substance abuse
- Moscow Family Medicine student health clinic is moving back to campus this year, which will provide additional resources for students, potentially including substance abuse
- Working to establish suboxone providers within the University of Idaho ECHO program, which connects rural patients with services not provided in the local area
- Need to explore partnerships with local crisis center to develop plans for follow-up care, including potential connection with GMC psychiatrists/mental health providers
- Exploring collaboration opportunities with the University of Idaho following replacement of university psychiatrist with nurse practitioner

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

- Pain management clinic opened: only program of its kind in the region, provider is one of 16 non-surgical pain management specialists in the country, and will have four MSPMs
- Recruited 2 psychiatrists (1 full time, 1 visits twice/month and specializes in children < 12)
- Intake form includes screening questions regarding mental health and substance abuse; following positive screening, provider will address and connect patient to needed resources
- GMC adheres to strict requirements in the ED for dispensing controlled substances, including education and counseling on proper usage and disposal
- GMC provides care management conferences to assist patients identified as having substance abuse challenges

- GMC shares aggregate data with the University of Idaho on drug and alcohol abuse among the student population (based on clinic visits)
- State-funded crisis center now open in community and some partnerships are forming between crisis center and Latah Recovery Center (crisis center is 24-hour)
- GMC is the first hospital in the region to implement electronic ordering of controlled substances

**Anticipated results from GMC Implementation Strategy**

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

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

- Readmissions within 30 days for ETOH diagnosis

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

- Excessive drinking
- Drug overdose deaths
- Alcohol-impaired driving deaths

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

| Organization | Contact Information |
|---|---|
| Latah Recovery Center | 531 S Main St, Moscow, ID 83843<br>(208) 883-1045<br>https://latahrecoverycenter.org/ |
| Business Psychology Associates | https://www.bpahealth.com |
| Moscow Family Health Medicine | |
| University of Idaho | |

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

| Organization | Contact Information |
|---|---|
| University of Idaho Counseling and Testing Center | 1210 Blake Ave, Moscow, ID 83844<br>(208) 885-6716<br>https://www.uidaho.edu/current-students/ctc |
| Weeks & Vietri Counseling | 818 S Washington St, Moscow, ID 83843<br>(208) 882-8514<br>www.weeksandvietricounseling.com |
| Alliance Family Services, Inc. | 212 Rodeo Drive, Suite 410, Moscow, ID<br>(208) 882-5960 |
| Mental Health & Alcohol Services | 626 8th Ave SE, Olympia, WA<br>(888) 713-6010 |
| Palouse River Counseling | 340 NE Maple, Pullman, WA<br>(509) 334-1133 |
| Spokane Heights Detox | 524 E. Francis Avenue, Spokane, WA<br>(888) 324-9870 |

5. **EDUCATION/PREVENTION – Local expert concern;** Residents of Latah County are less likely to receive routine cholesterol screenings and receive routine visit to their NP/PA compared to the national average

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

*This was not a significant health need in 2016, so no comments were solicited.*

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

- Providers adhere to US public health guidelines for screenings and interventions (e.g., BMI)
- GMC provides lunch and learns on a variety of health topics (open to employees)
- CME program provides additional training and education to providers
- GMC offers athletic trainer programs at some local schools
- Bosom Buddies program provides free mammograms to anyone in need
- Diabetes wellness classes hosted on site and free to public; free Fit & Fall proof class; discounted osteoporosis fitness group; Motherhood Connections (new mother support group); cancer resource center
- Gritman Van Service – provides free transportation for health and wellness classes and for appointments
- Gritman Family Clinics in Kendrick, Troy, and Potlach offering: Wellness Checks, Infant to senior care, Chronic Disease Management, Immunizations, Pregnancy and reproductive health testing, Care for coughs, colds, minor cuts and injuries, DOT & preemployment physicals, Women's Health, Dermatology, Sports Physicals
- Expanded value-based care contracts with payers track patient population screening rates (e.g., AC1, mammograms, colonoscopies) and promote better care coordination
- Participate in health fairs providing health and wellness information as well as free screenings for blood pressure, wound care assessments, and massage
- Offer Rocksteady Boxing program at Wellness Center to assist Parkinson's patients
- Offer PT/OT/Speech at local schools
- Offer DisABILITY program for disabled children (Enabling Explorers with Disability)
- Offer Stewards of Children Program aimed at training the trainer on prevention of child exploitation and abuse
- Offer health days and career days at schools and provide internship opportunities for students interested in the healthcare field
- Provide "safe sitter' and "safe at home" training for children and teens
- Created new, fully-mobile website, which provides features for patients such as: online appointment scheduling (not all services), patient bill pay, online education center and health resources, including embedded content on service-specific pages
- GMC leadership team members sit on college advisory boards for WWAMI and Walla Walla

- Teaching and education kitchen available for diabetes, nutrition, and cardiology patient classes
- Sponsor the region's longest-running breast cancer awareness and fundraising event
- GMC offers a "Teddy Bear Clinic" focused on bringing children and their families to the hospital to become familiar with GMC services and ensure a positive future experience
- CME program is the only accredited program among 5 hospitals within a 35-mile radius; GMC Is a participant in the University of Washington stewardship program, which provides education and training on infection prevention and infectious diseases
- Prostate screenings offered once per year
- Offer 12-month weight management class accredited through CDC and American Diabetes Program

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

- Expanding bullying and counseling programs

**Anticipated results from GMC Implementation Strategy**

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

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

- Number of participants in diabetes/clinical nutrition classes
- Number of health screenings
- Number of classes offered through the above two programs

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

- Obesity rate
- Smoking rate
- Diabetes rate

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

| Organization | Contact Information |
|---|---|
| Local school district | |
| University of Washington | |

6. **CHRONIC PAIN MANAGEMENT – Local expert concern;** Residents of Latah County are more likely to have chronic back pain compared to the national average

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

*This was not a significant health need in 2016, so no comments were solicited.*

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

- Pain management clinic opened: only program of its kind in the region, provider is one of 16 non-surgical pain management specialists in the country, and will have four MSPMs
- Radio frequency ablation offered through pain clinic
- GMC offers wellness pool classes and PT/OT designed to reduce pain
- GMC offers free Fit & Fall proof class
- GMC is connected to WWAMI through Telepain program
- Providers certified in non-surgical pain management represent a unique offering to the community (CRNA and MSPMs)
- GMC is the first hospital in the region to implement electronic ordering of controlled substances
- GMC adheres to strict requirements in the ED for dispensing controlled substances, including education and counseling on proper usage and disposal

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

- Future opportunity to offer GMC providers education on chronic pain management
- Working to establish suboxone providers within the University of Idaho ECHO program, which connects rural patients with services not provided in the local area

**Anticipated results from GMC Implementation Strategy**

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

| Community Benefit Attribute Element | Yes, Implementation Strategy Addresses | Implementation Strategy Does Not Address |
|---|---|---|
| 4. Enhances public health activities | | X |
| 5. Improves ability to withstand public health emergency | | X |
| 6. Otherwise would become responsibility of government or another tax-exempt organization | X | |
| 7. Increases knowledge; then benefits the public | | X |

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

- Interventional pain clinic visits

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

- Drug overdose deaths

## Other Needs Identified During CHNA Process

7. **Alcohol Abuse**
8. **Cancer**
9. **Obesity/Overweight – 2016 Significant Need**
10. **Women's Health**
11. **Dental**
12. **Heart Disease**
13. **Alzheimer's**
14. **Flu/Pneumonia**
15. **Diabetes**
16. **Respiratory Infections**
17. **Stroke**
18. **Smoking/Tobacco Use**
19. **Write-In: Addiction and health issues that are associated with cell phone/social media. Issues with overuse, disengagement, vulnerability of kids.**
20. **Accidents**
21. **Physical Inactivity**
22. **Hypertension**
23. **Write-In: Social services and better housing options for older adults**
24. **Write-In: Housing and food instability**
25. **Write-In: Continuity of care**
26. **Kidney Disease**
27. **Lung Disease**
28. **Write-In: Maintaining vaccination rates**
29. **Write-In: Hospitalist care**
30. **Liver Disease**
31. **Write-In: Prevention**

32. **Write-In: Community Health EMS Program**

33. **Write-In: Exercise programs for obese (specifically children but families as well)**

34. **Write-In: Integrative medicine options**

## Overall Community Need Statement and Priority Ranking Score

**Significant needs where hospital has implementation responsibility**[31]

1. Mental Health/Suicide – 2016 Significant Need
2. Affordability/Accessibility – 2016 Significant Need
3. Physicians – 2016 Significant Need
4. Substance Abuse – 2016 Significant Need
5. Education/Prevention
6. Chronic Pain Management

**Significant needs where hospital did not develop implementation strategy**[32]

1. N/A

**Other needs where hospital developed implementation strategy**

1. N/A

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

1. N/A

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

# APPENDIX

## Appendix A – Written Commentary on Prior CHNA (Local Expert Survey)

Hospital solicited written comments about its 2016 CHNA.[33] 31 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

| | Yes (Applies to Me) | No (Does Not Apply to Me) | Response Count |
|---|---|---|---|
| 1) **Public Health Expertise** | 9 | 14 | 23 |
| 2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital | 10 | 13 | 23 |
| 3) **Priority Populations** | 9 | 15 | 24 |
| 4) Representative/Member of **Chronic Disease Group** or Organization | 5 | 18 | 23 |
| 5) Represents the **Broad Interest of the Community** | 27 | 3 | 30 |
| Other | | | 3 |
| Answered Question | | | 31 |
| Skipped Question | | | 0 |

**Congress defines "Priority Populations" to include:**

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

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

- *Access to care for rural populations, especially older adults*
- *Lack of employer provided health insurance.*
- *Shortage of affordable mental health counseling, psychotherapy, crisis intervention for these groups. Shortage*

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

*of substance use disorder identification and treatment.*

- *Access to health care. Lack of qualified providers. Understaffed group homes for adults with disabilities. Family planning care for women in rural areas.*
- *Regular access to quality healthcare. Challenges include transportation and other social determinants of health*
- *Food, financial help, tolerance and protection from bullies*
- *accessible and affordable care*
- **coverage for uninsured, hopefully via Medicaid expansion. *more robust and timely surgical services. *expanded cardiology and gastroenterology services.*
- *Homelessness*
- *People with Mental Health Issues.*

**In the 2016 CHNA, there were five health needs identified as "significant" or most important:**

1. **Mental Health/Suicide**
2. **Substance Abuse**
3. **Physicians**
4. **Affordability/Accessibility**
5. **Obesity/Overweight**

**3. Should the hospital continue to consider and allocate resources to help improve the needs identified in the 2016 CHNA?**

| | Yes | No | Response Count |
|---|---|---|---|
| Mental Health/Suicide | 28 | 1 | 29 |
| Substance Abuse | 26 | 2 | 28 |
| Physicians | 28 | 2 | 30 |
| Affordability/Accessibility | 29 | 0 | 29 |
| Obesity/Overweight | 17 | 9 | 26 |

Comments:

- *Continued pressure on the legislature to permanently expand Medicaid without preconditions to address the gap in coverage*
- *Mental health and substance abuse treatments which are most evidence based include a central role of psychotherapy and counseling. Unfortunately, there are very few therapists and counselors who accept Medicare and./ or Medicaid patients, and if they do in very limited numbers and if even when available have very long waiting lists, delaying and limiting needed care.*
- *It is not just physicians, but the entire spectrum of health care workers, that are in short supply.*
- *In the last year GMC has made a major investment by hiring a full and partial-time psychiatrist, so the areas of mental health and substance abuse are now a lower priority for resource allocation.*

**4. Please share comments or observations about the actions GMC has taken to address <u>MENTAL HEALTH/SUICIDE.</u>**

- *The Latah Recovery Crisis Center is a valuable resource.*
- *The Latah Recovery Center expansion has been a welcome and valued resource. Efforts should continue in this area.*
- *Good first steps. Need to coordinate with other stakeholders as well*
- *Psychiatrist recruited – done; Crisis Center - in construction, in progress; Unknown about MPD transfers*
- *While psychiatric care is helpful, the benefit is restricted due to the limitations of necessary associated treatments and treatment professionals for the target groups in our area: Psychotherapy, counseling, and case management services in particular. While safe rooms have been established and a psychiatrist recruited, the value of these is dramatically less effective without 24 hour availability of counseling/case management services. As of yet, a crisis center has not been established. Police dept. efforts have resulted in better communication, though transfer issues have hinged mostly on the availability of beds at these facilities.*
- *GMC has successfully recruited a psychiatrist. GMC has only expanded 1 safe room in ed*
- *Crisis center is soon to open, but still having difficulty finding a provider agency. I'm not sure how much GMC assisted with this.*
- *Has been improved*
- *Good actions, how about outreach lectures in the high schools*
- *Some providers obtained. However not stable, move on.*
- *Opened a safe room in Ed, did recruit a psychiatrist and working to help expand the Crisis Center affiliated with Latah Recovery. Also worked to increase knowledge and outreach.*
- *Gritman has successfully taken all of the identified action steps*
- *(see comment in previous section)*
- *We need to find affordable immediate mental health care for whomever needs it. It is a major problem that the public who needs it most, cannot afford it. Drugs and alcohol are often coping mechanisms for people who can't get help.*
- *Unsure if ED remodel has been successful. Regarding a psychiatrist, understand that Gritman has hired, but not clear what they do and we still have the issue of Gritman not being able to admit and treat patients for mental illness. Crisis Center should be online soon*
- *Gritman has been very responsive to the community and works as partner to law enforcement and MH agencies to find options for patients who are experiencing a crisis.*
- *Good strides toward 2016 stated goals.*
- *We now have a community crisis center, recruited the first psychiatrist and have discussed transfer issues. I believe that changes have been made to the emergency department.*

- *More services and holding facility other than E.R*

**5. Please share comments or observations about the actions GMC has taken to address <u>SUBSTANCE ABUSE.</u>**

- *Pain management techniques are now taught at GMC. Bravo!*
- *Excellent progress here*
- *Psychiatrist recruited – done; Crisis Center - in construction, in progress*
- *Pain management alternatives have been developed, though medication assisted treatments, esp. for opioid use remain limited. A significant factor is that these services effectiveness hinges on strong connection to Substance use treatment programs: individual and group counseling and treatment. Availability and coordination of these are extremely limited for this group and are the core treatments to address substance use disorders longitudinally*
- *Gritman has been a partner in the new Crisis Center.*
- *GMC has recruited a psychiatrist.*
- *This is very individual depending on the physician.*
- *Always aware*
- *Education lectures on facts about potency and medical results of use.*
- *Gritman has successfully taken all of the identified action steps*
- *(see comment in previous section)*
- *Alcoholism and drug use are often the symptom of a failed mental health program.*
- *see above regarding psychiatrist and crisis center - unaware of what else Gritman is contributing regarding substance abuse and whether psychiatric services are being provided for substance abuse*
- *Gritman ER is actively making referrals to the Latah Recovery Center where individuals can make contacts for counseling SA treatment options.*
- *Actions still scratching the surface. Centers are a big plus in this area. Problem continues to be widespread.*
- *Crisis center and psychiatrist have been completed. On pain management, I know that much has been done to communicate with and inform the community about the role of the emergency department in pain management.*
- *Continue working with the Recovery Center*

**6. Please share comments or observations about the actions GMC has taken to address <u>PHYSICIANS</u>.**

- *We've noticed you have recruited more physicians and your partnership with WWAMI should be beneficial.*
- *Great work recruiting new physicians to the area.*
- *Need to ensure that physicians are notified and aware of progress in all of these areas*

- *Recruiting efforts seem to have improved*
- *These steps have been effective. Additional focus on addressing physician retention and addressing physician burnout are still needed.*
- *Gritman has aggressively sought out additional physicians and specialty care groups, including a psychiatrist.*
- *GMC has recruited a CMO. Multiple doctors have been recruited.*
- *As shared above, we need nurses, PA's, CNA's and all aspects of health care staffing to address the needs, especially rural.*
- *Markedly improved*
- *Try to get regional intern program*
- *More obtained. More access.*
- *I am aware of their continued effort to recruit and retain competent physicians in all areas.*
- *Through its acquisition of MFM, Gritman has been successful in recruiting additional doctors to the practice; it has also recruited a number of needed specialists and appointed a part-time CMO. It has also partnered with the WWAMI program by leasing space to it in the new medical office bldg and by providing opportunities for students to have hands on experience in the hospital*
- *GMC has recently recruited a number of specialty and family practice physicians, but the task needs to continue to achieve more robust medical care for our region. General surgery is an area that continues to be a challenge in terms of providing timely care for emergency dept. patients and avoiding unnecessary transfers to other hospitals. to some degree this is also true for orthopedic surgery as well. Recent turnovers in the GMC hospitalist program have presented challenges and hopefully this program can be fully staffed and begin to operate more effectively in the coming year.*
- *More physicians with different skills make a better overall system*
- *GMC needs to do whatever it takes to be a welcoming place to work for all physicians.*
- *I've seen new physicians in the Emergency room. I like that Gritman has partnered with Moscow Family Practice as it provides a continuum of care across services.*
- *Recruiting appears to be working by filling in needed gaps.*
- *Great Job bringing Physicians into our area.*

**7. Please share comments or observations about the actions GMC has taken to address <u>ACCESSIBILITY/AFFORDABILITY</u>.**

- *Affordability is still an issue. Perhaps a greater cash discount for those without insurance?*
- *Gritman has done an outstanding job here*
- *Gritman has extensively expanded in this area with the expansion including Moscow Family Medicine. Care coordination that is consistent across the newly expanded outpatient clinics would be of significant additional*

*benefit.*

- *GMC has recruited multiple family doctors to the community.*
- *Continue, please, to expand rural health clinics to include mental health services.*
- *Improved*
- *Offer educational lessons on nutrition and inexpensive meal ideas.*
- *Great steps taken to provide this*
- *GMC has worked to bring more services to the community like Oncology and CHAS so that folks can be treated locally and not have to travel.*
- *Has met most of these goals*
- *GMC has always strived to deliver the highest level of patient care at the lowest cost possible. This is reflected in high patient satisfaction and GMC very low (too low) operating margin. Hopefully Medicaid expansion in the state will be able to provide coverage to the many uninsured in our service area and reduce GMC's bad debt and charity care financials. In terms of accessibility, GMC has greatly expanded and stabilized family practice providers and has added new specialty expertise in internal medicine, neurology, oncology, psychiatry, pulmonology (stellar accomplishments in the era of acute physician storages)*
- *We need better insurance interface with the patient. I hear a lot of complaints about billing and how affordability is only driven to insurance companies.*
- *From personal/family experience, and conversations with others, it doesn't appear that Gritman has done anything to make care more affordable.*
- *Billing department is knowledgeable and helpful when contacted. Personally, I did know the cost before making decisions regarding health care.*
- *Clinics are necessary and do well at serving community. As population ages, demand will increase.*
- *In a challenging environment I believe Gritman continues to be as affordable as possible, as transparent about rates as possible and has improved accessibility to services to the community.*

**8. Please share comments or observations about the actions GMC has taken to address <u>OBESITY/OVERWEIGHT</u>.**

- *Exercise efforts in this area are too targeted to those who have had heart attacks. Would like to see a focus on children and associated programming in this area.*
- *Cooking classes, outreach.*
- *In particular, the cardiac rehab program is helpful and well accepted by members of the community.*
- *GMC has provided healthy cooking classes and has recently recruited a bariatric surgeon*
- *Public classes on nutrition/cooking are good. Coordinate with extension and take advantage of the new Latah Co Commercial Kitchen.*
- *Several programs including nutritional counseling*

- *Education outreach on subjects such as sugar consumption*
- *Offering classes on Obesity, Diabetes, Nutrition etc*
- *Has met most of these goals*
- *Our diabetes and nutrition programs have been expanded and along with the expansion of family practice providers and Medicaid expansion should more adequately address the issue of obesity.*
- *Need more focus on exercise and diet.*
- *Shouldn't obesity education be a part of the solution? Education as in encouraging people to obtain a healthy weight.*
- *I personally have talked with nutrition experts and my physician talks about healthy weight and options at visits. I am also aware that Moscow has access to specialists in this field.*
- *Problem can be addressed but will never go away.*

## Appendix B – Identification & Prioritization of Community Needs (Local Expert Survey Results)

| Need Topic | Total Votes | Number of Local Experts Voting for Needs | Percent of Votes | Cumulative Votes | Need Determination |
|---|---|---|---|---|---|
| Mental Health/Suicide* | 422 | 22 | 17.6% | 17.6% | Significant Needs |
| Affordability/Accessibility* | 279 | 18 | 11.6% | 29.2% | |
| Physicians* | 240 | 15 | 10.0% | 39.2% | |
| Substance Abuse* | 233 | 16 | 9.7% | 48.9% | |
| Education/Prevention | 142 | 14 | 5.9% | 54.8% | |
| Chronic Pain Management | 139 | 12 | 5.8% | 60.6% | |
| Alcohol Abuse | 132 | 13 | 5.5% | 66.1% | Other Identified Needs |
| Cancer | 102 | 11 | 4.3% | 70.4% | |
| Obesity/Overweight* | 101 | 10 | 4.2% | 74.6% | |
| Women's Health | 84 | 11 | 3.5% | 78.1% | |
| Dental | 65 | 9 | 2.7% | 80.8% | |
| Heart Disease | 60 | 8 | 2.5% | 83.3% | |
| Alzheimer's | 55 | 8 | 2.3% | 85.6% | |
| Flu/Pneumonia | 40 | 7 | 1.7% | 87.3% | |
| Diabetes | 37 | 6 | 1.5% | 88.8% | |
| Respiratory Infections | 29 | 5 | 1.2% | 90.0% | |
| Stroke | 29 | 6 | 1.2% | 91.2% | |
| Smoking/Tobacco Use | 22 | 6 | 0.9% | 92.1% | |
| Write-In: Addiction and health issues that are associated with cell phone/social media. Issues with overuse, disengagement, vulnerability of kids. | 20 | 1 | 0.8% | 93.0% | |
| Accidents | 17 | 5 | 0.7% | 93.7% | |
| Physical Inactivity | 17 | 5 | 0.7% | 94.4% | |
| Hypertension | 16 | 4 | 0.7% | 95.0% | |
| Write-In: Social services and better housing options for older adults | 16 | 1 | 0.7% | 95.7% | |
| Write-In: Housing and food instability | 16 | 1 | 0.7% | 96.4% | |
| Write-In: Continuity of care | 15 | 1 | 0.6% | 97.0% | |
| Kidney Disease | 11 | 4 | 0.5% | 97.5% | |
| Lung Disease | 10 | 4 | 0.4% | 97.9% | |
| Write-In: Maintaining vaccination rates | 10 | 1 | 0.4% | 98.3% | |
| Write-In: Hospitalist care | 10 | 1 | 0.4% | 98.7% | |
| Liver Disease | 8 | 4 | 0.3% | 99.0% | |
| Write-In: Prevention | 8 | 1 | 0.3% | 99.4% | |
| Write-In: Community Health EMS Program | 7.5 | 1 | 0.3% | 99.7% | |
| Write-In: Exercise programs for obese (specifically children but families as well) | 5 | 1 | 0.2% | 99.9% | |
| Write-In: Integrative medicine options | 2.5 | 1 | 0.1% | 100.0% | |

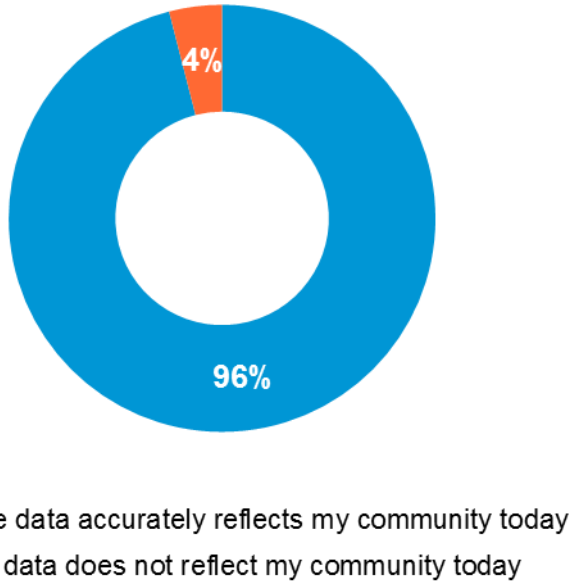
**= 2016 Significant Needs*

**Individuals Participating as Local Expert Advisors**[34]

| | Yes (Applies to Me) | No (Does Not Apply to Me) | Response Count |
|---|---|---|---|
| 1) **Public Health Expertise** | 9 | 14 | 23 |
| 2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital | 10 | 13 | 23 |
| 3) **Priority Populations** | 9 | 15 | 24 |
| 4) Representative/Member of **Chronic Disease Group** or Organization | 5 | 18 | 23 |
| 5) Represents the **Broad Interest of the Community** | 27 | 3 | 30 |
| Other | | | 3 |
| Answered Question | | | 31 |
| Skipped Question | | | 0 |

**Advice Received from Local Expert Advisors**

**Question: Do you agree with the comparison of Latah County to all other Idaho counties?**




Comments:

- *ongoing access to clear and accurate information about reproduction, birth control, and access to abortion services are critical for maintaining a low teen pregnancy rate.*

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

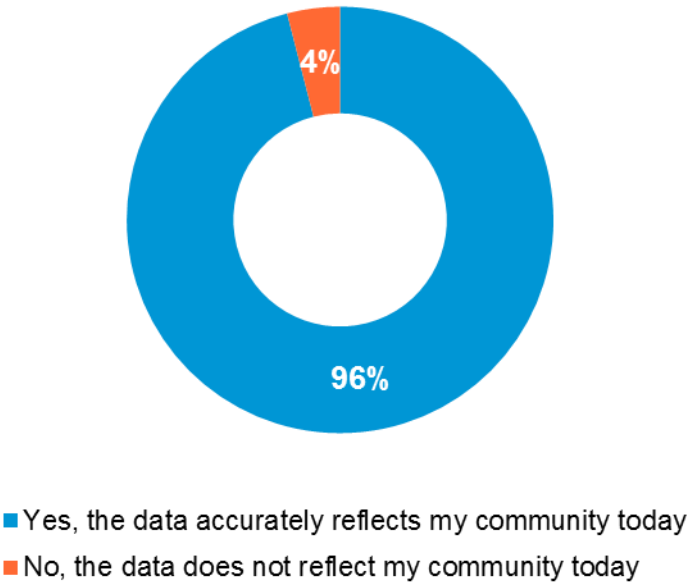
- *I do not believe the population to primary care doctor or population to mental health provider ratios. If this data that is true, why is our HIPSA score so low.*
- *Being so new to my role and not knowing where or how to access past data I can't and don't feel comfortable answering this question.*
- *I do not know how accurate this data. Seems to me it is an ever shifting set of data.*
- *The physical environment ranking is surprisingly mid-range and seems like the two factors that makeup this category are too narrow to give a full picture of the physical environment of Latah County and surrounding areas. Overall the physical environment is amazing around here with trails, access to the outdoors, walkability of our community etc.*
- *I have no way to judge if this information is correct. If the numbers are correct, it looks good for Latah County. I wonder when the air pollution number was determined (in the middle of a fire, during a dusty summer day)? It is hard for me to think that we have an air pollution problem in Latah County.*
- *I believe social and economic factors coupled with living wage problems and scarcity of professional resources add to the negative impact in several of these areas.*

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


Comments:

- *Again, I am too new in my role to answer this question.*
- *Could reduce emergency visits by having a professional available 24 hours at Quick care, especially on weekends. Extensively Publicize news of the hours and the rules of being seen at Quick care, is. Texting or emailing gets a patient seen quicker than the person who arrives without prior notice.*
- *I have no way to determine if this data is accurate. My casual observations of the population would tend to confirm that fact that we are a predominately "white" community. Given that we are a college town, a higher percentage of childbearing women compared to the state and US would seem reasonable.*
- *This reflects my believe that we live in an economically depressed area with few resources and do have a high proportion of seniors on fixed incomes.*

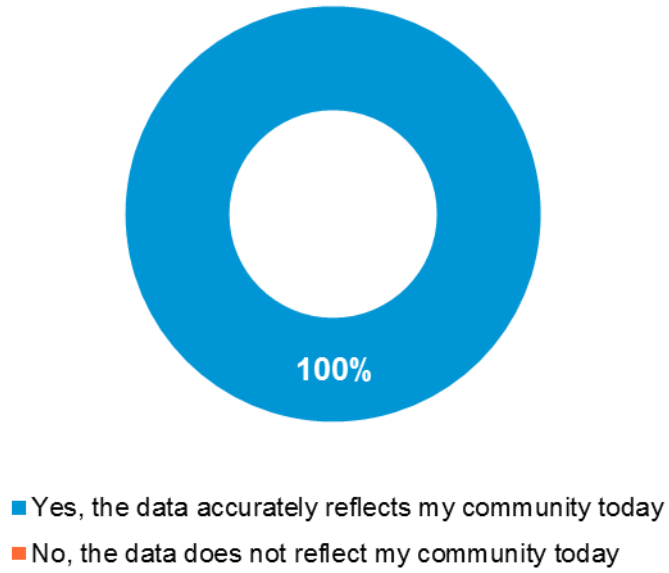
**Question: Do you agree with the overall social vulnerability index for Latah County?**




Comments:

- *Our rule communities east of us are definitely much more vulnerable than indicated on this map.*
- *Again, too new in role to answer this question.*
- *I would like to see this data with the transient student population removed just for comparison.*
- *Agree other than the graph about race, ethnicity... don't know what it means*
- *No way for me to confirm these numbers. I do know there are poor people in Latah county that would have difficulty coping with natural or human caused disasters.*
- *This is interesting because it looks like the highest population area also experienced the highest vulnerabilities in all of the areas listed.*

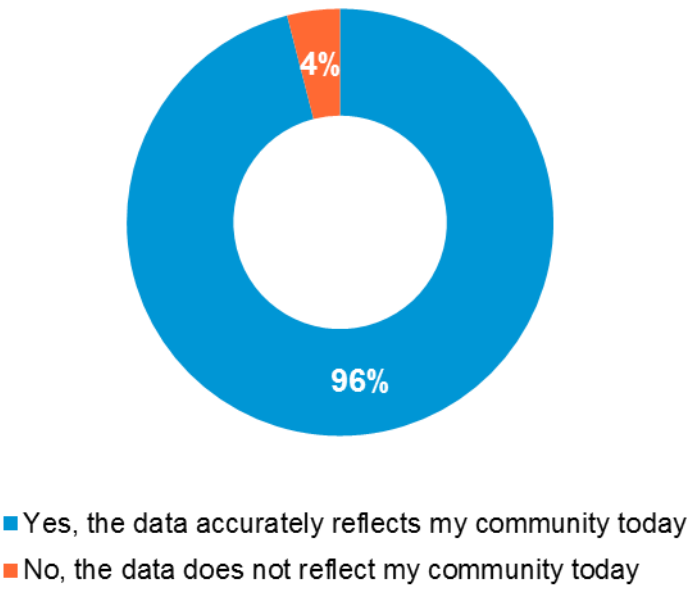
**Question: Do you agree with the national rankings and leading causes of death?**




Comments:

- *Again, too new in role to answer this question.*
- *If the numbers are correct, I guess it reflects our community. Why are we #1 for Parkinson's?*
- *Really no way for me to confirm this but the numbers seem to be about right based upon what I read.*
- *I believe this is reflective of how the populations responds to healthcare suggestions. In more rural areas like Latah County, people are more reluctant to seek medical or behavioral health services due to the perception of being more independent and "off the Grid" in rural areas. We have to take care of ourselves. I also believe there is room for more preventative health care education starting at an early age, such as in the schools where children are encouraged to take the information home and share.*

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




Comments:

- *Again, too new in role to answer this question.*
- *Hence the need for improved mental health services, especially in our rural areas.*
- *It is if the numbers are correct.  I wonder if the numbers include Theayah people who see Pullman doctors*
- *I cannot confirm these numbers.*
- *don't know whether this appears currently accurate*
- *Personally, I believe the Women's Imaging Center at Gritman does a fantastic job at making early screening available and pleasant.*

## Appendix C – National Healthcare Quality and Disparities Report[35]

The National Healthcare Quality and Disparities Reports (QDR; annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 300 healthcare process, outcome, and access measures, covering a wide variety of conditions and settings. Data years vary across measures; most trend analyses include data points from 2000-2002 to 2012-2015. An exception is rates of uninsured, which we are able to track through 2017. The reports are produced with the support of an HHS Interagency Work Group (IWG) and guided by input from AHRQ's National Advisory Council and the Institute of Medicine (IOM), now known as the Health and Medicine Division of the National Academies of Sciences, Medicine, and Engineering.

For the 15th year in a row, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving healthcare quality and reducing healthcare disparities. As mandated by the U.S. Congress, the report focuses on "national trends in the quality of health care provided to the American people" (42 U.S.C. 299b-2(b)(2)) and "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations" (42 U.S.C. 299a-1(a)(6)).

The 2017 report and chartbooks are organized around the concepts of access to care, quality of care, disparities in care, and six priority areas—including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Summaries of the status of access, quality, and disparities can be found in the report.

The report presents information on trends, disparities, and changes in disparities over time, as well as federal initiatives to improve quality and reduce disparities. It includes the following:

- **Overview of Quality and Access in the U.S. Healthcare System** that describes the healthcare systems, encounters, and workers; disease burden; and healthcare costs.
- **Variation in Health Care Quality and Disparities** that presents state differences in quality and disparities.
- **Access and Disparities in Access to Healthcare** that tracks progress on making healthcare available to all Americans.
- **Trends in Quality of Healthcare** that tracks progress on ensuring that all Americans receive appropriate services.
- **Trends in Disparities** that tracks progress in closing the gap between minority racial and ethnic groups and Whites, as well as income and geographic location gaps (e.g., rural/suburban disparities).
- **Looking Forward** that summarizes future directions for healthcare quality initiatives.

**Key Findings**

**Access:** An estimated 43% of access measures showed improvement (2000-2016), 43% did not show improvement, and 14% showed worsening. For example, from 2000 to 2017, there were significant gains in the percentage of people who reported having health insurance.

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

**Quality:** Quality of healthcare improved overall from 2000 through 2014-2015, but the pace of improvement varied by priority area:

- Person-Centered Care: Almost 70% of person-centered care measures were improving overall.
- Patient Safety: More than two-thirds of patient safety measures were improving overall.
- Healthy Living: More than half of healthy living measures were improving overall.
- Effective Treatment: More than half of effective treatment measures were improving overall.
- Care Coordination: Half of care coordination measures were improving overall.
- Care Affordability: Eighty percent of care affordability measures *did not* change overall.

**Disparities:** Overall, some disparities were getting smaller from 2000 through 2014-2015; but disparities persist, especially for poor and uninsured populations in all priority areas.

**Trends**

- Trends show that about 55% percent of quality measures are improving overall for Blacks.[36] However, most recent data in 2014-2015 show that about 40% of quality measures were worse for Blacks compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Asians. However, most recent data in 2014-2015 show that 20% of quality measures were worse for Asians compared with Whites.
- Trends show that almost 35% of quality measures are improving overall for American Indians/Alaska Natives (AI/ANs). However, most recent data in 2014-2015 show that about 30% of quality measures were worse for AI/ANs compared with Whites.
- Trends show that approximately 25% of quality measures are improving overall for Native Hawaiians/Pacific Islanders (NHPIs). However, most recent data in 2014-2015 show that nearly 33% of quality measures were worse for NHPIs compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Hispanics, but in 2014-2015, nearly 33% of quality measures were worse for Hispanics compared with non-Hispanic Whites.
- Variation in care persisted across the urban-rural continuum in 2014-2016, especially in access to care and care coordination.

**Looking Forward**

The National Healthcare Quality and Disparities Report (QDR) continues to track the nation's performance on healthcare access, quality, and disparities. The QDR data demonstrate significant progress in some areas and identify other areas that merit more attention where wide variations persist. The number of measures in each priority area varies, and some measures carry more significance than others as they affect more people or have more significant consequences. The summary charts are a way to quantify and illustrate progress toward achieving accessible, high-quality, and affordable

[36] Throughout this report and its appendixes, "Blacks" refers to Blacks or African Americans, and "Hispanics" refers to Hispanics or Latinos. More information is available in the Reporting Conventions section of the Introduction and Methods.

care at the national level using available nationally representative data. The summary charts are accessible via the link below.

This report shows that while performance for most access measures did not change significantly over time (2000-2014), insurance coverage rates did improve (2000-2016). Quality of healthcare improved in most areas but some disparities persist, especially for poor and low-income households and those without health insurance.

U.S. Department of Health and Human Services (HHS) agencies are working on research and conducting programs in many of the priority areas—most notably opioid misuse, patient safety, effective treatment, and health disparities.

**Link to the full report:**

https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2017qdr.pdf

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

**Illustrative IRS Schedule h Part V Section B (Form 990)[37]**

**Community Health Need Assessment Illustrative Answers**

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

   *No*

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

   *No*

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

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

      *See footnote 16 on page 11*

   b. **Demographics of the community**

      *See footnote 19 on page 12*

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

      *See footnote 29 on page 25 and footnote 30 on page 27*

   d. **How data was obtained**

      *See footnote 11 on page 8*

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

      *See footnote 28 on page 24*

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

      *See footnote 12 on page 9*

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

      *See footnote 15 on page 9*

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

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

*See footnotes 13 on page 9*

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

*See footnote 10 on page 8, footnotes 14 on page 9, and footnote 23 on page 16*

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

*N/A*

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

*2016*

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

*Yes, see footnote 14 on page 9 and footnote 34 on page 57*

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

*No*

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

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

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

*Yes*

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

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

*https://gritman.org/*

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

*No other website*

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

*Yes*

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

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

*Yes*

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

   *2016*

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

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

       *https://gritman.org/wp-content/uploads/CHNA_Gritman_2016.pdf*

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

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

    *See footnote 29 on page 25*

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

    *None incurred*

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

    *Nothing to report*

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

    *Nothing to report*