COMMUNITY BENEFITS REPORTING FORM

Pursuant to RSA 7:32-c-l

FOR FISCAL YEAR BEGINNING 10/01/2013

to be filed with:
Office of the Attorney General
Charitable Trusts Unit
33 Capitol Street, Concord, NH 03301-6397
603-271-3591

Section 1: ORGANIZATIONAL INFORMATION

Organization Name Monadnock Community Hospital

Street Address 452 Old Street Road

City Peterborough County 06 - Hillsborough State NH Zip Code 03458

Federal ID # 02-0222157 State Registration # 02507

Website Address: www.monadnockhospital.org

Is the organization's community benefit plan on the organization's website? Yes

Has the organization filed its Community Benefits Plan Initial Filing Information form? Yes

IF NO, please complete and attach the Initial Filing Information Form.
IF YES, has any of the initial filing information changed since the date of submission?
No IF YES, please attach the updated information.

Chief Executive: Cynthia K. McGuire (603) 924-7191 x 1115
Cynthia.McGuire@mchmail.org

Board Chair: Carole Monroe (603) 563-8889
cdmonroe@myfairpoint.net

Community Benefits Plan Contact: LeeAnn Clark (603) 924-1700
LeeAnn.Clark@mchmail.org

Is this report being filed on behalf of more than one health care charitable trust? No

IF YES, please complete a copy of this page for each individual organization included in this filing.

Section 2: MISSION & COMMUNITY SERVED

Mission Statement: We are committed to improving the health and well-being of our community.
Has the Mission Statement been reaffirmed in the past year (*RSA 7:32e-I)*? Yes

Please describe the community served by the health care charitable trust. "Community" may be defined as a geographic service area and/or a population segment.

Service Area (Identify Towns or Region describing the trust's primary service area):
The Hospital's primary service area consists of 13 towns including Antrim, Bennington, Dublin, Francestown, Greenfield, Greenville, Hancock, Jaffrey, New Ipswich, Peterborough, Rindge, Sharon, and Temple.

Service Population (Describe demographic or other characteristics if the trust primarily serves a population other than the general population):
The Hospital serves the general population of the primary service area referenced above.

Section 3: COMMUNITY NEEDS ASSESSMENT

In what year was the last community needs assessment conducted to assist in determining the activities to be included in the community benefit plan?
2012 *(Please attach a copy of the needs assessment if completed in the past year)*

Was the assessment conducted in conjunction with other health care charitable trusts in your community? Yes

Based on the needs assessment and community engagement process, what are the priority needs and health concerns of your community?

	NEED (Please enter code # from attached list of community needs)
1	101
2	370
3	420
4	601
5	600
6	600
7	407
8	501
9	100

What other important health care needs or community characteristics were considered in the development of the current community benefits plan (e.g. essential needs or services not specifically identified in the community needs assessment)?

	NEED (Please enter code # from attached list of community needs)
A	122
B	200
C	350
D	533
E	341
F	300
G	603

Please provide additional description or comments on community needs including description of "other" needs (code 999) if applicable. *Attach additional pages if necessary*:
128, 124, 320, 602, 301, 330, 121, 607, 125, 999

Section 4: COMMUNITY BENEFIT ACTIVITIES

Identify the categories of Community Benefit activities provided in the preceding year and planned for the upcoming year (note: some categories may be blank). For each area where your organization has activities, report the past and/or projected unreimbursed costs for *all* community benefit activities in that category. For each category, also indicate the *primary* community needs that are addressed by these activities by referring to the applicable number or letter from the lists on the previous page (i.e. the listed needs may relate to only a subset of the total reported costs in some categories).

A. Community Health Services	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Community Health Education	B 1 2	$108,885.00	$128,557.00
Community-based Clinical Services	2 A 6	$207,077.00	$261,337.00
Health Care Support Services	2 9 C	$2,969.00	$704.00
Other:	1 5 G	$549,698.00	$500,000.00

B. Health Professions Education	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Provision of Clinical Settings for Undergraduate Training	-- -- --		
Intern/Residency Education	-- -- --		
Scholarships/Funding for Health Professions Ed.	Other Other Other	$9,529.00	$12,168.00
Other:	-- -- --		

C. Subsidized Health Services	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Type of Service: Cardiac Rehabilitation and Anticoag	1 2 D	$25,136.00	$30,000.00
Type of Service: Diabetes Rehabilitation	1 2 E	$16,947.00	$20,000.00
Type of Service: Pulmonary Rehabilitation	1 2 F	$10,658.00	$12,000.00
Type of Service:	2 4 5	$479,784.00	$500,000.00

Outpatient Behavioral Health			
Type of Service: *Emergency Department*	1 2 6	$533,538.00	$550,000.00

D. Research	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Clinical Research	-- -- --		
Community Health Research	-- -- --		
Other:	-- -- --		

E. Financial Contributions	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Cash Donations	2 6 7	$15,000.00	$15,000.00
Grants	2 6 7	$3,105.00	$20,000.00
In-Kind Assistance	5 Other 6	$118,250.00	$120,000.00
Resource Development Assistance	-- -- --		

F. Community Building Activities	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Physical Infrastructure Improvement	-- -- --		
Economic Development	-- -- --		
Support Systems Enhancement	-- -- --		
Environmental Improvements	-- -- --		
Leadership Development; Training for Community Members	-- -- --		
Coalition Building	-- -- --		
Community Health Advocacy	-- -- --		

G. Community Benefit Operations	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Dedicated Staff Costs	-- -- --		
Community Needs/Asset Assessment	-- -- --		
Other Operations	-- -- --		

H. Charity Care	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Free & Discounted Health Care Services	1 2 6	$2,079,191.00	$2,202,193.00

I. Government-Sponsored Health Care	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Medicare Costs exceeding reimbursement	1 2 6	$766,965.00	$900,000.00
Medicaid Costs exceeding reimbursement	1 2 6	$1,427,769.00	$1,500,000.00
Other Publicly-funded health care costs exceeding reimbursement	1 2 6	$1,206,046.00	$1,200,000.00

Section 5: SUMMARY FINANCIAL MEASURES

Financial Information for Most Recent Fiscal Year	***Dollar Amount***
Gross Receipts from Operations	$130,524,721.00
Net Revenue from Patient Services	$69,431,099.00
Total Operating Expenses	$74,489,395.00
Net Medicare Revenue	$24,886,386.00
Medicare Costs	$25,354,714.00
Net Medicaid Revenue	$2,333,286.00
Medicaid Costs	$3,761,055.00
Unreimbursed Charity Care Expenses	$2,079,191.00
Unreimbursed Expenses of Other Community Benefits	$5,481,355.00
Total Unreimbursed Community Benefit Expenses	$7,560,546.00
Leveraged Revenue for Community Benefit Activities	$40,796.00
Total Community Benefits including Leveraged Revenue for Community Benefit Activities	$7,601,342.00

Section 6: COMMUNITY ENGAGEMENT in the Community Benefits Process

List the Community Organizations, Local Government Officials and other Representatives of the Public consulted in the community benefits planning process. Indicate the role of each in the process.	***Identification of Need***	***Prioritization of Need***	***Development of the Plan***	***Commented on Proposed Plan***
1) Contoocook Valley Transportation Company	☒	☒	☒	☒
2) ConVal School District	☒	☒	☒	☒
3) Crotched Mountain Rehabilitation Center	☒	☒	☐	☐
4) Good Shepherd Rehabilitation and Nursing Center	☒	☒	☒	☒
5) Home Healthcare Hospice and Community Services	☒	☒	☒	☒
6) Monadnock Family Services	☒	☒	☒	☒
7) Greater Peterborough Chamber of Commerce	☒	☒	☐	☐
8) Jaffrey Monadnock Adult Care	☒	☒	☐	☐
9) Jaffrey Police Department	☒	☒	☐	☐
10) Monadnock Area Food Bank	☒	☒	☐	☐
11) Monadnock Area Transitional Shelter	☒	☒	☐	☐
12) Monadnock At Home	☒	☒	☒	☒
13) Monadnock Community Early Learning Center	☒	☒	☐	☐
14) Peter Cerroni Dentistry	☒	☒	☐	☐
15) Monadnock Developmental Services	☒	☒	☐	☒
16) Monadnock Family Services	☒	☒	☒	☒
17) NH Catholic Charities	☒	☒	☒	☒
18) Pine Hill Child Care Center	☒	☒	☐	☒
19) Shelter From the Storm	☒	☒	☐	☐
20) The Grapevine	☒	☒	☒	☒
21) The River Center	☒	☒	☒	☒
22) The Town of Peterborough	☒	☒	☐	☐
23) The Town of New Ipswich	☒	☒	☐	☐
24)	☐	☐	☐	☐
25)	☐	☐	☐	☐

Please provide a description of the methods used to solicit community input on community needs (attach additional pages if necessary):

The State of New Hampshire requires not-for-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every five years. In addition, the Affordable Care Act of 2010 requires one to be done every three years. In mid-2012, MCH completed its CHNA with the goal to clearly identify and prioritize service gaps and ways that it can help improve community health – in addition to meeting state and federal regulations. MCH engaged Crescendo Consulting Group to assist with this important project.

Needs Prioritization Methodology:

MCH used a multi-phased methodology to achieve the objectives of the assessment. The

methodology included the following stages:

- Establishing a Leadership Team to provide project guidance and insight regarding local health resources and perspectives of community needs
- Strategic secondary research
- Four qualitative discussion groups with healthcare consumers, service providers, and other community opinion leaders
- Needs prioritization process

Each of these stages is described below.

Establishing a Leadership Team:

Purpose: The objective of the Leadership Group was to engage a broad cross-section of the community that could reasonably represent the very diverse consumers who comprise the MCH service area.

The MCH Leadership Group was established early in the project process in order to develop communication channels with, and to learn about the insights of, a diverse set of community stakeholders. In order to generate the information, MCH incorporated 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. Group members were selected based upon their perceived community health vision, knowledge, and power to impact the well-being of the community. The steering committee included the following members:

- Contoocook Valley Transportation Company, Rebecca Harris, Project Coordinator
- ConVal School District, Pam Murphy, School Nurse
- ConVal School District, Rick Matte, Director of Student Services
- Crotched Mountain, Liz LaRose, Director of Marketing
- Good Shepherd Healthcare Center, Suzanne Singer, Marketing Executive
- Greater Peterborough Chamber of Commerce, Jack Burnett, Executive Director
- Home Healthcare & Hospice, Cathy Sorenson, Chief Clinical Operating Officer
- Jaffrey Monadnock Adult Care, Christine Selmer, Director
- Jaffrey Police Department, Bill Oswalt, Chief
- Monadnock Area Food Bank, Meredith White, Director
- Monadnock Area Transitional Shelter, Hope Pettigrew, Board of Trustees
- Monadnock at Home, Owen Houghton, Vice Chair of the Board of Directors
- Monadnock Community Early Learning Center, Edna Coates, Business Director
- Monadnock Community Hospital, Peter Cerroni, Dentist / DMD
- Monadnock Development Services, Alan Greene, Executive Director
- Monadnock Family Services, Katherine Cook, Director of Child and Family Services
- New Hampshire Catholic Charities, Ann Nunn, Administrator
- Pine Hill Child Care Center, Peggy Waterhouse, Executive Director
- Shelter From the Storm, Carol Gehlbach, Board of Directors
- The Grapevine, Kristen Vance, Executive Director
- The Grapevine, Siobhan Martin, Chair of the Board of Directors

- The River Center, Margaret Nelson, Executive Director
- Town of New Ipswich, Marie Knowlton, Town Administrator
- Town of Peterborough, Pam Brenner, Town Administrator

The steering committee also offered critical feedback on quantitative data; refined the list of community needs, helped develop the database of available resources, and participated in quantitative and qualitative research methods to build the prioritized list of community needs identified in this report.

Strategic Secondary Research:

Purpose: Statistical and demographic data was used to help develop a profile of the lifestyle, demographic, and disease incidence characteristics of the service area. Identifying disparities assists in the prioritization of needs later in the process.

Strategic secondary research included a search of existing published and electronically available data sources to determine statistical profiles of the morbidity, mortality, lifestyle, and demographic characteristics of the MCH service area – along with state and national comparisons, where helpful. The list below includes some of the data sources used to support this assessment.

-Demographic Data.
o U.S. Census
o State of New Hampshire, Employment Security
o State of New Hampshire, Office of Energy and Planning

-Health Risk Behavior Data from the U.S. Centers for Disease Control and Prevention
o Behavioral Risk Factor Surveillance System Survey (BRFSS).
o Youth Risk Behavior Survey (YRBS).
o State of New Hampshire, Department of Education

-Morbidity and Mortality by cause.
o State of New Hampshire, Department of Health and Human Services, Division of

-Public Health Services
o Hospital Discharge Data.
o Birth and Death Statistics.
o Cancer Registry.

-Existing materials from other organizations
We analyzed the secondary data from the sources above and developed a series of data tables to provide a profile of the MCH service area and, more importantly, to gain a better understanding of the relative magnitude of morbidity and mortality data – identifying regional outliers, where possible.

Qualitative Discussion Groups

Purpose: The objective of the discussion groups was to generate a comprehensive list of community health related needs and to develop access to a database of services. One of the outputs of the discussion groups was the list of 40 community needs that was used in the "prioritization" phase of research.

MCH conducted five discussion groups with individuals from a breadth of community groups regarding their perceptions of healthcare service gaps. The groups (roughly 90 minutes each) included in-depth discussion about topics such as community strengths, service gaps, needs prioritization, and ways that MCH may be able to help address community needs. The information gleaned was used to help triangulate statistical data and qualitative information collected through other research modalities.

The discussion groups included the following community segments:

• Leadership Group Members – three groups. As noted above, the Leadership Group included executives from a diverse range of organizations that have direct contact with healthcare consumers and/or provide affiliated services. The Group helped identify an extensive list of community resources, health needs, and service gaps. The participants also reviewed secondary data and provided feedback on the results of the community opinion leader discussion group.

• Healthcare Consumers. Consumer sectors who participated in the MCH CHNA discussion group included people from diverse age groups and economic strata, individuals with varying degrees of chronic illnesses, and others. Healthcare consumers provided insights regarding community health needs and reflected on the results of the secondary data research.

• Community Opinion Leaders. The Community Opinion Leader Group was comprised of healthcare consumers living in the MCH service area and also providing community services such as faith-based networking and in-school nursing. In addition to Leadership Group members, participants in this discussion group were able to help MCH ―cast a broad net with regard to seeking and identifying insights from a broad range of consumers.

Members included representatives from the following organizations:

o Greenfield Covenant Church
o Crotched Mountain Rehabilitation Center
o The River Center Family and Community Resource
o The Grapevine Family & Community Resource Center
o Monadnock RSVP
o Southwestern Community Services
o Town of Rindge
o Town of Peterborough

Needs Prioritization Process:

Purpose: This stage used a mixed modality approach to rank order the 40 community needs

identified in earlier research. The approach is designed to help build consensus around the results and thoroughly evaluate community needs.

In a method originally pioneered by the RAND Corporation in the 1950s and 1960s, Crescendo helped MCH implement a quantitative and qualitative survey method that is used to collect, distill, and reach prioritized consensus around creative ideas and/or qualitative issues and questions.

Leadership Group members rated health initiatives and provided qualitative feedback. The process included three steps.

• Leadership Group members were asked to quantitatively and qualitatively evaluate each of the 40 community needs (identified by discussion group participants and through the data analysis research phase) using an electronic survey.

• The resulting needs were rank-ordered based upon the average score and aggregated qualitative comments. The survey results were sent to Leadership Group members in the form of a second survey. The second survey included the same list of 40 needs, the ranking of each of the community needs based on previous survey, and a list of qualitative comments submitted by survey participants. Leadership Group members re-rated the 40 needs based on their own opinions and the insights of others as expressed in the list of aggregated comments.

• The results of the second survey were rank-ordered based on the average scores. The complete list of the community needs evaluated in the process is included in the comprehensive Community Health Needs Assessment report, available on our website. The assessment represents input from the steering committee meetings; analysis of local, state of New Hampshire, and federal quantitative data; community input; and, the needs evaluation process.

Section 7: CHARITY CARE COMPLIANCE

Please characterize the charity care policies and procedures of your organization according to the following:	**YES**	**NO**	Not Applicable
The valuation of charity does not include any bad debt, receivables or revenue	☒	☐	☐
Written charity care policy available to the public	☒	☐	☐
Any individual can apply for charity care	☒	☐	☐
Any applicant will receive a prompt decision on eligibility and amount of charity care offered	☒	☐	☐
Notices of policy in lobbies	☒	☐	☐
Notice of policy in waiting rooms	☒	☐	☐
Notice of policy in other public areas	☒	☐	☐
Notice given to recipients who are served in their home	☐	☐	☒

List of Potential Community Needs for Use on Section 3

100 - Access to Care; General
101 - Access to Care; Financial Barriers
102 - Access to Care; Geographic Barriers
103 - Access to Care; Language/Cultural Barriers to Care
120 - Availability of Primary Care
121 - Availability of Dental/Oral Health Care
122 - Availability of Behavioral Health Care
123 - Availability of Other Medical Specialties
124 - Availability of Home Health Care
125 - Availability of Long Term Care or Assisted Living
126 - Availability of Physical/Occupational Therapy
127 - Availability of Other Health Professionals/Services
128 - Availability of Prescription Medications

200 - Maternal & Child Health; General
201 - Perinatal Care Access
202 - Infant Mortality
203 - Teen Pregnancy
204 - Access/Availability of Family Planning Services
206 - Infant & Child Nutrition
220 - School Health Services

300 - Chronic Disease – Prevention and Care; General
301 - Breast Cancer
302 - Cervical Cancer
303 - Colorectal Cancer
304 - Lung Cancer
305 - Prostate Cancer
319 - Other Cancer
320 - Hypertension/HBP
321 - Coronary Heart Disease
322 - Cerebrovascular Disease/Stroke
330 - Diabetes
340 - Asthma
341 - Chronic Obstructive Pulmonary Disease
350 - Access/Availability of Chronic Disease Screening Services

360 - Infectious Disease – Prevention and Care; General
361 - Immunization Rates
362 - STDs/HIV
363 - Influenza/Pneumonia
364 - Food borne disease
365 - Vector borne disease

370 - Mental Health/Psychiatric Disorders – Prevention and Care; General
371 - Suicide Prevention
372 - Child and adolescent mental health
372 - Alzheimer's/Dementia
373 - Depression
374 - Serious Mental Illness

400 - Substance Use; Lifestyle Issues
401 - Youth Alcohol Use
402 - Adult Alcohol Use
403 - Youth Drug Use
404 - Adult Drug Use
405 - Youth Tobacco Use
406 - Adult Tobacco Use
407 - Access/Availability of Alcohol/Drug Treatment

420 - Obesity
421 - Physical Activity
422 - Nutrition Education
430 - Family/Parent Support Services

500 – Socioeconomic Issues; General
501 - Aging Population
502 - Immigrants/Refugees
503 - Poverty
504 - Unemployment
505 - Homelessness
506 - Economic Development
507 - Educational Attainment
508 - High School Completion
509 - Housing Adequacy

520 - Community Safety & Injury; General
521 - Availability of Emergency Medical Services
522 - Local Emergency Readiness & Response
523 - Motor Vehicle-related Injury/Mortality
524 - Driving Under Influence
525 - Vandalism/Crime
526 - Domestic Abuse
527 - Child Abuse/Neglect
528 - Lead Poisoning
529 - Work-related injury
530 - Fall Injuries
531 - Brain Injury
532 - Other Unintentional Injury

533 - Air Quality
534 - Water Quality

600 - Community Supports; General
601 - Transportation Services
602 - Information & Referral Services
603 - Senior Services
604 - Prescription Assistance
605 - Medical Interpretation
606 - Services for Physical & Developmental Disabilities
607 - Housing Assistance
608 - Fuel Assistance
609 - Food Assistance
610 - Child Care Assistance
611 - Respite Care

999 – Other Community Need