Northwestern Medical Center
2016 Community Health Needs Assessment

Overview and Summary of Top Six Priorities

NMC
Northwestern Medical Center

NMC's mission is to provide exceptional care for our community.

2016 Community Health Needs Assessment

NMC's Process

- Assessment conducted every three years
- Facilitated by Quorum Health Resources
- Aligned with mandated Federal requirements
- Informed by analysis of local, state, and national data
- Prioritized by broad-based panel of local experts
- Becomes basis for intervention strategies, informs hospital planning efforts, and is available to community partners

2016 Community Health Needs Assessment

The 2016 Top Priorities

1. Mental Health & Substance Abuse
2. Obesity
3. Smoking
4. Cancer
5. Suicide
6. Domestic & Sexual Assault

2016 Community Health Needs Assessment

Other Needs Identified and Ranked Outside Top Priorities

- Access to Healthcare & Physicians
- Health Insurance / Uninsured
- High Blood Pressure
- Coronary Heart Disease
- Diabetes
- Physical Environment
- Behavior/Social
- Violent Crime
- Chronic Lung Disease / Chronic Asthma
- Alzheimer's
- Stroke
- ER / Urgent Care use
- Teen Births
- Cholesterol
- Kidney
- Fall related injuries
- Premature death.
- Accidents
- Homicide
- Sexual Disease
- Back Pain,
- Transportation
- Liver
- Blood Poisoning
- Flu/Pneumonia

1. Mental Health & Substance Abuse

NMC related services, programs, and resources include:

- Northwestern Comprehensive Pain practice
- Northwestern Medical Center's Emergency Department (with embedded services)
- Northwestern Primary Care & Northwestern Georgia Health Center
- Pediatrics
- Northwestern OB/GYN & NMC's Family Birth Center
- Case Management services (inpatient, emergent, outpatient)
- Interventional Pain service
- Vermont Blueprint for Health facilitation in area primary care practices
- Urine Toxicology services (expected to launch in 2016)

NMC's Intervention strategy is envisioned to include:

- Increase access to addiction services through recruitment and collaboration
- Embed Mental Health Care Managers into Primary Care, continue with embedded in ED
- Increase access to interventional pain through recruitment

Leading Indicator:

- Depression Screening as per Accountable Care Organization

Lagging Indicator:

- Deaths From Overdose

2. Obesity

NMC related services, programs, and resources include:

- NMC Lifestyle Medicine
- RiseVT Community Campaign to Embrace Healthy Lifestyles
- Northwestern Primary Care & Northwestern Georgia Health Center
- Northwestern Pediatrics

NMC's Intervention strategy is envisioned to include:

- Continue the evidence based RiseVT Community Campaign
- Continue primary prevention work of advocacy, Healthy Roots, community walkability, etc
- Establish the public offering of the Lifestyle Medicine Clinic
- Expand use of dietitians by primary care referral through Lifestyle Medicine and Blueprint
- Expand business wellness services at worksites
- Explore implementation of best practice model for obesity reduction (possibly EPODE)

Leading Indicator:

- Adult BMI Rate from OneCare Vermont Accountable Care Organization
- Children BMI Rate from OneCare Vermont Accountable Care Organization

Lagging Indicator:

- Adult Obesity Rate
- Childhood Obesity Rate

3. Smoking

NMC related services, programs, and resources include:

- NMC Lifestyle Medicine
- RiseVT Community Campaign to Embrace Healthy Lifestyles
- Northwestern Primary Care & Northwestern Georgia Health Center
- Northwestern Pediatrics
- Northwestern OB/GYN

NMC's Intervention strategy is envisioned to include:

- Continue the evidence based RiseVT Community Campaign
- Continue primary prevention work of advocacy, Healthy Retailing, Smoke Free Environments, etc
- Expand use of smoking cession by primary care referral through Lifestyle Medicine and Blueprint
- Expand business wellness services at worksites

Leading Indicator:

- Tobacco Use Assessment and Cessation Referral Through ACO Measure

Lagging Indicator:

- Adult smoking rate
- Youth smoking rate

4. Cancer

NMC related services, programs, and resources include:

- NMC Cancer Committee
- NMC Diagnostic Imaging
- Northwestern Primary Care & Northwestern Georgia Health Center
- Northwestern Pediatrics
- Northwestern OB/GYN
- RiseVT Community Campaign to Embrace Healthy Lifestyles
- Northwestern Lifestyle Medicine

NMC's Intervention strategy is envisioned to include:

- Continue the activities of NMC's accredited community cancer committee
- Expand access to mammography through the Breast Cancer Navigator and other strategies
- Increase referrals to screenings through partnership with the Vermont Blueprint for Health
- Increase community awareness of importance of early detection and available treatment
- Continue primary prevention work of advocacy, Healthy Retailing, Smoke Free Environments, etc
- Expand use of smoking cession by primary care referral through Lifestyle Medicine and Blueprint

Leading Indicator:

- Colorectal cancer/screening data from OneCare Vermont Accountable Care Organization
- Breast cancer/screening data from OneCare Vermont Accountable Care Organization

Lagging Indicator:

- Death rates from cancer

5. Suicide

NMC related services, programs, and resources include:

- Northwestern Comprehensive Pain
- NMC Emergency Department
- Northwestern Primary Care & Northwestern Georgia Health Center
- Northwestern Pediatrics

NMC's Intervention strategy is envisioned to include:

- Expand access to addiction services
- Continue embedded mental health care management in ED
- Implement embedded mental health care management in Primary Care
- Explore ways to support the work of key community partners

Leading Indicator:

- Depression Screening from OneCare Vermont Accountable Care Organization

Lagging Indicator:

- Suicide Rate

6. Domestic and Sexual Abuse

NMC related services, programs, and resources include:

- NMC Emergency Department
- Northwestern Primary Care & Northwestern Georgia Health Center
- Northwestern Pediatrics
- Northwestern OB/GYN

NMC's Intervention strategy is envisioned to include:

- Continue the work of NMC Sexual Assault Nurse Examiners
- Identification and referral from ED, Primary Care, Pediatrics, OB/GYN, etc
- Explore ways to support the work of key community partners

Leading Indicator:

- Response to Do You Feel Safe in Home from NMC Emergency Department and Practices

Lagging Indicator:

- Incidents of Domestic Violence
- Incidents of Sexual Assault

Northwestern Medical Center

St. Albans, Vermont

QUORUM | HEALTH RESOURCES®

Community Health Needs Assessment
and Implementation Strategy

Adopted by NMC Board March 2, 2016[1]

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

Dear Community Member:

Northwestern Medical Center's (NMC's) history of caring for our community dates back to the first St. Albans Hospital established in 1883. Our efforts to provide exceptional healthcare for the people of the greater Franklin and Grand Isle counties region has long been in alignment with the needs of our community. Now, in compliance with the Affordable Care Act, all not-for-profit hospitals are required to develop and share a formal report on the medical and health needs of the communities they serve. We welcome you to review this document as part of our continuing efforts to meet your health and medical needs.

The "Fiscal Year 2016 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how NMC will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, NMC, are meeting our obligations to efficiently deliver medical services.

NMC 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.

No single organization has the 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 in addition to the response of organizations. We view this as a plan for how we, along with other community partners, can collaborate to bring the best each has to offer to support change and leverage improvement as we wort together to address the most pressing identified needs.

As this report fulfills 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 non-tax return purposes, they are not important. The primary purpose of this report is to guide our actions and the efforts of others to make needed health and medical improvements in our area.

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

Thank You,

Jill Berry Bowen, Chief Executive Officer
Northwestern Medical Center

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EXECUTIVE SUMMARY

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

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

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

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

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

Project Objectives

NMC 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 – 990h schedule
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

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

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

- An Emergency Room open to all, regardless of ability to pay

[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 2014 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

- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

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

[5] Section 6652

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.

[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

APPROACH

APPROACH

To complete a CHNA:

> *"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:*
>
> *(1) A definition of the community served by the hospital facility and a description of how the community was determined;*
>
> *(2) a description of the process and methods used to conduct the CHNA;*
>
> *(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*
>
> *(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and*
>
> *(5) a description of resources potentially available to address the significant health needs identified through the CHNA.*
>
> *… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."*[7]

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

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

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

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

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies,

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

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

with current data or other information relevant to the health needs of the community served by the hospital facility

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

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

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

Other (please specify)

QHR also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Franklin and Grand Isle Counties compared to all State counties	March 15, 2015	2005 to 2013
www.communityhealth.hhs.gov	Assessment of health needs of Franklin and Grand Isle Counties compared to its national set of "peer counties"	March 15, 2015	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-	July 14, 2015	2012 to 2014

[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 QHR written comment solicitation classifications, with whom the Hospital solicited to participate in the QHR/Hospital CHNA process. Response to Schedule h (Form 990) V B 3 h

[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

	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		
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	March 15, 2015	2014
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	March 15, 2015	2014
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	March 15, 2015	2000 to 2010
www.dataplace.org	To determine availability of specific health resources	March 15, 2015	2006
www.cdc.gov	To examine area trends for heart disease and stroke	March 15, 2015	2008 to 2010
http://svi.cdc.gov/map.aspx?txtzipcode=37083&btnzipcode=Submit	To identify the Social Vulnerability Index value	June 17, 2015	2010
www.CHNA.org	To identify potential needs from a variety of resource and health need metrics	March 15, 2015	2003 to 2014
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	March 15, 2015	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	June 2, 2015	CDC official final deaths 2013 published 1/26/2015
www.stlouisfed.org/fred2	To determine unemployment rate	July 20, 2015	2015

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

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations and to solicit comments on the 2012 Significant Needs. 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 regions geographically and ethnically diverse population. We received community input from 29 Local Expert Advisors. Survey responses started June 26, 2015 at 4:34 PM and ended on July 14, 2015 at 10:04 PM. All written comments are presented verbatim in the Appendix to this Report. No unsolicited written comments have been received by the hospital. [12]

- Information analysis augmented by local opinions showed how Grand Isle and Franklin counties each 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.[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:
  - "Generational poverty, substance abuse, and domestic violence are creating perfect storms of mental and physical health problems...the ACE study clearly shows the long-term effects on the body and the correlating need for extensive health care i consider this a public health crisis in our community and would look to our Medical Center to take the lead in creating the public health response"
  - "One issue I believe confronting priority populations is chronic disease management. We have many people attending our adult day who have diabetes, respiratory problems, heart disease and neurological health problems. A non-health need is safe housing that meets people's needs."
  - "I really worry about the impact on rural poverty. Lack of transportation and services available for these individuals is a real problem. I'd like to see more outreach supports in our poorer towns such as Alburg and Richford in particular."

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[14] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[15] Consultation with 21 Local Experts occurred again via an internet-based survey (explained below) beginning September 4, 2015 at 2:45 PM and ending September 15, 2015 at 8:49 PM.

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.[16]

In the NMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings. We developed a summary of all needs

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

identified by any of the analyzed data sets. The Local Experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

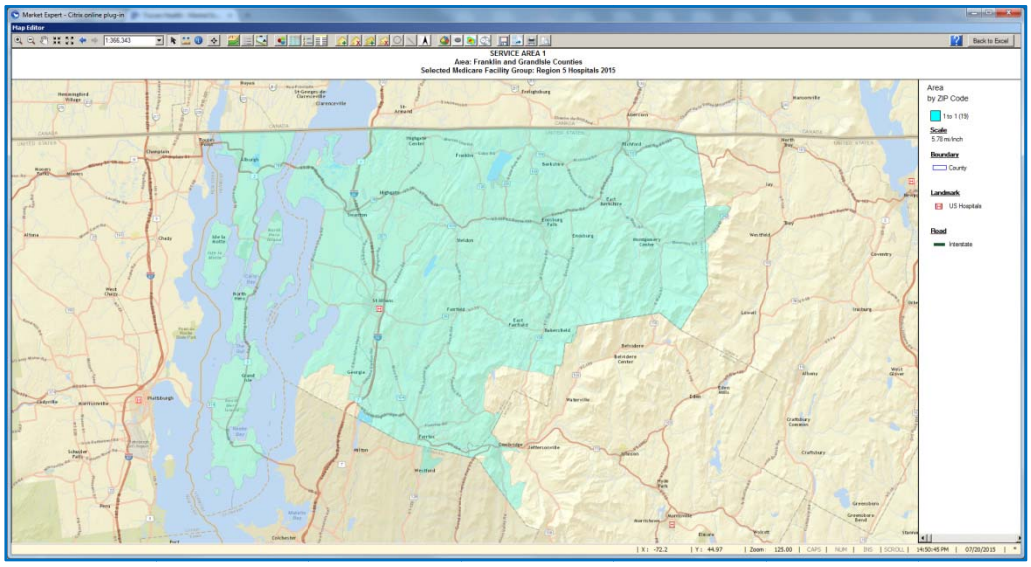
We dichotomized the rank order of prioritized needs into two groups: “Significant” and “Other Identified Needs.” Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation by Quorum and the NMC executive team where a reasonable break point in rank order occurred.[17]

[17] Response to Schedule h (Form 990) Part V B 3 g

FINDINGS

FINDINGS

Definition of Area Served by the Hospital[18]



NMC, in conjunction with Quorum, defines its service area as Franklin and Grand Isle Counties in Vermont, which includes the following ZIP codes:[19]

Franklin County		**Grand Isle County**
05441 – Bakersfield	05459 – Highgate Center	05440 – Alburgh
05447 – Berkshire	05470 – Montgomery	05458 – Grand Isle
05444 – Cambridge	05471 – Montgomery Center	05463 – Isle la Motte
05448 – East Fairfield	05476 – Richford	05474 – North Hero
05450 – Enosburg Falls	05478 – Saint Albans	05486 – South Hero
05454 – Fairfax	05481 – Saint Albans Bay	
05455 – Fairfield	05483 – Sheldon	
05457 – Franklin	05488 – Swanton	

In 2013, the Hospital received 87.5% of its patients from this area.[20]

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

Demographic of the Community[21] [22]

The 2015 population for Franklin County is estimated to be 48,825[23] and is expected to increase at a rate of 1.1%. This is in contrast to the 3.5% national rate of growth, while Vermont's population is expected to grow 0.3%. Truven anticipates Franklin County in 2020 as having a population of 47,348.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2015 median age for the county is 40.8 years, younger than the Vermont median age (42.7 years) and older than the national median age of 37.9 years. The 2015 Median Household Income for the area is $60,651, higher than the Vermont median income of $57,436 and the national median income of $53,375. Median Household Wealth value is also higher than the National value ($48,894) and the Vermont value ($70,091). Median Home Values for Franklin ($215,514) is lower than the Vermont median ($228,176) but is higher than the National value ($190,970). Franklin's unemployment rate as of May, 2015 was 3.1%[24], which is in line with the 3.6% statewide rate but is much better than the 5.5% national civilian unemployment rate.

The portion of the population in the county over 65 is 14.5%, compared to Vermont (17.0%) and the national average (14.7%). The portion of the population of women of childbearing age is 18.6%, slightly higher than the Vermont average of 18.3% but lower than the national rate of 19.7%. 94% of the population is White non-Hispanic, the largest minority. The Hispanic population comprises 1.6% of the total.[25]

The 2015 population for Grand Isle County is estimated to be 6,985[26] and expected to increase at a rate of 0.4%. This is in contrast to the 3.5% national rate of growth, while Vermont's population is expected to grow 0.3%. Truven anticipates Grand Isle County in 2020 as having a population of 7,016.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2015 median age for the county is 47.4 years, older than the Vermont median age (42.7 years) and older than the national median age of 37.9 years. The 2015 Median Household Income for the area is $65,449, higher than the Vermont median income of $57,436 and the national median income of $53,375. Median Household Wealth value ($114,577) is much higher than the National and the Vermont value. Median Home Values for Grand Isle ($276,363) is higher than the comparison values, the Vermont median of $228,176 and the national median of $190,970. Grand Isle's unemployment rate as of May 2015 was 3.2%[27], which is in line with the 3.6% statewide rate but is much better than the 5.5% national civilian unemployment rate.

The portion of the population in the county over 65 is 17.5%, compared to Vermont (17.0%) and the national average (14.7%). The portion of the population of women of childbearing age is 15.6%, over two percent lower than the Vermont average of 18.3% and more than four percent lower than the national rate of 19.7%. 93.3% of the population is White

[21] Responds to IRS Schedule h (Form 990) Part V B 3 b
[22] The tables below were created by Truven Market Planner, a national marketing company
[23] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[24] http://research.stlouisfed.org/fred2/series/TNMACO1URN; http://research.stlouisfed.org/fred2/series/TNUR; http://research.stlouisfed.org/fred2/series/UNRATE
[25] The tables below were created by Truven Market Planner, a national marketing company.
[26] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[27] http://research.stlouisfed.org/fred2/series/TNMACO1URN; http://research.stlouisfed.org/fred2/series/TNUR; http://research.stlouisfed.org/fred2/series/UNRATE

non-Hispanic, the largest minority. The Hispanic population comprises 2.1% of the total.[28]

	Franklin County	Grand Isle County	State	U.S.
2015 Population	48,825	6,985		
% Increase/Decline	1.1%	0.4%	0.3%	3.5%
Estimated Population in 2020	47,348	7,016		
% White, non-Hispanic	94%	93.3%		
% Hispanic	1.6%	2.1%		
Median Age	40.8	47.4	37.9	42.7
Median Household Income	$60,651	$65,449	$57,436	$53,375
Unemployment Rate	3.1%	3.2%	3.6%	5.5%
% Population >65	14.5%	17.5%	17.0%	14.7%
% Women of Childbearing Age	18.6%	15.6%	18.3%	19.7%

Demographics Expert 2.7
2015 Demographic Snapshot
Area: Franklin County, VT
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	46,126	308,745,538
2015 Total Population	46,825	319,459,991
2020 Total Population	47,348	330,689,365
% Change 2015 - 2020	1.1%	3.5%
Average Household Income	$73,634	$74,165

	2015	2020	% Change
Total Male Population	23,149	23,355	0.9%
Total Female Population	23,676	23,993	1.3%
Females, Child Bearing Age (15-44)	8,720	8,573	-1.7%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2015	% of Total	2020	% of Total	USA 2015 % of Total
0-14	8,739	18.7%	8,391	17.7%	19.1%
15-17	1,940	4.1%	1,908	4.0%	4.0%
18-24	3,947	8.4%	4,247	9.0%	9.9%
25-34	5,353	11.4%	5,297	11.2%	13.3%
35-54	13,317	28.4%	12,174	25.7%	26.3%
55-64	6,740	14.4%	7,134	15.1%	12.7%
65+	6,789	14.5%	8,197	17.3%	14.7%
Total	46,825	100.0%	47,348	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2015 Household Income	HH Count	% of Total	USA % of Total
<$15K	1,698	9.1%	12.7%
$15-25K	1,777	9.6%	10.8%
$25-50K	4,122	22.2%	23.9%
$50-75K	3,821	20.6%	17.8%
$75-100K	2,679	14.4%	12.0%
Over $100K	4,466	24.1%	22.8%
Total	18,563	100.0%	100.0%

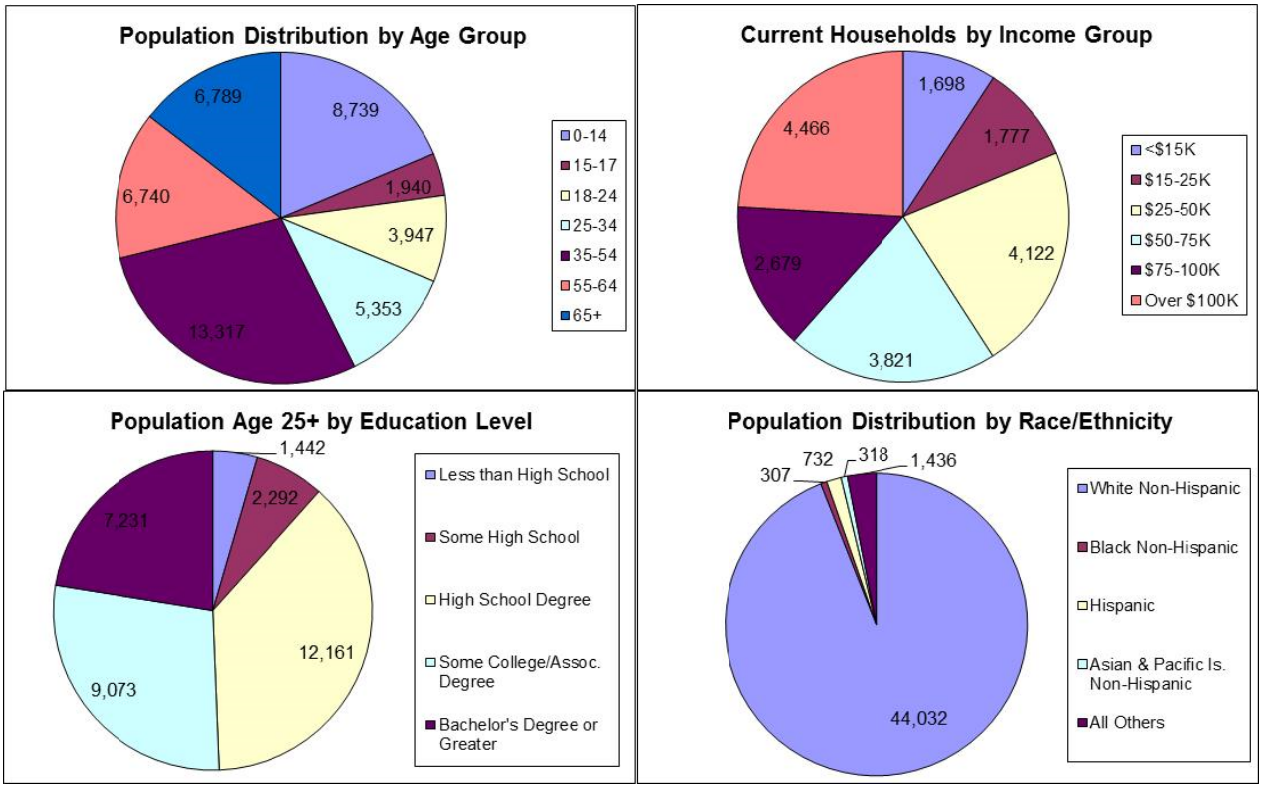
EDUCATION LEVEL

	Education Level Distribution		
2015 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	1,442	4.5%	5.9%
Some High School	2,292	7.1%	8.0%
High School Degree	12,161	37.8%	28.1%
Some College/Assoc. Degree	9,073	28.2%	29.1%
Bachelor's Degree or Greater	7,231	22.5%	28.9%
Total	32,199	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2015 Pop	% of Total	USA % of Total
White Non-Hispanic	44,032	94.0%	61.8%
Black Non-Hispanic	307	0.7%	12.3%
Hispanic	732	1.6%	17.6%
Asian & Pacific Is. Non-Hispanic	318	0.7%	5.3%
All Others	1,436	3.1%	3.1%
Total	46,825	100.0%	100.0%

[28] The tables below were created by Truven Market Planner, a national marketing company.



Demographics Expert 2.7
2015 Demographic Snapshot
Area: Grand Isle County VT
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	6,959	308,745,538
2015 Total Population	6,985	319,459,991
2020 Total Population	7,016	330,689,365
% Change 2015 - 2020	0.4%	3.5%
Average Household Income	$88,713	$74,165

	2015	2020	% Change
Total Male Population	3,485	3,500	0.4%
Total Female Population	3,500	3,516	0.5%
Females, Child Bearing Age (15-44)	1,091	1,069	-2.0%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2015	% of Total	2020	% of Total	USA 2015 % of Total
0-14	1,030	14.7%	982	14.0%	19.1%
15-17	240	3.4%	233	3.3%	4.0%
18-24	529	7.6%	530	7.6%	9.9%
25-34	686	9.8%	715	10.2%	13.3%
35-54	1,901	27.2%	1,627	23.2%	26.3%
55-64	1,379	19.7%	1,492	21.3%	12.7%
65+	1,220	17.5%	1,437	20.5%	14.7%
Total	6,985	100.0%	7,016	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

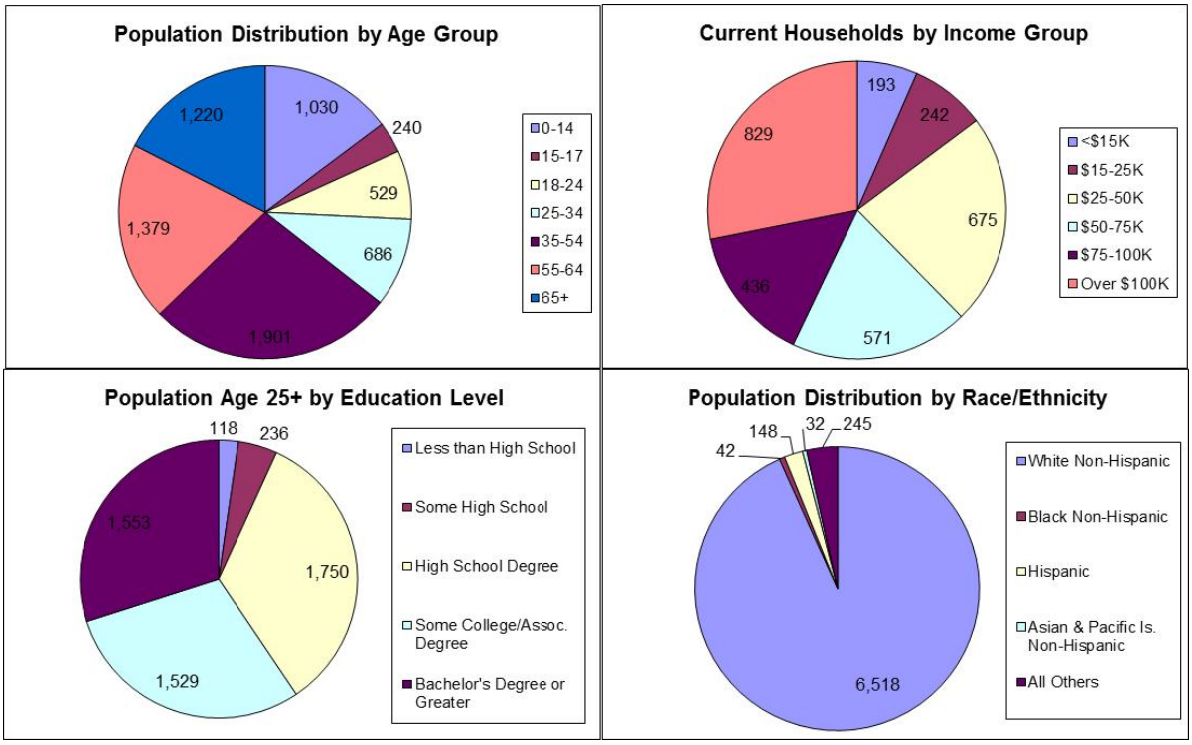
	Income Distribution		
2015 Household Income	HH Count	% of Total	USA % of Total
<$15K	193	6.6%	12.7%
$15-25K	242	8.2%	10.8%
$25-50K	675	22.9%	23.9%
$50-75K	571	19.4%	17.8%
$75-100K	436	14.8%	12.0%
Over $100K	829	28.1%	22.8%
Total	2,946	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2015 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	118	2.3%	5.9%
Some High School	236	4.6%	8.0%
High School Degree	1,750	33.7%	28.1%
Some College/Assoc. Degree	1,529	29.5%	29.1%
Bachelor's Degree or Greater	1,553	29.9%	28.9%
Total	5,186	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2015 Pop	% of Total	USA % of Total
White Non-Hispanic	6,518	93.3%	61.8%
Black Non-Hispanic	42	0.6%	12.3%
Hispanic	148	2.1%	17.6%
Asian & Pacific Is. Non-Hispanic	32	0.5%	5.3%
All Others	245	3.5%	3.1%
Total	6,985	100.0%	100.0%



2015 Benchmarks
Area: Franklin County, VT
Level of Geography: ZIP Code

Area	2015-2020 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2015-2020	Females 15-44 % of Total Population	Females 15-44 % Change 2015-2020	Median Household Income	Median Household Wealth	Median Home Value
USA	3.5%	37.9	14.7%	17.7%	19.7%	1.2%	$53,375	$48,894	$190,970
Vermont	0.3%	42.7	17.0%	15.5%	18.3%	-1.3%	$57,436	$70,091	$228,176
Selected Area	1.1%	40.8	14.5%	20.7%	18.6%	-1.7%	$60,651	$77,593	$215,514

Demographics Expert 2.7
DEMO0003.SQP

2015 Benchmarks
Area: Grand Isle County VT
Level of Geography: ZIP Code

Area	2015-2020 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2015-2020	Females 15-44 % of Total Population	Females 15-44 % Change 2015-2020	Median Household Income	Median Household Wealth	Median Home Value
USA	3.5%	37.9	14.7%	17.7%	19.7%	1.2%	$53,375	$48,894	$190,970
Vermont	0.3%	42.7	17.0%	15.5%	18.3%	-1.3%	$57,436	$70,091	$228,176
Selected Area	0.4%	47.4	17.5%	17.8%	15.6%	-2.0%	$65,449	$114,577	$276,253

Demographics Expert 2.7
DEMO0003.SQP

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

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

national average, or norm, is represented as 100%. Where Franklin and Grand Isle Counties vary more than 5% above or below that norm (that is, less than 95% or greater than 105%), it is considered significant.

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

Franklin County

Health Service Topic	Demand as % of National	% of Population Effected	Health Service Topic	Demand as % of National	% of Population Effected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	105.8%	32.4%	Mammography in Past Yr	97.8%	44.6%
Vigorous Exercise	103.3%	59.1%	Cancer Screen: Colorectal 2 yr	99.5%	25.4%
Chronic Diabetes	96.2%	12.0%	Cancer Screen: Pap/Cerv Test 2 yr	96.7%	58.0%
Healthy Eating Habits	95.5%	28.3%	Routine Screen: Prostate 2 yr	96.2%	30.9%
Ate Breakfast Yesterday	101.3%	77.6%	**Orthopedic**		
Slept Less Than 6 Hours	100.0%	14.2%	Chronic Lower Back Pain	100.5%	23.7%
Consumed Alcohol in the Past 30 Days	94.7%	51.2%	Chronic Osteoporosis	85.4%	8.4%
Consumed 3+ Drinks Per Session	105.4%	29.6%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.3%	91.2%
I Will Travel to Obtain Medical Care	98.4%	22.6%	Used Midlevel in last 6 Months	108.3%	44.8%
I am Responsible for My Health	101.3%	66.2%	OB/Gyn 1+ Visit	98.1%	45.3%
I Follow Treatment Recommendations	103.7%	53.8%	Medication: Received Prescription	101.7%	60.5%
Pulmonary			**Internet Usage**		
Chronic COPD	90.2%	3.6%	Use Internet to Talk to MD	90.8%	11.0%
Tobacco Use: Cigarettes	92.8%	23.6%	Facebook Opinions	92.1%	9.5%
Heart			Looked for Provider Rating	98.5%	13.9%
Chronic High Cholesterol	99.1%	21.7%	**Emergency Service**		
Routine Cholesterol Screening	97.9%	49.7%	Emergency Room Use	99.7%	33.7%
Chronic Heart Failure	103.4%	4.2%	Urgent Care Use	107.1%	24.9%

Grand Isle

Health Service Topic	Demand as % of National	% of Population Effected
Weight / Lifestyle		
BMI: Morbid/Obese	88.7%	27.3%
Vigorous Exercise	104.6%	60.1%
Chronic Diabetes	86.3%	10.8%
Healthy Eating Habits	103.8%	30.8%
Ate Breakfast Yesterday	102.9%	81.8%
Slept Less Than 6 Hours	90.4%	12.4%
Consumed Alcohol in the Past 30 Days	100.9%	54.4%
Consumed 3+ Drinks Per Session	90.8%	25.7%
Behavior		
I Will Travel to Obtain Medical Care	97.7%	22.2%
I am Responsible for My Health	103.6%	67.7%
I Follow Treatment Recommendations	107.1%	55.6%
Pulmonary		
Chronic COPD	99.2%	3.9%
Tobacco Use: Cigarettes	83.0%	21.1%
Heart		
Chronic High Cholesterol	105.8%	23.2%
Routine Cholesterol Screening	102.6%	52.1%
Chronic Heart Failure	106.8%	4.2%

Health Service Topic	Demand as % of National	% of Population Effected
Cancer		
Mammography in Past Yr	103.6%	47.2%
Cancer Screen: Colorectal 2 yr	112.6%	28.8%
Cancer Screen: Pap/Cerv Test 2 yr	96.8%	58.0%
Routine Screen: Prostate 2 yr	105.2%	33.7%
Orthopedic		
Chronic Lower Back Pain	90.9%	21.5%
Chronic Osteoporosis	92.9%	9.2%
Routine Services		
FP/GP: 1+ Visit	101.4%	89.5%
Used Midlevel in last 6 Months	108.4%	44.8%
OB/Gyn 1+ Visit	96.1%	44.4%
Medication: Received Prescription	106.1%	64.0%
Internet Usage		
Use Internet to Talk to MD	91.5%	11.1%
Facebook Opinions	90.4%	9.3%
Looked for Provider Rating	99.8%	14.1%
Emergency Service		
Emergency Room Use	91.9%	31.1%
Urgent Care Use	101.0%	23.5%

Leading Causes of Death

Franklin County

Cause of Death			Rank among all counties in VT (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
VT Rank	Franklin Rank	Condition		VT	Franklin	
1	2	Cancer	2 of 14	163.4	194.2	As expected
2	1	Heart Disease	1 of 14	149.6	223.5	As expected
3	3	Lung	7 of 14	44.1	50.2	As expected
4	4	Accidents	6 of 14	49.6	44.9	As expected
5	7	Alzheimer's	12 of 14	32.9	21.5	As expected
6	5	Stroke	11 of 14	31.7	36.4	Lower than expected
7	6	Diabetes	2 of 14	17.4	30.5	Higher than expected
8	8	Suicide	4 of 14	16.8	15.9	Higher than expected
9	9	Flu - Pneumonia	9 of 14	9.3	13.0	Lower than expected
10	11	Liver	8 of 14	9.5	7.1	Lower than expected
11	12	Parkinson's	11 of 14	9.3	6.5	As expected
12	13	Hypertension	10 of 14	8.4	5.4	As expected
13	14	Blood Poisoning	11 of 14	5.8	4.2	Lower than expected
14	10	Kidney	2 of 14	3.8	9.6	Lower than expected
15	15	Homicide	8 of 14	0.0	2.0	As expected

Grand Isle County

Cause of Death			Rank among all counties in VT (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
VT Rank	Grand Isle Rank	Condition		VT	Grand Isle	
1	2	Cancer	1 of 14	163.4	205.2	Higher than expected
2	1	Heart Disease	2 of 14	149.6	212.3	As expected
3	3	Lung	1 of 14	44.1	69.5	Higher than expected
4	5	Accidents	12 of 14	49.6	41.1	As expected
5	7	Alzheimer's	14 of 14	32.9	18.6	As expected
6	4	Stroke	1 of 14	31.7	49.1	As expected
7	6	Diabetes	8 of 14	17.4	22.6	As expected
8	8	Suicide	8 of 14	16.8	14.3	Higher than expected
9	12	Flu - Pneumonia	14 of 14	9.3	7.6	Lower than expected
10	14	Liver	14 of 14	9.5	2.8	Lower than expected
11	13	Parkinson's	10 of 14	9.3	6.7	As expected
12	9	Hypertension	1 of 14	8.4	9.7	Higher than expected
13	11	Blood Poisoning	1 of 14	5.8	8.8	As expected
14	10	Kidney	3 of 14	3.8	9.3	Lower than expected
15	15	Homicide	12 of 14	0.0	1.5	Lower than expected

National Healthcare Disparities Report – Priority Populations[29]

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

The National Healthcare Quality and Disparities Reports (QDR) 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 our 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 reports are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Beginning with this 2014 report, findings on healthcare quality and healthcare disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report (QDR) highlights the importance of examining quality and disparities together to gain a complete picture of healthcare. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The key findings of the 2014 QDR are organized around three axes: access to healthcare, quality of healthcare, and NQS priorities.

To obtain high-quality care, Americans must first gain entry into the healthcare system. Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location.

ACCESS: After years without improvement, the rate of un-insurance among adults ages 18-64 decreased substantially during the first half of 2014.

The Affordable Care Act is the most far-reaching effort to improve access to care since the enactment of Medicare and Medicaid in 1965. Provisions to increase health insurance options for young adults, early retirees, and Americans with pre-existing conditions were implemented in 2010. Open enrollment in health insurance marketplaces began in October 2013 and coverage began in January 2014. Expanded

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

access to Medicaid in many states began in January 2014, although a few had opted to expand Medicaid earlier.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[30] consistent with these trends.

ACCESS: Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.

Trends

- From 2002 to 2012, the percentage of people who were able to get care and appointments as soon as wanted improved for children but did not improve for adults ages 18-64.

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18-64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

ACCESS DISPARITIES: During the first half of 2014, declines in rates of un-insurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[31]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.

[30] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.
[31] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[32]

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities, followed by Hispanics and Blacks.

Disparities

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).
- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

ACCESS DISPARITIES: Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- I n four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

QUALITY: Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).
- Almost all measures of Person-Centered Care improved.
- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.
- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

QUALITY: Through 2012, the pace of improvement varied across NQS priorities.

[32] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities:
  - Median change in quality was 3.6% per year among measures of Patient Safety.
  - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
  - Median improvement in quality was 1.7% per year among measures of Effective Treatment.
  - Median improvement in quality was 1.1% per year among measures of Healthy Living.
  - There were insufficient data to assess Care Coordination and Care Affordability.

QUALITY: Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

- *Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes*
- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year
- *Hospital patients with pneumonia who had blood cultures before antibiotics were administered*
- *Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination*
- *Hospital patients age 50+ with pneumonia who received influenza screening or vaccination*
- *Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge*
- *Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations*
- *Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival*
- Adults with HIV and CD4 cell counts of 200 or less who received Pneumocystis pneumonia prophylaxis during the year
- People with a usual source of care for whom health care providers explained and provided all treatment options
- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data are available to ensure that they do not fall below 95%.

Improving Quickly

Through 2012, a number of measures showed rapid improvement, defined as an average annual rate of change greater than 10% per year. Of these measures that improved quickly, four are adolescent vaccination measures (italic).

- *Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- Hospital patients with heart failure who were given complete written discharge instructions
- *Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of meningococcal conjugate vaccine*
- Patients with colon cancer who received surgical resection that included 12+ lymph nodes pathologically examined
- Central line-associated bloodstream infection per 1,000 medical and surgical discharges, age 18+ or obstetric admissions
- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at time of surgery

Worsening

Through 2012, a number of measures showed worsening quality. Of these measures that showed declines in quality, three track chronic diseases (italic). Note that these declines occurred prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

- Maternal deaths per 100,000 live births
- Children ages 19-35 months who received 3 or more doses of Haemophilus influenzae type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- *Admissions with diabetes with short-term complications per 100,000 population, age 18+*
- *Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year*
- Women ages 50-74 who received a mammogram in the last 2 years

- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- *People with current asthma who are now taking preventive medicine daily or almost daily*
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

QUALITY DISPARITIES: Disparities remained prevalent across a broad spectrum of quality measures. People in poor households experienced the largest number of disparities, followed by Blacks and Hispanics.

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).
- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems.

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

QUALITY DISPARITIES: Through 2012, few disparities in quality of care were eliminated while a small number became larger.

Disparities Trends

- Through 2012, several disparities were eliminated.
  - One disparity in vaccination rates was eliminated for Blacks (measles-mumps-rubella), Asians (influenza), American Indians and Alaska Natives (hepatitis B), and people in poor households (human papillomavirus).
  - Four disparities related to hospital adverse events were eliminated for Blacks.
  - Three disparities related to chronic diseases and two disparities related to communication with providers were eliminated for Asians.
  - On the other hand, a few disparities grew larger because improvements in quality for Whites did not extend uniformly to other groups.

- At least one disparity related to hospice care grew larger for Blacks, American Indians and Alaska Natives, and Hispanics.
- People in poor households experienced worsening disparities related to chronic diseases.

QUALITY DISPARITIES: Overall quality and racial/ethnic disparities varied widely across states and often not in the same direction.

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality while states in the South census region tended to have lower quality.
- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities.
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

National Quality Strategy: Measures of Patient Safety improved, led by a 17% reduction in hospital-acquired conditions.

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[33]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.

[33] Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html

- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

- Black-White differences in four Patient Safety measures were eliminated.
- Asian-White differences in admissions with iatrogenic pneumothorax grew larger.

National Quality Strategy: Measures of Person-Centered Care improved steadily, especially for children.

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial/ethnic and income groups.
- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

Disparities

In almost all years, the percentage of children whose parents reported poor communication with their health providers was:

- Higher for Hispanics and Blacks compared with Whites.
- Higher for poor, low-income, and middle-income families compared with high-income families.

Disparities Trends

- Asian-White differences in two measures related to communication were eliminated.
- Four Person-Centered Care disparities related to hospice care grew larger.

National Quality Strategy: Measures of Care Coordination improved as providers enhanced discharge processes and adopted health information technologies.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes, and for all racial/ethnic groups.
- There are few measures to assess trends in Care Coordination.

Disparities

- In all years, the percentage of hospital patients with heart failure who were given complete written discharge instructions was lower among American Indians and Alaska Natives compared with Whites.

National Quality Strategy: Many measures of Effective Treatment achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary

intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.

- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.
- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often disappeared as measures achieved high levels of performance.

Disparities Trends

- Asian-White differences in three chronic disease management measures were eliminated but income-related disparities in two measures related to diabetes and joint symptoms grew larger.

National Quality Strategy: Healthy Living improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.
- About half of all Healthy Living measures tracked in the QDR improved.
- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

- Adolescents ages 16-17 in nonmetropolitan areas were less likely to receive meningococcal conjugate vaccine than adolescents in metropolitan areas in all years.
- Adolescents in poor, low-income, and middle-income households were less likely to receive meningococcal conjugate vaccine than adolescents in high-income households in almost all years.

Disparities Trends

- Four disparities related to child and adult immunizations were eliminated.
- Black-White differences in two Healthy Living measures grew larger.

National Quality Strategy: Measures of Care Affordability worsened from 2002 to 2010 and then leveled off.

From 2002 to 2010, prior to the Affordable Care Act, care affordability was worsening. Since 2010, the Affordable Care Act has made health insurance accessible to many Americans with limited financial resources.

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[34]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines who indicated a financial or insurance reason for the problem was:
  - Higher among uninsured people and people with public insurance compared with people with any private insurance.
  - Higher among poor, low-income, and middle-income families compared with high-income families.

CONCLUSION

The 2014 Quality and Disparities Reports demonstrate that access to care improved. After years of stagnation, rates of un-insurance among adults decreased in the first half of 2014 as a result of Affordable Care Act insurance expansion. However, disparities in access to care, while diminishing, remained.

Quality of healthcare continued to improve, although wide variation across populations and parts of the country remained. Among the NQS priorities, measures of Person-Centered Care improved broadly. Most measures of Patient Safety, Effective Treatment, and Healthy Living also improved, but some measures of chronic disease management and cancer screening lagged behind and may benefit from additional attention. Data to assess Care Coordination and Affordable Care were limited and measurement of these priorities should be expanded.

[34] Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[35]

- Abenaki Indian population and under 50 self neglect patients.
- affordable housing for elderly, families and low/moderate income is desperately needed
- Domestic Violence survivor's and their children and drug addicts and their children. Collaboration between community partners.
- generational poverty, substance abuse, and domestic violence are creating perfect storms of mental and physical health problems...the ACE study clearly shows the long-term effects on the body and the correlating need for extensive health care i consider this a public health crisis in our community and would look to our Medical Center to take the lead in creating the public health response
- I really worry about the impact on rural poverty. Lack of transportation and services available for these individuals is a real problem. I'd like to see more outreach supports in our poorer towns such as Alburg and Richford in particular.
- I would identify people with unstable housing as a "priority population". Of course the issue goes much deeper than just housing. We see an increasing trend where people with serious socio-economic needs are being pushed to areas of the county where rent is very cheap which makes sense if you are just thinking about getting a roof over a person's head for the lowest possible cost. Unfortunately these towns with low rent have very little in the way of employment opportunity and none of the social support systems required by this population. I just had an opportunity to meet a man who had been homeless until the middle of this past winter. He now is working with Pathways and has an apartment the size of a big bedroom and a $70/week allowance which he basically drinks. Though he lives in a building with other people he is basically isolated, lonely, and so depressed he burst into tears within minutes of the beginning of our conversation. This is one example, there are many other similar situations like re-entry from corrections, mental/behavioral clients, and patients with serious medical needs where people are "placed" in cheap or transitional housing with little or no support.
- low income, rural, children Outreach must be done by any service organization including health, education and government These folks can not get to the services they need and may not even know about services due to isolation
- Making treatment services available to everyone who suffer from addiction, I find that it is difficult for people to navigate the process in which to find and receive treatment services.
- n/a
- Obesity and Drug Addiction

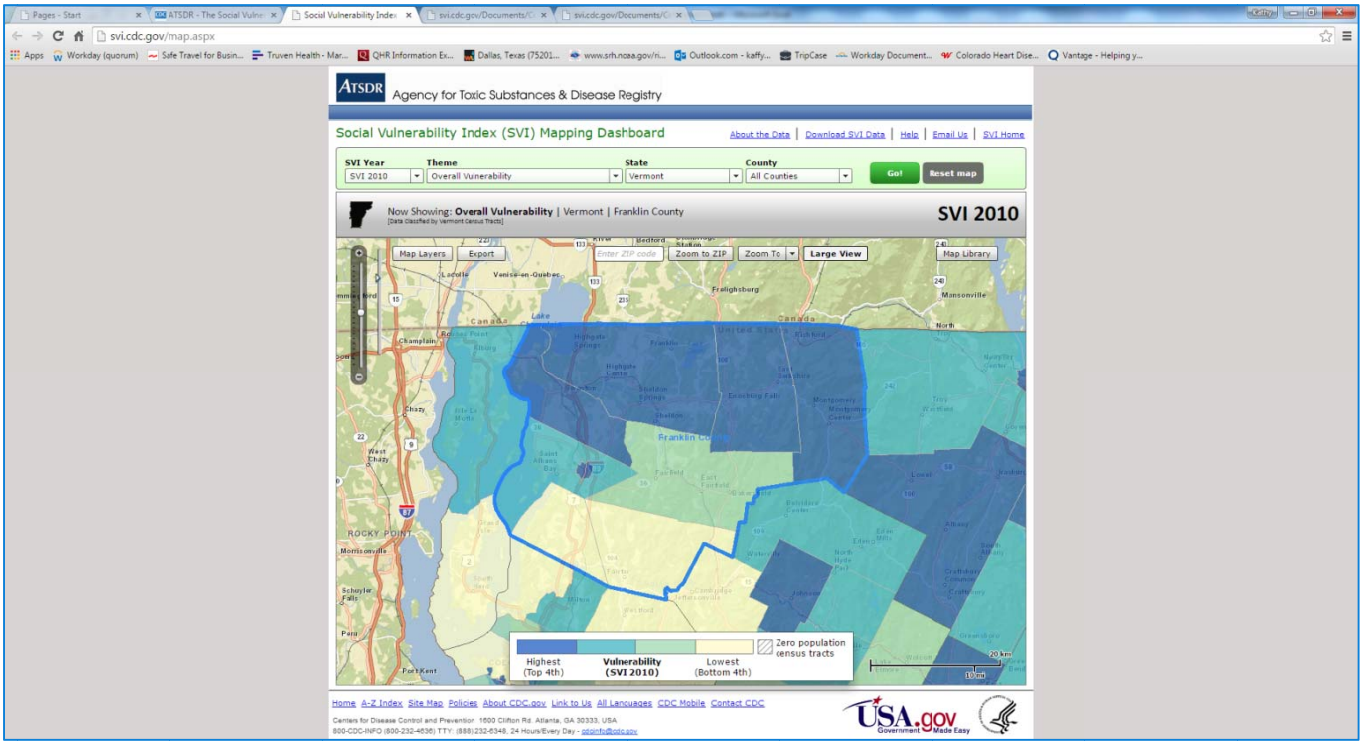
[35] All comments and the analytical framework behind developing this summary appear in Appendix A

- One issue I believe confronting priority populations is chronic disease management. We have many people attending our adult day who have diabetes, respiratory problems, heart disease and neurological health problems. A non-health need is safe housing that meets people's needs.
- Opiate addiction is out of control and we need other treatment options and long term residential treatment programs. We need to stop prescribing suboxone to most everyone who is addicted to opiates. Many people are diverting it and some people are getting addicted to suboxone as their first opiate.
- population with low health literacy non English speaking population of farm workers have difficulty accessing health care services. I would like to see leadership from the hospital and the farming community
- -substance abuse assistance -financial and housing assistance -legal assistance
- The elderly, minors, homebound
- There are groups of people placed in substandard housing in small communities with no support system. Corrections, community mental health and other social service agencies need to pool resources to work with this population.
- Transportation to and from hospital and medical appointments can be an issue for those situated in rural areas not served by bus line.
- Unique issues where we need a a social worker to get these patients to the respectable locations for special treatments; for example: dental social worker and nutritional Counselors to treat chronic dental problems outside ER. Prevention!
- unknown
- Yes. A majority of the "priority populations" listed above are at greater risk for negative health impacts, as they have higher risk factors impacting health. Typically, priority populations use tobacco at higher rates, have poorer access for healthy food, have limited ability for regular physical activity and may be impacted by a variety of other factors. Supporting priority populations in achieving lifelong health requires an integrated and strong system as well as long-term commitment.

Social Vulnerability

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

The northern portion of Franklin County is noted as being in the highest national quartile of vulnerability. The northern portion of Grand Isle Counties is noted as being in the second highest national quartile of vulnerability.



Consideration of Written Comments from Prior CHNA

A group of 29 individuals provided written comment in regard to the 2012 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

Respondent Characteristics	Yes (Applies to Me)	Percent Responding YES	No (Does Not Apply to Me)	No Opinion	Total Participants
1) Public Health Expertise (public health dept volunteers / employees, one holding an MPH degree and/or employed in a capacity where one is required)	6	21%	15	8	29
2) Departments and Agencies Federal, tribal, regional, State or local agencies with relevant data/information regarding health needs of the community served by the hospital	11	38%	14	4	29
3) Priority Populations (represented by public elected officials, religious officials, long term care / work shelter executives; and/or members of LGBT community, medically underserved, low income, minorities)	6	21%	13	10	29
4) Representative of or member of chronic disease group or organization	4	14%	18	7	29
5) Broad Interest of the Community (school system exec's, employers, leadership of civic organizations, voluntary health groups, Chamber of Commerce, Industrial Development)	15	52%	10	4	29

Specific comments or observations about Mental Health & Substance Abuse as being among the most significant needs for the Hospital to work on to seek improvements?

- We must achieve better collaboration among providers (NCSS, NMC, NOTCH and private practices to provide these services.
- Work with ncss and the Howard center
- It seems that some people are falling through the cracks, especially with mental health needs. Current resources do not seem to be adequately meeting the needs of many individuals.
- This issue is definitely at the root of many of the issues we face in Franklin and Grand Isle Counties. I would suggest adding "Behavioral Health" as well.
- Although that topic is of utmost importance in our community and a major impact to good health, NMC has limited expertise in contributing to its solution. I believe NMC should be a partner in addressing MH & SA, but I don't think it is where we can be most impactful.
- We need to get people away from substance abuse. I'm concerned that providing them legal drugs that they use seemingly forever is just replacing one drug addiction for another.
- All narcotic prescribers should be required to used the states drug registry. All narcotic prescribers should be familiar alternative to opiates for pain management.
- Medically assisted treatment and opiate addiction is one of our biggest societal woes in Franklin/Grand Isle county.
- absolutely agree that this is one of the most significant needs love that there are medical social workers at NOTCH programs hate that the waiting list for a counselor through NCSS is almost 8 months hate that there are not enough therapists trained to work with mental health AND substance abuse problems hate that there are

not enough therapists who understand the dynamics of domestic violence hate that the medical community doesn't see the underbelly of what the suboxone/methadone programs are doing to our community (diversion of medication, ongoing culture of addiction rather than recovery)

- Mental Health and substance abuse plague those involved and the community at large, costing many dollars if left unaddressed.
- Ability to identify patients and connect them with necessary resources.
- High on list
- Quick access to services including medication for mentally ill folks who are homeless. Focus on how to help opiate addicts get clean without using suboxone. Only use suboxone for detox.
- As long as we have increased numbers of addiction we will need continued resources applied to Mental Health and Substance Abuse.

Specific comments or observations about Access/Availability to Healthcare & Physicians as being among the most significant needs for the Hospital to work on to seek improvements?

- I believe there is adequate access access/availability in St. Albans, particularly with the two new Urgent Care facilities. This issue is no longer significant.
- There is an excess of Primary care. The walk in clinics do not support the patient center medical home and if it continues NMC should demonstrate that all patients information get back to the PCP. NMC must do better with reducing ED visits. There are models in this country that have proven it can be done.
- There remains a shortage of primary care providers for adults in Franklin co.
- We have done well with increasing our number of providers as well as the addition of the Urgent Care clinic, to provide access to healthcare.
- we need more and better transportation options for folks.
- absolutely agree that this is one of the most significant needs
- Organizations must be able to "bill" for services resulting in the wrong services or lack of services including preventive medical care.
- Significant improvements made, increased hours with practices and urgent care facilities.
- I do not see this as a significant need
- I think this continues to be an issue to address. Even as access/availability improved, changes in 1-2 large practices are major set-backs. I think a strong network with strong primary care relationships is how individuals begin maintain good health.
- Too many people in poverty don't get the medical attention they need - for a variety of reasons. More connection to local communities and transportation support are necessary.

Specific comments or observations about Obesity as being among the most significant needs for the Hospital to work on to seek improvements?

- Encourage community participation in the Diabetes Prevention Program, Heathier Living with Diabetes, and the other healthier living workshops. I will tell you, that, as much as I have heard it is not, eating healthy is expensive. We are on a rigid, managing diabetes with diet (no medication) plan - and it certainly costs more.
- Certainly this is a significant need
- Obesity continues to plague our region, from childhood through adulthood. It is a major risk factor in heart disease, diabetes, and cancer. We cannot make improvements on those aspects of health without working to address the very complex issue that is obesity. It continues to be among the most significant needs in our region.
- Major problem in schools - especially in our poorer communities.
- it's big, but not as big as some of the other issues (pun intended)
- Continues to be a root cause of health concerns.
- Treatment should be moving. It should be high on the list.
- We offer plenty of healthy food choices in our cafe as well as access to CSA offerings and additional fitness offerings.

Specific comments or observations about Smoking as being among the most significant needs for the Hospital to work on to seek improvements?

- Don't smoke, so no information. I do know that it is very difficult to get people to stop.
- Certainly this is a significant need
- Tobacco use continues to be the number 1 cause of death in VT and in our region. It is still the major risk factor in heart disease, cancer, COPD and acute childhood respiratory infections. Its impact is a major driver of health care costs. NMC cannot address many of its other significant needs without effectively addressing tobacco. Furthermore, although tobacco use rates among
- i appreciate the tobacco money, but i don't think it's a major area of concern lung cancer, however, IS a concern
- Should be a supportive role and not leading initiative
- Preventing kids from using E-cig. Lobbying for tougher laws.
- We have had continual representation in the business and professional community as well as public to provide ongoing education in the area of tobacco cessation.

Specific comments or observations about Cancer as being among the most significant needs for the Hospital to work on to seek improvements?

- Cancer rates continue to be high in our region, as are cancer death rates. Many types of cancer are preventable

or detectable at an early stage. There is more work to be done in these areas (see obesity and tobacco comments)

- as a woman, i'm ready to move out of VT just because of the god-awful number of breast cancer survivors here
- Cancer is prevalent in our Counties,
- Early screenings. Education and good systems to treat.

Specific comments or observations about Health Insurance / Uninsured as being among the most significant needs or the Hospital to work on to seek improvements?

- Cost of insurance is a significant issue.
- Now on medicare. I do know that navigating VT Health Connect was very challenging - also more expensive than catamount. I have heard that some complanies are implementing standards, such as weight (not necessarily a healthy weight, but not obese,either)
- Those without health insurance or who are underinsured are less likely to access care - including primary care or cancer screenings (see above). That means that when they do access care, they may be more acute or further along in a disease state, with higher complexity and higher costs. Although ACA helps insure many more people, ensuring that high deductibles don't impact care is still essential.
- i'm not really sure how i feel about this one i think health care should be a right
- Not a primary issues. MPNMC has various programs to assist patients that need charity or financial assistance.
- Unsure numbers

Specific comments or observations about Suicide as being among the most significant needs for the Hospital to work on to seek improvements?

- I have no specific comments.
- unless NMC sees suicide as an indicator of poor public health (which includes mental health) access, then yall should maintain your "not within our direct scope of expertise" stand but i think suicide is certainly a symptom
- We need to be a collaborative partner with all agencies. need to be a continued resource.

Specific comments or observations about Domestic and Sexual Abuse as being among the most significant needs for the Hospital to work on to seek improvements?

- It is still a relevant issue faced by our community.
- goodness gracious, YES!! victims/survivors suffer chronic physical health concerns resulting from years (or a even a lifetime) of living in toxic environments the corresponding mental health issues are untreated due to the lack of appropriately-trained clinicians self-medicating is rampant among this population parents are often

emotionally unavailable to their children and often less able to parent adequately

- We need to work with other agencies but can not be the lead.

Specific comments or observations about Coronary Heart Disease as being among the most significant needs for the Hospital to work on to seek improvements?

- Certainly this is a significant need
- Heart Disease is still the #1 killer of our community's residents. Its issue should receive high attention.
- if it's the #2 killer, then it is a significant need
- Heart disease is important to our community.

Specific comments or observations about Chronic Lung Disease and Chronic Asthma as being among the most significant needs for the Hospital to work on to seek improvements?

- Certainly this is a significant need
- Much like Heart Disease, COPD and Asthma continue to be major diseases of our community, causing death and disability, including low worker productivity and high health costs. It should continue to be a focus area.
- why is it so high in Grand Isle?

Specific comments or observations about High Blood Pressure as being among the most significant needs for the Hospital to work on to seek improvements?

- Certainly this is a significant need
- High Blood Pressure is a major risk factor in Heart Disease, still our region's #1 killer. NMC should continue to be a focus area through an emphasis on obesity prevention and tobacco control.
- no specific comments
- Kidneys failure, high BP, stroke are all related. And is important in the community.

Finally, after thinking about our questions and the information we seek, is there anything else you think important as we review and revise our thinking about significant health needs within the two Counties?

- nothing else
- The biggest thing is for everyone to work together. The new electronic records seem to be a great step in allowing all providers access to the same information. It might (hopefully) help with prescription abuse, since all providers know all prescribed medications.

- Healthcare is changing, it is no longer about just being there and being open or throwing money and resources at a problem. To make improvement in the needs mentioned in this survey we must truly engage people and somehow get Franklin and Grand Isle counties to want to be healthier. I know, easy to say, very difficult to do.
- not at this time.
- LGBQT sensitivity and support non-gendered restrooms, forms that allow for answers beyond the gender binary, etc
- Outreach and home visits are research based and proven to work. The Nurse Family Partnership is a good example of this.
- Are we prepared to meet the needs of our aging population?
- The more community involvement, the less you will see in all of the trouble categories. Keep people engaged and involve them in healthy and fun choices and families will strive. Also, I think we need to have a strong infrastructure on young women with drug problems. They need to be nurtured to prevent unplanned pregnancy and relapsing into depression and drug use.
- that we keep up what we are doing and continue to provide the support necessary in all areas of identified needs to better serve our poplulation in our community.
- Please carefully consider the cost of health care when taking on large scale construction projects. These projects are funded by increasing the costs of the services provided. There is a fine line and at some point we are going to tip over to the side where it's just too costly to get the services that folks need. I agree the hospital is an important piece in our community. I also see health care increasing becoming like college, going up at such a rate that only the top % earners can afford.

Conclusions from Public Input

Our group of 29 Local Expert Advisors participated in an online survey to offer opinions about their perceptions of community health needs and the potential needs of unique populations. Complete verbatim written comments appear in the Appendix to this report.

NMC received the following responses to the question: "*What advice do you give us about written comments on maintaining the prior identified priority needs?"*

2012 Significant Need	Yes Retain in 2015	% Responding Yes	No Do Not retain in 2015	No Opinion
Mental Health & Substance Abuse	23	79%	0	6
Access / Availability to Healthcare & Physicians	19	66%	4	6
Obesity	21	72%	2	6
Smoking	19	66%	2	8
Cancer	20	69%	2	7
Health Insurance / Uninsured	18	62%	3	8
Suicide	17	59%	2	10
Domestic and Sexual Abuse	20	69%	1	8
Coronary Heart Disease	20	69%	2	7
Chronic Lung Disease and Chronic Asthma	19	66%	3	7
High Blood Pressure	18	62%	4	7

Summary of Observations: Comparison to Other Vermont Counties

In general, Franklin County residents are in lower than average health while Grand Isle County residents are in slightly better than average health compared to the healthiest in Vermont.

In a health status classification termed "Health Outcomes", Franklin ranks number 10 among the 14 Vermont ranked counties (best being #1) while Grand Isle ranks number 6. Premature Death (deaths prior to age 75) represent Grand Isle as 2nd best in Vermont and Franklin is at the Vermont average, ranking #7 of the Vermont 14 counties.

In another health status classification "Health Factors", Franklin County ranks 11 among the 14 Vermont counties, with adult obesity, smoking, physical inactivity, sexually transmitted disease and teen births being above the VT average and the US best rates. Grand Isle ranks 5th best with adult smoking and adult obesity exceeding VT average and the best US rates.

In the “Clinical Care” classification, Grand Isle again is favorably ranked, number 6, with adverse values for the population to physician ratio (7 times VT average) and population to dentist ratio (4.4 times VT average) both indicating a lack of medical practitioners. Franklin again is unfavorably ranked, number 11. It also has a large population to physician ratio (1.8 times VT average) and an adverse indicator for preventable hospital stays (1.3 times VT average) which indicates a lack of physician early intervention to avoid the need to hospitalize a patient.

In the “Social and Economic Factors” classification, Franklin County performs its best, ranking number 7. Adverse metrics include a lower than average percent of resident have some college attendance (57% compared to 65.8% VT average), Social Associations (# of organizations per 10,000) is 8.5, below the VT value of 13.1. And Violent Crime is 1.3 times the VT average. Grand Isle only adverse indicator in this classification is some college, with only 54.6% attending.

In the “Physical Environment” classification, Grand Isle has is most adverse ranking, coming in at number 11. Air Pollution, particulate matter and Driving alone to work both exceed the VT and US average or best values. Franklin ranks number 13, second worse in VT, but this results from an aggregate ranking as individual metrics are not pulled out for focused improvement being needed.

Summary of Observations: Peer Comparisons

The Federal Government administers a process to allocate all counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. Better county rating are in the top quartile, worse are in the lowest quartile. Franklin has 49 peer counties. Grand Isle has 33 peers. Franklin and Grand Isle are in different Peer Groups.

FRANKLIN

Mortality

- Better – **Stroke Deaths**
- Worse **–**
  - **Cancer** 3rd worst among peers, 196.6/100,000 (US avg. 185);
  - **Coronary Heart Disease** Deaths worst among peers 150.8/100,000 (US avg. 126.7);
  - **Diabetes** Deaths 3rd worst among peers 28.8/100,000 (US avg. 24.7);
  - **Motor Vehicle Deaths** 10th worst among peers 16.6/100,000 but better than US avg. 19.2;
  - **Unintentional Injury** 12th worst among peers 45.9 but better than US avg. 50.8

Morbidity

- Better - **Alzheimer's disease; Gonorrhea; Preterm births**
- Worse –
  - **Older adult depression** 4th worse among peers 15.7% (US avg. 12.4%);
  - **Syphilis** 9th worse among peers 2.1 per 100,000 (US avg. 0)

Health Care Access and Quality

- Better – **Uninsured**
- Worse – **Older Adult Preventable Hospitalization** 10th worse among peers 67.1/100,000 but lower than the US avg. 71.3

Health Behaviors

- Better – none
- Worse – none

Social Factors

- Better – **On-Time High School Graduation**
- Worse –
  - **High Housing Cost** 3rd worse among peers, 35.1% (US avg. 27.3%),
  - **Inadequate Social Support** (self-reporting)12th worse among peers but better than US avg. 19.6%

Physical Environment

- Better – **Limited Access to Healthy Food**; **Living near Highways**
- Worse –
  - **Access to Parks** 5% 3rd worse among peers but better than 14% US avg.;
  - **Housing Stress** (at least 1 deficiency) 34% 4th worse among peers

GRAND ISLE

Mortality

- Better – Nothing
- Worse –
  - **Cancer** worst among peers, 228.7/100,000 (US average 185);
  - **Chronic Lower Respiratory Disease** Deaths 2nd worse among peers 66.8/100,000 (US average 49.6);
  - **Stroke** Deaths worst among peers 53.2/100,000 (U.S. average 49.6)

Morbidity

- Better – **Adult Diabetes**; **Overall health status**; **Alzheimer's disease**; **Gonorrhea**; **Older Adult Asthma**; **Syphilis**
- Worse –
  - **Adult Obesity** worst among peers 34.1% (US average 30.4%);
  - **Cancer** 2nd worse among peers 534.9/100,000 (US average 457.6)

Health Care Access and Quality

- Better – **Uninsured**
- Worse –
  - **Primary Care** Provider Access 4th worse among peers 57.7 physicians /100,000 but better than the US average of 48

Health Behaviors

- Better – **Adult Female Routine Pap Test**
- Worse –
  - **Adult Binge Drinking** 6th worse among peers 20% (US average 16.3%)

Social Factors

- Better – **Children in Single Parent Homes; Inadequate Social Support; Poverty; Unemployment; Violent Crime**
- Worse – nothing

Physical Environment

- Better – **Housing Stress; Limited Access to Health Food; Living Near Highways**
- Worse –
  - **Access to Parks** 2nd worse 8% among peers but better than US avg. 14%

Conclusions from Demographic Analysis Compared to National Averages

FRANKLIN

The 2015 population for Franklin County is estimated to be 48,825 and is expected to increase at a rate of 1.1%. This is in contrast to the 3.5% national rate of growth, while Vermont's population is expected to grow 0.3%. Truven anticipates Franklin County in 2020 as having a population of 47,348.

According to the population estimates, the 2015 median age for the county is 40.8 years, younger than the Vermont median age (42.7 years) and older than the national median age of 37.9 years. The 2015 Median Household Income for the area is $60,651, higher than the Vermont median income of $57,436 and the national median income of $53,375. Median Household Wealth value is also higher than the National value ($48,894) and the Vermont value ($70,091). Median Home Value for Franklin ($215,514) is lower than the Vermont median ($228,176) but is higher than the National value ($190,970). Franklin's unemployment rate as of May, 2015 was 3.1%, which is in line with the 3.6% statewide rate but is much better than the 5.5% national civilian unemployment rate.

The population in the county over 65 is 14.5%, compared to Vermont (17.0%) and the national average (14.7%). The population of women of childbearing age is 18.6%, slightly higher than the Vermont average of 18.3% but lower than the 19.7% national rate. 94% of the population is White non-Hispanic. The largest minority the Hispanic population, comprises 1.6% of the total

The population was examined according to characteristics in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The mix of Prizm segments and its characteristics, is contrasted to the national population averages to determine probable presenting lifestyle and medical conditions. The national average, or norm, is represented as 100%. Where Franklin Counties varies more than 5% above or below that norm (that is, less than 95% or greater than 105%), it is considered significant.

Worse –

- **BMI: Morbid/Obese** 5.8% above avg. impacting 32.4% of pop.;
- **Consumed 3 or more drinks per session** 5.4% above avg. impacting 29.6% of pop.;
- **Urgent Care Use** 7.1% above avg. impacting 24.9% of pop.

Better –

- **Consumed alcohol in past 30 days** 5.3% below avg. impacting 51.2% of pop.;
- **Used Midlevel** 8.3% below avg. impacting 44.8% of pop.;
- **Use of Tobacco** 7.2% below avg. impacting 23.6% of pop;
- **Chronic COPD (lung disease)** 9.8% below avg. impacting 3.6% of pop.

GRAND ISLE

The 2015 population for Grand Isle County is estimated to be 6,985 and expected to increase at a rate of 0.4%. This is in contrast to the 3.5% national rate of growth, while Vermont's population is expected to grow 0.3%. Truven anticipates Grand Isle County in 2020 as having a population of 7,016.

According to Truven population estimates, the 2015 median age is 47.4 years, older than the Vermont median age (42.7 years) and older than the national median age of 37.9 years. The 2015 Median Household Income is $65,449, lower than the Vermont median income of $57,436 and the national median income of $53,375. Median Household Wealth value ($114,577) is much higher than the National and the Vermont value. Median Home Value for Grand Isle ($276,363) is higher than the comparison values, the Vermont median of $228,176 and the national median of $190,970. Grand Isle's unemployment rate as of May, 2015 was 3.2% , which is in line with the 3.6% statewide rate but is much better than the 5.5% national civilian unemployment rate.

The portion of the population in the county over 65 is 17.5%, compared to Vermont (17.0%) and the national average (14.7%). The portion of the population of women of childbearing age is 15.6%, over two percent lower than the Vermont average of 18.3% and more than four percent lower than the national 19.7% rate. 93.3% of the population is White non-Hispanic. The largest minority, Hispanic population comprises 2.1% of the total.

The population was examined according to characteristics in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The mix of Prizm segments and its characteristics, is contrasted to the national population averages to determine probable presenting lifestyle and medical conditions. The national average, or norm, is represented as 100%. Where Grand Isle varies more than 5% above or below than norm (that is, less than 95% or greater than 105%), it is considered significant.

Worse –

- **Received a Prescription** 6.1% above avg. impacts 64% of pop.;
- **Chronic High Cholesterol** 5.8% above avg. impacts 23.2% of pop.;
- **Chronic Heart Failure** 6.8% above avg. impacts 4.2% of pop.

Better - 12 of 31 indicators are significantly better;

- **Follows treatment recommendation** 7.1% above avg. impacts 55.6% of pop.;
- **Used Midlevel** 8.4% above avg. impacts 44.8% of pop.;
- **Prostate screening** 5.2% above avg. impacts 33.7% of pop.;
- **Emergency Room use** 8.1% below avg. impacts 31.1% of pop.;
- **Colorectal screening** 12.6% above avg. impacts 28.8% of pop.;
- **Chronic Back Pain** 9.1% below avg. impacts 21.5% of pop.;
- **Morbid Obese** 11.3% below avg. impacting 27.3% of pop.;

- **Consumed 3+ drinks per session** 9.2% below avg. impacting 25.7% of pop.;
- **Tobacco use** 17% below avg. impacting 21.1% of pop.;
- **Less than 6 hours sleep** 9.6% below avg. impacting 12.4% of pop.;
- **Chronic Diabetic** 13.7% below avg. impacts 10.8% of pop.;
- **Chronic Osteoporosis** 17.1% below avg. impacts 8.4% of pop.

Cause of Death and National Ranking

FRANKLIN

Among top 15 Leading Causes of Death, 8 of the 15 occurred at expected rates. Diabetes (#6 cause of death) and Suicide (#8) occurred at higher than expected rates. Stroke (#5), Flue/Pneumonia (#9), Blood Poisoning (#14) and Kidney (#10) occurred at a lower than expected rate. The top 10 Causes of Death are:

1. Heart Disease with Franklin ranking #1 among VT 14 Counties (Where #1 is worst in State)
2. Cancer ranking #2 in VT
3. Lung ranking #7 in VT
4. Accidents ranking #6 in VT
5. Stroke ranking #11 in VT
6. Diabetes ranking #2 in VT
7. Alzheimer's ranking #12 in VT
8. Suicide ranking #4 in VT
9. Flu/Pneumonia ranking #9 in VT
10. Kidney ranking #2 in VT

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 US counties or equivalents applying small area estimation techniques to the most recent county information.

Above National avg. and improving – none

Above National avg. and position eroding

- Male Heavy drinking prevalence in 15% of the pop. (2.3 pct. point increase since 2005). It ranks at the 93rd national percentile (1st is best)
- Female Heavy drinking prevalence in 8% of the pop (2.4 pct. point increase since 2005). It ranks at the 86th national percentile
- Female Binge drinking prevalence in 14.7% of the pop. (3.9 pct. point increase since 2002). It ranks at the 78th national percentile
- Male Binge drinking prevalence 28.4% of the pop. (0.5% pct. point increase since 2002). It ranks at the 73rd national percentile

Below National avg. (beneficial position) and improving

- Female Life expectancy 80.5 years (increasing 3.4 years since 1985). It ranks at the 43rd national percentile (1st is best)
- Male Life expectancy is 76.5 years (increasing 6 years since 1985). It ranks at the 31st national percentile
- Female Smoking prevalence is 19.1% (declining 2.4 pct. points since 1996). It ranks at the 25th national percentile
- Male Smoking prevalence is 22.1% (declining 8.3 pct. points since 1996). It ranks at the 19th national percentile

- Female Recommended physical activity prevalence is 53.8% (increasing 1.2 pct. points since 2001). It ranks at the 30th national percentile

Below National avg. but beneficial position eroding

- Female Obesity prevalence is 36.8% (increasing 10.3 pct. points since 2001). It ranks at the 36th national percentile
- Male Obesity prevalence is 35.4% (increasing 8.4 pct. points since 2001). It ranks at the 24th national percentile
- Male Recommended physical activity prevalence is 53.8% (declining 2.9 pct. points since 2001). It ranks at the 48th national percentile

GRAND ISLE

Among top 15 Leading Causes of Death, 7 occurred at expected rates. Cancer (#2 cause of death), Lung (#3), Suicide (#8) and Hypertension (#9) occurred at higher than expected rates. Flu/Pneumonia (#12), Liver (#14), Kidney (#10) and Homicide (#15) occurred at a lower than expected rate. Top 10 Causes of Death:

1. Heart Disease ranking #2 among VT 14 Counties (#1 is worst in State)
2. Cancer ranking #1 (highest rate) in VT
3. Lung ranking #1 (highest rate) in VT
4. Stroke ranking #1 (highest rate) in VT
5. Accidents ranking #12 in VT
6. Diabetes ranking #8 in VT
7. Alzheimer's ranking #14 (lowest rate) in VT
8. Suicide ranking #8 in VT
9. Hypertension ranking #1 (highest rate) in VT
10. Kidney ranking #3 in VT

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 US counties applying small area estimation techniques to the most recent county information.

Above National avg. and improving – none

Above National avg. and position eroding

- Male Heavy drinking prevalence in 14.3% of the pop. (2.9 pct. point increase since 2005). It ranks at the 90rd national percentile (1st is best)
- Female Heavy drinking prevalence in 8.8% of the pop (2.3 pct. point increase since 2005). It ranks at the 88th national percentile

- Female Binge drinking prevalence in 14.2% of the pop. (3.3 pct. point increase since 2002). It ranks at the 74th national percentile
- Male Binge drinking prevalence 28.5% of the pop. (0.5% pct. point increase since 2002). It ranks at the 74rd national percentile

Below National avg. (beneficial position) and improving

- Female Life expectancy 82.2 years (increasing 4.8 years since 1985). It ranks at the 15rd national percentile (1st is best)
- Male Life expectancy is 78.1 years (increasing 6.1 years since 1985). It ranks at the 11st national percentile
- Female Smoking prevalence is 14.8% (declining 6.5 pct. points since 1996). It ranks at the 6th national percentile
- Male Smoking prevalence is 18% (declining 8.1 pct. points since 1996). It ranks at the 4th national percentile
- Female Recommended physical activity prevalence is 60.1% (increasing 1.4 pct. points since 2001). It ranks at the 6th national percentile
- Male Recommended physical activity prevalence is 64.7% (increasing 4.5 pct. points since 2001). It ranks at the 3th national percentile

Below National avg. but beneficial position eroding

- Female Obesity prevalence is 31.6% (increasing 5.4 pct. points since 2001). It ranks at the 7th national percentile
- Male Obesity prevalence is 33.6% (increasing 9.9 pct. points since 2001). It ranks at the 14th national percentile

Conclusions from Prior CHNA Implementation Activities

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

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

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

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

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

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

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

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

Northwestern Medical Center, in collaboration with a panel of local experts, conducted a formal Community Health Needs Assessment (CHNA) for the community of Vermont's Franklin and Grand Isles Counties in the Fall of 2012. The CHNA process calls upon the identification of high priority and lower priority health needs facing a community. These are then divided into those for which the hospital has a level of "high responsibility" (those which are closely aligned with the scope and services of the hospital) and those which the hospital has "low responsibility" (those which are less directly related to the scope and service of the hospital, but in which the hospital may still play a supportive role).

The following is an overview of Northwestern Medical Center (NMC) initiatives and collaborative responses to the issues identified in the 2012 Community Health Needs, presented within the framework of level of hospital responsibility. The numerical ranking indicates the overall ranking of a particular priority within the CHNA.

High Priority Needs where Northwestern Medical Center holds High Responsibility

2. Access/Availability to Healthcare & Physicians:

- Investing in Recruitment/Retention Infrastructure: NMC has invested in its physician and advanced practice provider recruitment and retention infrastructure by hiring a new Physician Recruiter and investing in that individual's training, development, and mentorship. The hospital has invested significant operational expenses for physician recruiting in the 2.5 years since the 2012 Community Health Needs Assessment. Numerous departing physicians and advanced practice providers have been replaced, preventing those departures from creating additional access issues in both Primary Care and Specialty Care. We have also supported the recruitment of providers at our local Federally Qualified Health Center and area practices to ensure access across our service area.
- Expanded Service: Access to Urgent Care was expanded with the June, 2014 opening of Northwestern Urgent Care's site in St. Albans. This site provides care 7 days per week, with convenient evening hours. Its providers communicate with primary care providers to help continuity of care amidst episodic visits. As of March, 2015 the office was seeing approximately 23 patients a day, providing an appropriate option for non-emergent care when primary care is not available. In addition, NMC and other Primary Care Providers have expanded Primary Care practice hours into weekday evenings.
- Established Expanded Local Access: NMC contracts with UVM Medical Center Cardiologists to staff Northwestern Cardiology to bring important medical cardiology services into our community. As that practice grew steadily, NMC invested in larger interim space for this specialty to continue to facilitate improved access. This is a significant enhancement for individuals suffering from heart disease. This eliminates or greatly reduces travel as a barrier to access to care for this service.
- Re-established Local Access: NMC employed Dr. Stephen Gorman and established Northwestern Pulmonology to bring important medical pulmonology services back into our community. This is a significant enhancement for individuals suffering from chronic lung disease and asthma. This eliminates or greatly reduces travel as a barrier to access to care for this service.
- Expanded Service: NMC employed Dr. William Roberts and established Northwestern Comprehensive Pain

Services to help address access concerns. This broad practice provides enhanced access to care for chronic pain and seamless access to interventional pain procedures. It also provides treatment of narcotic addiction, offered in close collaboration with The Howard Center and other community partners. It has grown to involve multiple physicians with addition of a 2nd physician and an APP to the team, as well as the integration of primary care providers.

- Improved Access: NMC engaged the providers and staff of Northwestern Orthopaedics in significant process improvement and system redesign efforts within that practice to significantly reduce waiting times for appointments and waiting times within the office. This has significantly reduced timeliness of service as a barrier to care.
- Improved Access: NMC has contracted with University of Vermont Medical Center to improve access to Urology services through the creation of Northwestern Urology.
- Expanded Service: In response to a request from the providers at Cambridge Health Center, a facility located adjacent to the NMC service area and caring for members of our service area who travel east for their care, NMC established a physical therapy satellite at the Cambridge Health Center. This fills a need for an adjacent community while improving access for a portion of the southeastern corner of our service area.
- Expanding Capacity: NMC is currently working collaboratively with NOTCH (Northern Tier Centers for Health), the Federally Qualified Health Center serving our community through five sites, to expand their Primary Care practice in St. Albans. To better accommodate growth in demand, NOTCH is in the process of relocating its St. Albans office to larger space on the NMC campus. This move is being subsidized in part by NMC in support of improved access to care for our community and increased inter-organization collaboration.
- Increasing Awareness: NMC has integrated discussion of local healthcare and physicians/APPs into ongoing communications from the hospital in various forms to increase awareness in the community. The methods used include the NMC Viewbook, mailed annually to 36,000 households; the Insights newsletter, mailed 6 times per year to those same households; the CEO's weekly column which appears in the local newspaper and is then shared on the NMC website and through social media; the CEO's newly established twice-monthly public access television show "Health Beat" which is also shared on the NMC website and through social media; and the provision of provider listings and other informational materials at NMC booths at event such as the St. Albans Rotary Expo, the Healthy Hearts On The Move fair, etc.

3. Obesity:

- Building Community Engagement Through RiseVT: NMC partnered with the Vermont Department of Health to create "the Community Committee on Healthy Lifestyles" with an initial focus on addressing obesity. That committee consists of community leaders from a broad selection of healthcare, social agencies, municipalities, businesses, schools, media, etc. The committee used the "results based accountability (RBA) approach to determine its specific focus and approach. A two-year, $400,000 grant has been secured, and supplemented with $200,000 of operating expenses from NMC itself, to launch the evidence-based RiseVT initiative to actively engage the community in better eating habits, increased physical activity, heightened health understanding through health coaching, infrastructure and policy changes, and other lifestyle related

improvements to ultimately reduce the impact of obesity on our community's health. The full launch of that initiative is set for June of 2015.

- Building on BetterU to Explore a Lifestyle Medicine Clinic: Based in part on the success of the BetterU initiative created by Dr. Elisabeth Fontaine in alignment with an offering from the American Heart Association, NMC is piloting a Lifestyle Medicine Clinic to provide an additional resource to those seeking to make positive behavior changes and impact health risk factors such as Obesity, Cholesterol, Blood Pressure, etc. This project could emerge as a payment reform pilot in collaboration with insurers to create sustainable funding for evidence-based health improvement counseling.
- Building Community Engagement for Long-Term, Sustainable Change: NMC employs a health educator to engage the community in policy, systems, and environmental prevention activities through a combination of hospital funding and grant funding. These efforts are focused in 6 Franklin and Grand Isle communities with the goals of increasing walking and biking infrastructure; supporting mixed-use development; increasing access to parks, recreation and open spaces; and increasing access to healthy foods. Successes include several active Safe Routes to School initiatives, new recreation spaces, the establishment of a recreation committee, and several new walking/biking paths. There is continued work to raise awareness through regular snippets in the area newspaper, in social media, and in partnership with agencies throughout the region.
- Facilitating The Vermont Blueprint For Health Implementation: NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as obesity are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.
- Improving Access to Local, Fresh, Healthy Foods: NMC is partner in the Healthy Roots initiative, serving as the host organization for the coordinator position, financial contributor, and active program participant as a business. Healthy Roots is a collaborative with the Franklin County Industrial Development Corporation and other partners to create/strengthen our local farm to table initiatives and improve access to local fresh healthy food choices. Healthy Roots has created a cold storage facility for foods in the community, added transportation resources for food delivery, worked with companies and municipalities on increasing farmers' markets and CSA's (community supported agriculture) and participated in events to raise awareness.
- Advocacy: Through its registered lobbyists, NMC has been active in advocating for the establishment of an excise tax on sugary beverages, which now account for the largest source of calories among Vermont's youth and are a proven contributor to obesity at all ages. Research shows that such a tax can prompt a reduction of consumption, in alignment with the socio-ecological model for behavior change.
- Increasing Awareness: NMC has integrated discussion of obesity related conditions (sedentary lifestyles, poor nutrition choices, etc) into ongoing communications from the hospital in various forms to increase awareness in the community. The methods used include the programming offered to individuals and businesses through NMC's Lifestyle Medicine Department; the Insights newsletter, mailed 6 times per year to those same households; the CEO's weekly column which appears in the local newspaper and is then shared on the NMC website and through social media; the CEO's newly established twice-monthly public

access television show "Health Beat" which is also shared on the NMC website and through social media; and interactive activities and informational materials at NMC booths at event such as the Big Shabang in the Islands, the Healthy Hearts On The Move fair, etc.

4. Smoking:

- Focus on Tobacco Prevention: NMC employs a health educator to engage the community in tobacco prevention activities through a combination of hospital funding and grant funding. This includes policy- and systems-level work with youth, municipalities, schools, work places, retailers, and the decision makers. Successes include designation of "smoke free parks," active "OVX" (Our Voices Xposed) youth groups, smoke free work places, and more. The health educator also works to increase awareness through regular snippets in area newspapers and social media. Efforts also fund tobacco efforts with partner organizations that reach our community's most vulnerable populations, including Franklin Grand Isle Community Action and the Franklin Grand Isle Building Bright Futures Coalition. NMC's tobacco prevention expert also serves as the chairperson of Vermont's Tobacco Evaluation and Review Board, pushing for continued, comprehensive evidence-based efforts at the State level including policy-level interventions, such as increased tobacco prices, to cessation, media and local level initiatives. Recent data shows that for the first time, NMC's adult smoking rate is now below that of the State of Vermont.
- Providing Tobacco Cessation Services: NMC's Lifestyle Medicine Department provides local access to tobacco cessation services and integrated access to State-based tobacco cessation support. This includes individual and group counseling and support, access to free nicotine replacement, inpatient cessation services, and more. On-site cessation services are offered to local organizations and businesses transitioning to a tobacco free policy.
- Advocacy: Through its registered lobbyists, NMC has been active in advocating for an increase in the tobacco tax, an evidence-based method of prompting reduction of tobacco use and increasing cessation, in alignment with the socio-ecological model for behavior change.
- Hosting Healthy Hearts on the Move: In an effort to address heart disease and related conditions, NMC created and hosts the "Healthy Hearts on the Move" fair, which features free health screenings, interactive educational opportunities, healthy eating options, and fun physical activities for all ages. The event has grown in participation from under 50 in its first year to more than 350 in year three. Participants leave the event with better understandings of factors impacting their health including quitting tobacco use, heightened awareness of lifestyle choices they can make to improve their health, and lists of resources which can help support such efforts.
- Facilitating The Vermont Blueprint For Health Implementation: NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as tobacco use are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.
- Building on BetterU to Explore a Lifestyle Medicine Clinic: Based in part on the success of the BetterU

initiative created by Dr. Elisabeth Fontaine in alignment with an offering from the American Heart Association, NMC is piloting a Lifestyle Medicine Clinic to provide an additional resource to those seeking to make positive behavior changes and impact health risk factors such as Obesity, Cholesterol, Blood Pressure, etc. This project could emerge as a payment reform pilot in collaboration with insurers to create sustainable funding for evidence-based health improvement counseling.

5. Cancer:

- Certified Community Hospital Cancer Committee: NMC continues to operate a community hospital cancer committee, certified by the American College of Surgeons. This involves meeting specific national standards relating to data, access to treatment, multi-disciplinary meetings, and outreach. Awareness efforts and screenings for colon cancer have been integrated into public communications and events. Promotion of the importance and availability of mammography has been ongoing.
- Focus on Tobacco Prevention: NMC employs a health educator to engage the community in tobacco prevention activities through a combination of hospital funding and grant funding. This includes policy- and systems-level work with youth, municipalities, schools, work places, retailers, and the decision makers. Successes include designation of "smoke free parks," active "OVX" (Our Voices Xposed) youth groups, smoke free work places, and more. The health educator also works to increase awareness through regular snippets in are newspapers and social media. Efforts also fund tobacco efforts with partner organizations that reach our community's most vulnerable populations, including Franklin Grand Isle Community Action and the Franklin Grand Isle Building Bright Futures Coalition. NMC's tobacco prevention expert also serves as the chairperson of Vermont's Tobacco Evaluation and Review Board, pushing for continued, comprehensive evidence-based efforts at the State level including policy-level interventions, such as increased tobacco prices, to cessation, media and local level initiatives. Recent data shows that for the first time, NMC's adult smoking rate is now below that of the State of Vermont.
- Care Navigation: NMC has hired a Breast Care Navigator to promote prevention efforts and early detection through wellness screenings. The Navigator is advancing clinical practice as well as ensuring women receive prevention and diagnostic interventions as well as guides the individual through the care path needed for evidenced based best practice.
- Providing Tobacco Cessation Services: NMC's Lifestyle Medicine Department provides local access to tobacco cessation services and integrated access to State-based tobacco cessation support. This includes individual and group counseling and support, access to free nicotine replacement, inpatient cessation services, and more. On-site cessation services are offered to local organizations and businesses transitioning to a tobacco free policy.
- Facilitating The Vermont Blueprint For Health Implementation: NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as smoking are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.

9. Coronary Heart Disease:

- Established Local Access: NMC contracts with UVM Medical Center Cardiologists to staff Northwestern Cardiology to bring important medical cardiology services into our community. As that practice grew steadily, NMC invested in larger interim space for this specialty to continue to facilitate improved access. This is a significant enhancement for individuals suffering from heart disease. This eliminates or greatly reduces travel as a barrier to access to care for this service.
- Hosting Healthy Hearts on the Move: In an effort to address heart disease and related conditions, NMC created and hosts the "Healthy Hearts on the Move" fair, which features free health screenings, interactive educational opportunities, healthy eating options, and fun physical activities for all ages. The event has grown in participation from under 50 in its first year to more than 350 in year three. Participants leave the event with better understandings of factors impacting their health including quitting tobacco use, heightened awareness of lifestyle choices they can make to improve their health, and lists of resources which can help support such efforts.
- Building Community Engagement Through RiseVT: NMC partnered with the Vermont Department of Health to create "the Community Committee on Healthy Lifestyles" with an initial focus on addressing obesity. That committee consists of community leaders from a broad selection of healthcare, social agencies, municipalities, businesses, schools, media, etc. The committee used the "results based accountability (RBA) approach to determine its specific focus and approach. A two-year, $400,000 grant has been secured, and supplemented with $200,000 of operating expenses from NMC itself, to launch the evidence-based RiseVT initiative to actively engage the community in better eating habits, increased physical activity, heightened health understanding through health coaching, infrastructure and policy changes, and other lifestyle related improvements to ultimately reduce the impact of obesity on our community's health. The full launch of that initiative is set for June of 2015.
- Supporting the American Heart/Stroke Association's Efforts: The American Heart Association is a critical partner in efforts to prevent heart disease, to raise awareness that leads to early effective intervention and in the work to find improved treatment options. As such, NMC is actively involved in supporting the Heart Association's work through funding and partnership. NMC's Chief Executive Officer chaired the Statewide "Go Red For Women" campaign and played a driving role in significantly raising the profile and effectiveness of that event in our region and Statewide. She was subsequently honored with the Crystal Heart Award, which generated significant cash contributions to the Heart Association in her honor from local businesses and individuals.
- Building on BetterU to Explore a Lifestyle Medicine Clinic: Based in part on the success of the BetterU initiative created by Dr. Elisabeth Fontaine in alignment with an offering from the American Heart Association, NMC is piloting a Lifestyle Medicine Clinic to provide an additional resource to those seeking to make positive behavior changes and impact health risk factors such as Obesity, Cholesterol, Blood Pressure, etc. This project could emerge as a payment reform pilot in collaboration with insurers to create sustainable funding for evidence-based health improvement counseling.

10. Chronic Lung Disease & Chronic Asthma

- Re-established Local Access: NMC employed Dr. Stephen Gorman and established Northwestern Pulmonology to bring important medical pulmonology services back into our community. This is a significant enhancement for individuals suffering from chronic lung disease and asthma. This eliminates or greatly reduces travel as a barrier to access to care for this service.
- Focus on Tobacco Prevention: NMC employs a health educator to engage the community in tobacco prevention activities through a combination of hospital funding and grant funding. This includes policy- and systems-level work with youth, municipalities, schools, work places, retailers, and the decision makers. Successes include designation of "smoke free parks," active "OVX" (Our Voices Xposed) youth groups, smoke free work places, and more. The health educator also works to increase awareness through regular snippets in are newspapers and social media. Efforts also fund tobacco efforts with partner organizations that reach our community's most vulnerable populations, including Franklin Grand Isle Community Action and the Franklin Grand Isle Building Bright Futures Coalition. NMC's tobacco prevention expert also serves as the chairperson of Vermont's Tobacco Evaluation and Review Board, pushing for continued, comprehensive evidence-based efforts at the State level including policy-level interventions, such as increased tobacco prices, to cessation, media and local level initiatives. Recent data shows that for the first time, NMC's adult smoking rate is now below that of the State of Vermont.
- Providing Tobacco Cessation Services: NMC's Lifestyle Medicine Department provides local access to tobacco cessation services and integrated access to State-based tobacco cessation support. This includes individual and group counseling and support, access to free nicotine replacement, inpatient cessation services, and more. On-site cessation services are offered to local organizations and businesses transitioning to a tobacco free policy.

11. High Blood Pressure:

- Hosting Healthy Hearts on the Move: In an effort to address heart disease and related conditions, NMC created and hosts the "Healthy Hearts on the Move" fair, which features free health screenings, interactive educational opportunities, healthy eating options, and fun physical activities for all ages. The event has grown in participation from under 50 in its first year to more than 350 in year three. Participants leave the event with better understandings of factors impacting their health including quitting tobacco use, heightened awareness of lifestyle choices they can make to improve their health, and lists of resources which can help support such efforts.
- Facilitating The Vermont Blueprint For Health Implementation: NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as high blood pressure are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.
- Building Community Engagement Through RiseVT: NMC partnered with the Vermont Department of Health to create "the Community Committee on Healthy Lifestyles" with an initial focus on addressing obesity.

That committee consists of community leaders from a broad selection of healthcare, social agencies, municipalities, businesses, schools, media, etc. The committee used the "results based accountability (RBA) approach to determine its specific focus and approach. A two-year, $400,000 grant has been secured, and supplemented with $200,000 of operating expenses from NMC itself, to launch the evidence-based RiseVT initiative to actively engage the community in better eating habits, increased physical activity, heightened health understanding through health coaching, infrastructure and policy changes, and other lifestyle related improvements to ultimately reduce the impact of obesity on our community's health. The full launch of that initiative is set for June of 2015.

- Building on BetterU to Explore a Lifestyle Medicine Clinic: Based in part on the success of the BetterU initiative created by Dr. Elisabeth Fontaine in alignment with an offering from the American Heart Association, NMC is piloting a Lifestyle Medicine Clinic to provide an additional resource to those seeking to make positive behavior changes and impact health risk factors such as Obesity, Cholesterol, Blood Pressure, etc. This project could emerge as a payment reform pilot in collaboration with insurers to create sustainable funding for evidence-based health improvement counseling.

High Priority Needs where Northwestern Medical Center holds Low Responsibility

1. Mental Health & Substance Abuse:

- Expanded Addiction Service: NMC employed Dr. William Roberts and established Northwestern Comprehensive Pain Services to help address access concerns. This broad practice provides enhanced access to care for chronic pain and seamless access to interventional pain procedures. It also provides treatment of narcotic addiction, offered in close collaboration with The Howard Center. It has grown to involve multiple physicians with addition of a 2nd physician and an APP to the team, as well as the integration of primary care providers.
- Improved Crisis Care in Emergency Department: NMC has worked collaboratively with Northwestern Counseling & Support Services to refine and expand our approach to caring for patients in mental health crisis who present at the hospital Emergency Department. Through improved access to mental health care clinicians and embedded case management, NMC and NCSS are now better able to meet the needs of those in mental health crisis who present to the Emergency Department.
- Enhanced Substance Abuse Identification and Case Management: NMC has obtained a grant to embed early identification of substance abuse issues, and associated patient education and case management, into the NMC Emergency Department. This promising initiative, proven successful in other locations, allows a credible clinician to positively impact a patient at a time when the possible severity of his/her choices is immediately clear.

6. Health Insurance/Uninsured:

- Assisting Navigators In Enrolling Vermonters: NMC has been a supportive, collaborative partner in the effort to help Vermonters transition to obtaining health insurance through the State exchange, Vermont Health Connect. Our CEO has published columns on key aspects of enrollment in the exchange (which appeared in

the newspaper and were shared on our website and through social media). NMC hosted official Navigators for the Exchange at our Healthy Hearts On The Move events. NMC actively referred patients and callers with questions about the Exchange to the official Navigators – both those based at NOTCH (the area FQHC) who focused on individuals and at the Franklin County Regional Chamber of Commerce who focused on small businesses.

7. Suicide

- NMC believes that its expanded work in narcotic addiction treatment and our related collaboration with The Howard Center, as well as our collaborative work on addressing mental health crisis care with Northwestern Counseling & Support Services, are particularly relevant to suicide prevention in our community. In addition, Dr. Bill Roberts has been a leading advocate for the in-the-field use of overdose remedies by law enforcement, leading to the prevention of inadvertent suicides through accidental overdose. By expanding and improving care for those suffering from addiction and mental health concerns, we believe we can help improve the individual's quality of life and reduce the temptation of suicide.

8. Domestic & Sexual Abuse:

- NMC continues to be a financial sponsor of "Voices Against Violence / Laurie's House," the community organization focused on Domestic & Sexual Abuse.
- NMC's Emergency Department continues its work through the Sexual Assault Nurse Examiners (SANE) program to assist victims of sexual assault and support law enforcement in the pursuit of justice relating to sexual assault.
- NMC believes that its expanded work in narcotic addiction treatment and our related collaboration with The Howard Center are particularly relevant to domestic and sexual abuse in our community. By expanding and improving care for those suffering from addiction, we believe we can help improve the individual's quality of life and reduce instances of abuse.

Low Priority Needs where Northwestern Medical Center holds High Responsibility

12. Stroke:

- Hosting Healthy Hearts on the Move: In an effort to address heart disease and related conditions, NMC created and hosts the "Healthy Hearts on the Move" fair, which features free health screenings, interactive educational opportunities, healthy eating options, and fun physical activities for all ages. The event has grown in participation from under 50 in its first year to more than 350 in year three. Participants leave the event with better understandings of factors impacting their health including quitting tobacco use, heightened awareness of lifestyle choices they can make to improve their health, and lists of resources which can help support such efforts.
- Supporting the American Heart/Stroke Association's Efforts: The American Heart Association is a critical partner in efforts to prevent heart disease, to raise awareness that leads to early effective intervention and

in the work to find improved treatment options. As such, NMC is actively involved in supporting the Heart Association's work through funding and partnership. NMC's Chief Executive Officer chaired the Statewide "Go Red For Women" campaign and played a driving role in significantly raising the profile and effectiveness of that event in our region and Statewide. She was subsequently honored with the Crystal Heart Award, which generated significant cash contributions to the Heart Association in her honor from local businesses and individuals.

13. Diabetes:

- Providing significant Diabetes programming: NMC's Certified Diabetes Educator provides one-on-one and group services for individuals with diabetes.
- Facilitating The Vermont Blueprint For Health Implementation: NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as diabetes are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.
- Hosting Healthy Hearts on the Move: In an effort to address heart disease and related conditions, NMC created and hosts the "Healthy Hearts on the Move" fair, which features free health screenings, interactive educational opportunities, healthy eating options, and fun physical activities for all ages. The event has grown in participation from under 50 in its first year to more than 350 in year three. Participants leave the event with better understandings of factors impacting their health including quitting tobacco use, heightened awareness of lifestyle choices they can make to improve their health, and lists of resources which can help support such efforts.

16. Palliative Care:

- Formalizing the Palliative Care Program: NMC has formalized its Palliative Care program, with the hiring of Dr. Juan Nunez as the program's medical director and the refinement of protocols. The hospital works closely with other organizations in the community, such as the Franklin County Home Health Agency and their hospice program in the provision of these services. Beyond the direct provision of care and the coordination of services, these efforts include continuing medical education for area providers, with speakers including Dr. Alan Ramsey of the University of Vermont Medical Center.

18. Births:

- Establishing Healthy Beginnings: NMC has enhanced the services of its Family Birth Center and its employed practice, Northwestern OB/GYN, by creating the "Healthy Beginnings" program in collaboration with the Vermont Department of Health and other community partners. This best-practice based approach provides enhanced education and support to expecting parents and is proven to result in healthier outcomes for both baby and mother.

- Addressing Narcotic Addiction in Pregnant Women: NMC's Comprehensive Pain program has worked closely with the Family Birth Center, Northwestern OB/GYN, local Pediatricians, community resources, and experts from the University of Vermont Medical Center to improve NMC's abilities and systems to allow pregnant moms who are addicted to opiates to deliver safely at NMC and for their newborn to receive the care he/she needs in the first days of his/her life and helping ensure the new family member has a safe start in life.
- Pursuing Baby Friendly Status: NMC has pursued the "Baby Friendly" designation, shaping its approach and policies to maternal and newborn care around the national standards of excellence.

21. Chronic High Cholesterol:

- Facilitating The Vermont Blueprint For Health Implementation: NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as high cholesterol are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.

Low Priority Needs where Northwestern Medical Center holds Low Responsibility

14. Homicide:

- NMC believes that its expanded work in narcotic addiction treatment and our related collaboration with The Howard Center is particularly relevant to homicide prevention in our community. By expanding and improving care for those suffering from addiction, we believe we can help improve the individual's quality of life and reduce the events which can lead up to homicide.

15. Jobs:

- Serving as A Major Employer: NMC's workforce has grown steadily in recent years and is now more than 700 employees strong. The hospital has made a significant investment in our scholarship work experience program to help area youth enter the health care field and in Organizational Development to build the skillsets of our existing employees to allow them to thrive in their existing roles and develop the necessary tools to position them for promotion.
- Serving as a Collaborative Partner: NMC actively supports and participates in the work of the Franklin County Regional Chamber of Commerce, the Franklin County Industrial Development Corporation, and the Workforce Investment Board as they pursue a variety of strategies designed to enhance jobs and job skills in our region.

17. Baby Deaths:

- Addressing Narcotic Addiction in Pregnant Women: NMC's Comprehensive Pain program has worked closely with the Family Birth Center, Northwestern OB/GYN, local Pediatricians, community resources, and experts from the University of Vermont Medical Center to improve NMC's abilities and systems to allow pregnant moms who are addicted to opiates to deliver safely at NMC and for their newborn to receive the care he/she needs in the first days of his/her life and helping ensure the new family member has a safe start in life.

19. Physical Environmental Factors:

- Serving as a Collaborative Partner: NMC actively supports and participates in the work of the Friends of Northern Lake Champlain as they pursue a variety of strategies designed to reduce the pollution of Lake Champlain.
- Increasing Walkable/Bikable Communities: NMC has been an active advocate for, and supporter of, changes to the physical environment which promote increased access to and safety of walking and biking. This includes efforts relating to safe routes to school, creation of bike paths and lanes, inclusion of sidewalks in municipal plans, etc.

20. Accidents:

- Providing the ENCARE Program: NMC's Emergency Department Nurses provide "ENCARE" (Emergency Nurses Cancelling Alcohol Related Emergencies) programs for area youth. This powerful program raises awareness of the hazards of drinking and driving and other dangerous behaviors and choices.

22. Chronic Osteoporosis:

- Facilitating The Vermont Blueprint For Health Implementation: NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as osteoporosis are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.

23. Sexually Transmitted Disease:

- Provision of Care: Through NMC's Primary Care and OB/GYN practices, physicians and advance practice providers provide education, treatment, and care relating to sexually transmitted disease.

24. Premature Death/Life Expectancy:

- Building Community Engagement Through RiseVT: NMC partnered with the Vermont Department of Health

to create "the Community Committee on Healthy Lifestyles" with an initial focus on addressing obesity. That committee consists of community leaders from a broad selection of healthcare, social agencies, municipalities, businesses, schools, media, etc. The committee used the "results based accountability (RBA) approach to determine its specific focus and approach. A two-year, $400,000 grant has been secured, and supplemented with $200,000 of operating expenses from NMC itself, to launch the evidence-based RiseVT initiative to actively engage the community in better eating habits, increased physical activity, heightened health understanding through health coaching, infrastructure and policy changes, and other lifestyle related improvements to ultimately reduce the impact of obesity on our community's health. The full launch of that initiative is set for June of 2015.

- Building Community Engagement for Long-Term, Sustainable Change: NMC employs a health educator to engage the community in policy-, systems-, and environmental prevention activities through a combination of hospital funding and grant funding. These efforts are focused in 6 Franklin and Grand Isle communities with the goals of increasing walking and biking infrastructure; supporting mixed-use development, increasing; increasing access to parks, recreation and open spaces; and increasing access to healthy foods. Successes include several active Safe Routes to School initiatives, new recreation spaces, the establishment of a recreation committee, and several new walking/biking paths. There is continued work to raise awareness through regular snippets in the area newspaper, in social media, and in partnership with agencies throughout the region.
- Facilitating The Vermont Blueprint For Health Implementation: NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as obesity and tobacco use which are direct factors in shortened life expectancy are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.
- Focus on Tobacco Prevention: NMC employs a health educator to engage the community in tobacco prevention activities through a combination of hospital funding and grant funding. This includes work with youth, municipalities, schools, work places, retailers, and the legislature. Successes include designation of "smoke free parks," active "OVX" (Our Voices Exposed) youth groups, "Healthy Retailers" who change how they sell cigarettes, smoke free work places, and more. NMC's tobacco prevention expert also serves as the chairperson of Vermont's Tobacco Review Control Board, pushing for continued evidence-based efforts at the State level to reinforce the work being done here at our local level. Recent data shows that for the first time in memory, NMC's adult smoking rate is now below that of the State of Vermont.
- Providing Tobacco Cessation Services: NMC's Lifestyle Medicine Department provides local access to tobacco cessation services and integrated access to State-based tobacco cessation support. This includes individual counseling and support (in person and online), access to free nicotine replacement, and more.

EXISTING HEALTHCARE FACILITIES, RESOURCES, & IMPLEMENTATION STRATEGY

SIGNIFICANT HEALTH NEEDS

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by NMC.[36] 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 NMC current efforts responding to the need including any written comments received regarding prior NMC implementation actions
- Establishes the Implementation Strategy programs and resources NMC will devote to attempt to achieve improvements
- Documents the Leading Indicators NMC will use to measure progress
- Presents the Lagging Indicators NMC 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, NMC is the major hospital in the service area. Northwestern Medical Center, a hospital licensed for 70 beds, is located in St. Albans, VT. The next closest facilities are outside the service area and include:

- University of Vermont Medical Center: a tertiary care facility licensed for 562 beds, located in Burlington, Vermont – 27 miles (approximately a 35 minute drive) from St. Albans;
- Copley Hospital: a critical access hospital, located in Morrisville, Vermont – 40 miles (approximately a 55 minute drive) from St. Albans;
- North Country Hospital: a critical access hospital, located in Newport, Vermont – 60 miles (approximately a 90 minute drive) from St. Albans.

All data items analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the NMC 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 Quorum application, Leading Indicators also must be within the ability of the hospital to influence and measure.

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

Vermont Community Benefit Requirements

Vermont requires all community hospitals to report certain community benefit expenses in annual "Hospital Community Reports."

Vermont community hospitals are required to submit Hospital Community Reports to the Commissioner of the Department of Financial regulation. The reports must include as a mandatory reporting category "a summary of the hospital's budget, including revenue by source and quantification of cost shifting to private payers." "Cost shifting to private payers" encompasses a hospital's costs associated with Medicare and Medicaid reimbursement shortfalls and uncompensated care costs. (http://legislature.vermont.gov/statutes/fullchapter/18/221)[37]

[37] http://www.hilltopinstitute.org/hcbpDocs/HCBP_CBL_vt.pdf

General Written Comments about Prior Implementation Plan

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

- Be the leadership to bring organizations together to address the needs of people on the fringe. NMC should not compete with organizations or private business but support them.
- Just making sure that all health care providers are aware of what is available for their patients as far as workshops, exercise programs, etc. Many are no to little cost. We have become a society that seems unwilling to take charge of our own health care - don't know how to change that other than education, and some way to increase compliance with providers suggestions for improvements. Don't have any "lightbulb" suggestions.
- As discussed in number 2, housing and all the thought that should go along with it.
- no
- Trauma in children needs to be a big focus of the hospital and our entire mental health system as well. This is an increasing problem/concern that effects students in school and in every day aspects of their lives.
- Accidental deaths among children or young adults- risky behavior choices, home safety, etc.
- I would like to see that all primary care providers able to provide the full range of services available e thru full participation in the Blueprint model.
- i LOVE that there are now co-located social workers at NOTCH programs
- low literacy
- Future of health care and affordability
- As a dentist, drug use is detrimental to teeth and the mouth. It must be addressed to prevent recurrent ER visits. Let's start a "how to improve oral health" with drug treatment.
- I like the idea of having NCSS in the PCP offices. More efforts should be made to coordinate efforts to reduce the cost of health services.

Significant Needs

1. MENTAL HEALTH & SUBSTANCE ABUSE

79% of Local Expert votes continue from 2012 as Need; FRC and GRI male & female heavy drinking and binge drinking adverse, eroding; GRI 3+ drinks per session adverse for 26% adverse FRC for 30%; GRI peer binge drinking 6th worse

Public comments received on previously adopted implementation strategy:

- Long term solutions have not succeeded at hospital level.
- NMC needs to support the agencies that are doing good work. There can not be duplication
- Need more community supports. Housing seems to be a big issue.
- Would suggest working closely with NCSS/Howard Ctr
- Outreach into schools and local community is key.
- we need more transportation for people to get to and from treatment
- see above!
- Stigma is prevalent and poses an obstacle to treatment and services
- Need to find appropriate facilities for these patients
- Target young- 16-29 year olds And target them with family counseling. "How to!" So they have ways to improve their situation.
- I feel the additional resources being offered through the Comprehensive Pain Clinic are a good improvement towards a healther population of substance abusers and people with mental health issues.

NMC services, programs, and resources available to respond to this need include:[38]

- Northwestern Comprehensive Pain practice
- Northwestern Medical Center's Emergency Department (with embedded substance abuse services and contracted mental health support)
- Northwestern Primary Care
- Northwestern Georgia Health Center
- Northwestern Pediatrics
- Northwestern OB/GYN & NMC's Family Birth Center
- Case Management services (inpatient, emergent, outpatient**)**
- Interventional Pain service
- Vermont Blueprint for Health facilitation in area primary care practices
- Urine Toxicology services (expected to launch in 2016)

Our strategies to address this priority include:

[38] 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

- Increasing access to addiction services through recruitment and collaboration;
- Embedding Mental Health Care Managers into Primary Care, continuing with embedded care management in the Emergency Department;
- Increasing access to interventional pain services through recruitment.

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

As described earlier in this assessment, NMC has taken a number of actions on this priority since the previous assessment. Those efforts have improved access to care and services relating to mental health and substance abuse. More work remains on this priority. Here is a reflection on the highlights of those efforts and their impact:

- Expanded Addiction Service: NMC employed Dr. William Roberts and established Northwestern Comprehensive Pain Services to help address access concerns. This broad practice provides enhanced access to care for chronic pain and seamless access to interventional pain procedures. It also provides treatment of narcotic addiction, offered in close collaboration with The Howard Center. It has grown to involve multiple physicians with addition of a 2nd physician and an APP to the team, as well as the integration of primary care providers. Following changes in physician staffing, the practice is returning to being staffed by two physicians and recruitment of an additional provider continues to keep pace with community need. This practice is an integral part of addiction services in the region and has provided important care for many suffering from addiction in our community.
- Improved Crisis Care in Emergency Department: NMC has worked collaboratively with Northwestern Counseling & Support Services to refine and expand our approach to caring for patients in mental health crisis who present at the hospital Emergency Department. Through improved access to mental health care clinicians and embedded case management, NMC and NCSS are now better able to meet the needs of those in mental health crisis who present to the Emergency Department. This effort is vitally important to helping ensure patients have timely access to necessary services in emergent or pressing times.
- Enhanced Substance Abuse Identification and Case Management: NMC has obtained a grant to embed early identification of substance abuse issues, and associated patient education and case management, into the NMC Emergency Department. This promising initiative, proven successful in other locations, allows a credible clinician to positively impact a patient at a time when the possible severity of his/her choices is immediately clear. This will be supplemented by an emphasis on care management and mental health services within our Primary Care practices, again, providing timely access to care and service for patients.

Anticipated results from NMC Implementation Strategy

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

4. Enhances public health activities		
5. Improves ability to withstand public health emergency		
6. Otherwise would become responsibility of government or another tax-exempt organization		
7. Increases knowledge; then benefits the public	YES	

NMC's Intervention strategy is envisioned to include:

- Increase access to addiction services through recruitment and collaboration
- Embed Mental Health Care Managers into Primary Care, continue with embedded in ED
- Increase access to interventional pain through recruitment

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

- Depression Screening as per Accountable Care Organization

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

- Deaths From Overdose

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

Organization	Contact Name	Contact Information
Northwestern Counseling & Support Services	Ted Mable	524-6554
The Howard Center	Ed Williamson	524-7265
Turning Point	Karen Heinlein-Grenier	782-8454
Vermont Department of Health	Judy Ashley	524-7970
Vermont Department of Corrections/ Northwest State Correctional Facility	Greg Hale	524-6771

Other local resources identified during the CHNA process that are believed available to respond to this need:[39]

Organization	Contact Name	Contact Information
Local Law Enforcement	Multiple	

[39] 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

Alcoholics Anonymous		741-7100
Narcotics Anonymous		862-4516

2. OBESITY

72% of Local Experts voted to continue from 2012 as Need; GRI 27% adversely obese, FRC adverse for 32%; GRI worse peer rate; FRC adverse for obesity and physical inactivity

Public comments received on previously adopted implementation strategy:

- RISE is probably a good activity.
- I have seldom eaten in the Courtyard Cafe, but know they do offer healthy choices. I do think the empty calorie choices should be very limited or eliminated. Gradually would cause less uproar.
- We need more access to a variety of activities that are free. This is a tough one. This is where the "Behavioral" component comes into play. Many of these Chronic Diseases can be greatly affected/avoided with behavior modification but this is more an art than science and requires people that are very good at motivating other people.
- NMC has stepped up its leadership in obesity prevention in the past two years as it supports its community-wide, evidence-based strategies both through large-scale funding of RiseVT, but its personnel support for community-based strategies and the Healthy Roots (farm to table) initiatives. Staff and expertise are more widely available within our community to make the sustainable changes that support more physical activity and healthy eating, the major components of obesity.
- public awareness on obesity as it related to certain cancers in addition to chronic disease. Provide Motivational Interviewing tool for all providers
- I LOVE the RISE program, more of this in more areas, not just st. albans proper
- from my work with families, i know that the energy for providing healthy meals for children is low cheap, pre-packaged food is tantalizing when you have a limited budget, limited time for cooking and cleaning, lmited mental availability for planning meals, and kids screaming in the grocery store so Hot Pockets and french fries and bug juice are a fabulous solution but the solution creates the obesity crisis getting under-privileged families to the exercise programs and nutrition programs outlined in your planned approach should be considered
- Rise Vermont is a key initiaitive Providing various workshops and programs
- Treatment should be walking with patients, and not sitting in a class or in a doctors office waiting.

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

- NMC Lifestyle Medicine
- RiseVT Community Campaign to Embrace Healthy Lifestyles

- Northwestern Primary Care
- Northwestern Georgia Health Center
- Northwestern Pediatrics
- Northwestern OB/GYN

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

- **Building Community Engagement Through RiseVT:** NMC partnered with the Vermont Department of Health to create "the Community Committee on Healthy Lifestyles" with an initial focus on addressing obesity. That committee consists of community leaders from a broad selection of healthcare, social agencies, municipalities, businesses, schools, media, etc. The committee used the "results based accountability (RBA) approach to determine its specific focus and approach. A two-year, $400,000 grant has been secured, and supplemented with $200,000 of operating expenses from NMC itself, to launch the evidence-based RiseVT initiative to actively engage the community in better eating habits, increased physical activity, heightened health understanding through health coaching, infrastructure and policy changes, and other lifestyle related improvements to ultimately reduce the impact of obesity on our community's health. The full launch of that initiative happened in June of 2015. The program has engaged 6,500 individuals, 42 businesses, 14 schools, and 8 communities.
- **Building on BetterU to Explore a Lifestyle Medicine Clinic:** Based in part on the success of the BetterU initiative created by Dr. Elisabeth Fontaine in alignment with an offering from the American Heart Association, NMC is piloting a Lifestyle Medicine Clinic to provide an additional resource to those seeking to make positive behavior changes and impact health risk factors such as Obesity, Cholesterol, Blood Pressure, etc. The initial pilot was based on individual appointments and a current pilot if focused on group visits using the CHIP curriculum. There is an initiative currently underway to supplement the Clinic with alignment with Wellcoach-trained health coaches to assist clinic participants in sustaining their gains. This project could emerge as a payment reform pilot in collaboration with insurers to create sustainable funding for evidence-based health improvement counseling.
- **Building Community Engagement for Long-Term, Sustainable Change:** NMC employs a health educator to engage the community in policy, systems, and environmental prevention activities through a combination of hospital funding and grant funding. These efforts are focused in 6 Franklin and Grand Isle communities with the goals of increasing walking and biking infrastructure; supporting mixed-use development; increasing access to parks, recreation and open spaces; and increasing access to healthy foods. Successes include several active Safe Routes to School initiatives, new recreation spaces, the establishment of a recreation committee, and several new walking/biking paths. There is continued work to raise awareness through regular snippets in the area newspaper, in social media, and in partnership with agencies throughout the region.
- **Facilitating The Vermont Blueprint For Health Implementation:** NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as obesity are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.
- **Improving Access to Local, Fresh, Healthy Foods:** NMC is partner in the Healthy Roots initiative, serving as the host organization for the coordinator position, financial contributor, and active program participant as a business. Healthy Roots is a collaborative with the Franklin County Industrial Development Corporation and other partners to create/strengthen our local farm to table initiatives and improve access to local fresh healthy food choices. Healthy Roots has created a cold storage facility for foods in the community, added transportation resources for food delivery, worked with companies and municipalities on increasing farmers' markets and CSA's (community supported agriculture) and participated in events to raise awareness.
- **Advocacy**: Through its registered lobbyists, NMC has been active in advocating for the establishment of an excise tax on sugary beverages, which now account for the largest source of calories among Vermont's youth

and are a proven contributor to obesity at all ages. Research shows that such a tax can prompt a reduction of consumption, in alignment with the socio-ecological model for behavior change.

- **Increasing Awareness:** NMC has integrated discussion of obesity related conditions (sedentary lifestyles, poor nutrition choices, etc) into ongoing communications from the hospital in various forms to increase awareness in the community. The methods used include the programming offered to individuals and businesses through NMC's Lifestyle Medicine Department; the Insights newsletter, mailed 6 times per year to those same households; the CEO's weekly column which appears in the local newspaper and is then shared on the NMC website and through social media; the CEO's newly established twice-monthly public access television show "Health Beat" which is also shared on the NMC website and through social media; and interactive activities and informational materials at NMC booths at event such as the Big Shabang in the Islands, the Healthy Hearts On The Move fair, etc.

Anticipated results from NMC Implementation Strategy

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

NMC's Intervention strategy is envisioned to include:

- Continue the evidence based RiseVT Community Campaign
- Continue primary prevention work of advocacy, Healthy Roots, community walkability, etc
- Establish the public offering of the Lifestyle Medicine Clinic
- Expand use of dietitians by primary care referral through Lifestyle Medicine and Blueprint
- Expand business wellness services at worksites
- Explore implementation of best practice model for obesity reduction (possibly EPODE)

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

- Adult BMI Rate from OneCare Vermont Accountable Care Organization
- Children BMI Rate from OneCare Vermont Accountable Care Organization

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

- Adult Obesity Rate
- Childhood Obesity Rate

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

Organization	Contact Name	Contact Information
Vermont Department of Health	Judy Ashley	524-7970
Vermont Blueprint For Health	Lesley Hendry	524-5911
Local Primary Care Providers	Multiple	Call 524-1280 for information
Local Pediatricians	Multiple	Call 524-1280 for information
Local Schools	Multiple	
Local Employers	Multiple	
Local Fitness Facilities	Multiple	
Local Merchants	Multiple	
Local Restaurants	Multiple	

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

Organization	Contact Name	Contact Information
All Aspects of the Community	Multiple	

3. SMOKING

66% of Local Experts voted to continue from 2012 as Need; GRI smoking adverse for 21% FRC below avg. for 24%; GRI Lower Respiratory deaths peer 2nd worse; GRI & FRC adverse smoking rate

Public comments received on previously adopted implementation strategy:

- Work more closely with PCP's Blueprint staff to identify and target potential candidates for Quit activities. This is where the "Behavioral" component comes into play. Many of these Chronic Diseases can be greatly affected/avoided with behavior modification but this is more an art than science and requires people that are very good at motivating other people.
- NMC has supported the Franklin and Grand Isle Tobacco Prevention Coalition for nearly 15 years. Community norms around tobacco use are improving, but there is still more work to be done. NMC has been a strong model

for reduced tobacco use as a hospital and as an employer which has provided good support for other organizations to follow the same path. Additionally, NMC has been a leader in pursuing strong and evidence-based strategies for our state which would decrease tobacco use, such as more smoke-free areas and higher tobacco prices.

- as Dr. Felitti would say, smoking is a solution to a public health crisis address the underlying reasons folk need to smoke (anxiety reduction, stress relief, appetite suppressant, anger management)
- There are various programs for smoking cessation. this should be an initiative advocated by primary care doctors.
- Lobbying for tougher laws.
- Chari Andersen does inpatient consults with smokers as well as sees patients on an outpatient basis 1:1 and also offers monthly classes throughout the community for the public as well as in corporations that express the need to have cessation representation on site. She also does 1 time information sessions at any location where a need is expressed or identified. Chari also does routine marketing in the community to keep offices and organizations up to date with proper advertising of available resources.

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

- NMC Lifestyle Medicine
- RiseVT Community Campaign to Embrace Healthy Lifestyles
- Northwestern Primary Care
- Northwestern Georgia Health Center
- Northwestern Pediatrics
- Northwestern OB/GYN

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

- **Focus on Tobacco Prevention**: NMC employs a health educator to engage the community in tobacco prevention activities through a combination of hospital funding and grant funding. This includes policy- and systems-level work with youth, municipalities, schools, work places, retailers, and the decision makers. Successes include designation of "smoke free parks," active "OVX" (Our Voices Xposed) youth groups, smoke free work places, and more. The health educator also works to increase awareness through regular snippets in area newspapers and social media. Efforts also fund tobacco efforts with partner organizations that reach our community's most vulnerable populations, including Franklin Grand Isle Community Action and the Franklin Grand Isle Building Bright Futures Coalition. NMC's tobacco prevention expert also serves as the chairperson of Vermont's Tobacco Evaluation and Review Board, pushing for continued, comprehensive evidence-based efforts at the State level including policy-level interventions, such as increased tobacco prices, to cessation, media and local level initiatives. Recent data shows that for the first time, NMC's adult smoking rate is now below that of the State of Vermont.
- **Providing Tobacco Cessation Services**: NMC's Lifestyle Medicine Department provides local access to tobacco cessation services and integrated access to State-based tobacco cessation support. This includes individual and group counseling and support, access to free nicotine replacement, inpatient cessation services, and more. On-site cessation services are offered to local organizations and businesses transitioning to a tobacco free policy.

- **Advocacy**: Through its registered lobbyists, NMC has been active in advocating for an increase in the tobacco tax, an evidence-based method of prompting reduction of tobacco use and increasing cessation, in alignment with the socio-ecological model for behavior change.
- **Hosting Healthy Hearts on the Move:** In an effort to address heart disease and related conditions, NMC created and hosts the "Healthy Hearts on the Move" fair, which features free health screenings, interactive educational opportunities, healthy eating options, and fun physical activities for all ages. The event has grown in participation from under 50 in its first year to more than 350 in year three. Participants leave the event with better understandings of factors impacting their health including quitting tobacco use, heightened awareness of lifestyle choices they can make to improve their health, and lists of resources which can help support such efforts.
- **Facilitating The Vermont Blueprint For Health Implementation:** NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified medical home status for primary care offices. Conditions such as tobacco use are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.
- **Building on BetterU to Explore a Lifestyle Medicine Clinic:** Based in part on the success of the BetterU initiative created by Dr. Elisabeth Fontaine in alignment with an offering from the American Heart Association, NMC is piloting a Lifestyle Medicine Clinic to provide an additional resource to those seeking to make positive behavior changes and impact health risk factors such as Obesity, Cholesterol, Blood Pressure, etc. The initial pilot was based on individual appointments and a current pilot if focused on group visits using the CHIP curriculum. There is an initiative currently underway to supplement the Clinic with alignment with Wellcoach-trained health coaches to assist clinic participants in sustaining their gains. This project could emerge as a payment reform pilot in collaboration with insurers to create sustainable funding for evidence-based health improvement counseling.

Anticipated results from NMC Implementation Strategy

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

NMC's Intervention strategy is envisioned to include:

- Continue the evidence based RiseVT Community Campaign

- Continue primary prevention work of advocacy, Healthy Retailing, Smoke Free Enviornments, etc
- Expand use of smoking cession by primary care referral through Lifestyle Medicine and Blueprint
- Expand business wellness services at worksites

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

- Tobacco Use Assessment and Cessation Referral Through ACO Measure

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

- Adult smoking rate
- Youth smoking rate

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

Organization	Contact Name	Contact Information
Franklin Grand Isle Tobacco Coalition	Amy Brewer	524-1227
Vermont Department of Health	Judy Ashley	524-7970
Vermont Blueprint for Health	Lesley Hendry	524-5911
Local Primary Care Providers	Multiple	Call 524-1280 for information
Local Pediatricians	Multiple	Call 524-1280 for information
Local Merchants	Multiple	
Local Employers	Multiple	
Local Municipalities	Multiple	

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

Organization	Contact Name	Contact Information
Local Legislators	Multiple	

4. CANCER

69% of Local Experts voted to continue from 2012 as Need; #2 cause of death both Co., GRI highest VT rate, FRC 2nd highest VT rate; GRI prostate test beneficial for 34%, colorectal test beneficial for 29%; GRI deaths peer worst, morbidity peer 2nd worse; FRC deaths peer 3rd worse

Public comments received on previously adopted implementation strategy:

- Although the hospital has been growing in its tobacco and obesity implementation leadership, our region still struggles with low cancer screening rates. There is more to be done in this realm.

- do more

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

- NMC Cancer Committee
- NMC Diagnostic Imaging
- Northwestern Primary Care
- Northwestern Georgia Health Center
- Northwestern Pediatrics
- Northwestern OB/GYN
- Northwestern Dermatology
- Northwestern Associates in Surgery
- RiseVT Community Campaign to Embrace Healthy Lifestyles
- Northwestern Lifestyle Medicine

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

- **Certified Community Hospital Cancer Committee:** NMC continues to operate a community hospital cancer committee, certified by the American College of Surgeons. This involves meeting specific national standards relating to data, access to treatment, multi-disciplinary meetings, and outreach. Awareness efforts and screenings for colon cancer have been integrated into public communications and events. Promotion of the importance and availability of mammography has been ongoing.
- **Focus on Tobacco Prevention**: NMC employs a health educator to engage the community in tobacco prevention activities through a combination of hospital funding and grant funding. This includes policy- and systems-level work with youth, municipalities, schools, work places, retailers, and the decision makers. Successes include designation of "smoke free parks," active "OVX" (Our Voices Xposed) youth groups, smoke free work places, and more. The health educator also works to increase awareness through regular snippets in are newspapers and social media. Efforts also fund tobacco efforts with partner organizations that reach our community's most vulnerable populations, including Franklin Grand Isle Community Action and the Franklin Grand Isle Building Bright Futures Coalition. NMC's tobacco prevention expert also serves as the chairperson of Vermont's Tobacco Evaluation and Review Board, pushing for continued, comprehensive evidence-based efforts at the State level including policy-level interventions, such as increased tobacco prices, to cessation, media and local level initiatives. Recent data shows that for the first time, NMC's adult smoking rate is now below that of the State of Vermont.
- **Care Navigation:** NMC has hired a Breast Care Navigator to promote prevention efforts and early detection through wellness screenings. The Navigator is advancing clinical practice as well as ensuring women receive prevention and diagnostic interventions as well as guides the individual through the care path needed for evidenced based best practice.
- **Providing Tobacco Cessation Services**: NMC's Lifestyle Medicine Department provides local access to tobacco cessation services and integrated access to State-based tobacco cessation support. This includes individual and group counseling and support, access to free nicotine replacement, inpatient cessation services, and more. On-site cessation services are offered to local organizations and businesses transitioning to a tobacco free policy.
- **Facilitating The Vermont Blueprint For Health Implementation:** NMC has been the facilitating agent for the Vermont Blueprint For Health in our region, a State initiative to improve primary care, address chronic disease, and expand prevention through the implementation of evidence-based practices and achievement of certified

medical home status for primary care offices. Conditions such as smoking are key considerations with the Blueprint approach and therefore are now receiving additional focus within the primary care setting.

Anticipated results from NMC Implementation Strategy

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

NMC's Intervention strategy is envisioned to include:

- Continue the activities of NMC's accredited community cancer committee
- Expand access to mammography through the Breast Cancer Navigator and other strategies
- Increase referrals to screenings through partnership with the Vermont Blueprint for Health
- Increase community awareness of importance of early detection and available treatment
- Continue primary prevention work of advocacy, Healthy Retailing, Smoke Free Enviornments, etc
- Expand use of smoking cession by primary care referral through Lifestyle Medicine and Blueprint

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

- Colorectal cancer/screening data from OneCare Vermont Accountable Care Organization
- Breast cancer/screening data from OneCare Vermont Accountable Care Organization

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

- Death rates from cancer

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

Organization	Contact Name	Contact Information

Vermont Department of Health	Judy Ashley	524-7970
Vermont Blueprint for Health	Lesley Hendry	524-5911
Local Primary Care Providers	Multiple	Call 524-1280 for information
Vermont Center for Cancer Medicine	Dr. Dennis Sanders	524-0537

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

Organization	Contact Name	Contact Information
Jim Bashaw Fund	Sarah Jemley	524-1097

5. SUICIDE

59% of Local Experts voted to continue from 2012 as Need; 8th cause of death both Co. FRC ranks #4 worse in VT, GRI #8

Public comments received on previously adopted implementation strategy:

- I am impressed that NMC has participated in Mental Health First Aid courses.
- nothing to say
- NMC is engaged as an active partner.

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

- Northwestern Comprehensive Pain
- NMC Emergency Department
- Northwestern Primary Care
- Northwestern Georgia Health Center
- Northwestern Pediatrics

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

- NMC believes that its expanded work in narcotic addiction treatment and our related collaboration with The Howard Center, as well as our collaborative work on addressing mental health crisis care with Northwestern Counseling & Support Services, are particularly relevant to suicide prevention in our community. In addition, during his service to NMC, Dr. Bill Roberts was a leading advocate for the in-the-field use of overdose remedies by law enforcement, leading to the prevention of inadvertent suicides through accidental overdose. By expanding and improving care for those suffering from addiction and mental health concerns, we believe we can help improve the individual's quality of life and reduce the temptation of suicide.

Anticipated results from NMC Implementation Strategy

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

NMC's Intervention strategy is envisioned to include:

- Expand access to addiction services
- Continue embedded mental health care management in ED
- Implement embedded mental health care management in Primary Care
- Explore ways to support the work of key community partners

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

- Depression Screening from OneCare Vermont Accountable Care Organization

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

- Suicide Rate

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

Organization	Contact Name	Contact Information
Northwestern Counseling & Support Services	Ted Mable	524-6554
Turning Point	Karen Heinlein-Grenier	782-8454
Voices Against Violence	Kris Lukens	524-6575
Building Bright Futures	Beth Crane	876-5010

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

Organization	Contact Name	Contact Information
Local Law Enforcement	Multiple	
Local private psychologists and counselors	Multiple	
Local School Systems	Multiple	

6. DOMESTIC and SEXUAL ABUSE

69% of Local Experts voted to continue from 2012 as Need

Public comments received on previously adopted implementation strategy:

- I do not know how NMC has participated in actions to address this issue.
- we appreciate more than we can say the SANE program and the MOU that requires ED staff to contact us when domestic violence is suspected at UVMC, the SANE nurses screen for and document evidence of DV as well as SV they call us when a Grand Isle resident arrives (because GI is in our catchment area) in December, a forensic nurse there was able to document a victim's head trauma and interview her about previous assaults...the victim was terrified to make a statement to law enforcement about her husband, but not to talk to the nurse...because of the nurse's affidavit, he was arrested and has been held without bail since and is awaiting trial...the victim has "plausible deniabilty" and is able to say to her husband that she DID NOT speak to law enforcement and can divert the blame to the ED staff and ultimately back to him because he assaulted her to the point of needing a medical transport..she will not need to testify against him in court..her future,whether he is released or not, is much safer because of the ED procedure at UVMC it would be great if we worked more closely with NMC to find areas where we can support the services you provide and the service providers in their work
- Always need to be able to identify abuse. assist and support primary care providers to identify and know how to assist patients.
- Giving patients reasons to improve. Resources to leave- Start with the youth.

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

- NMC Emergency Department
- Northwestern Primary Care
- Northwestern Georgia Health Center
- Northwestern Pediatrics
- Northwestern OB/GYN

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

- NMC continues to be a financial sponsor of “Voices Against Violence / Laurie’s House,” the community organization focused on Domestic & Sexual Abuse.
- NMC’s Emergency Department continues its work through the Sexual Assault Nurse Examiners (SANE) program to assist victims of sexual assault and support law enforcement in the pursuit of justice relating to sexual assault.

- NMC believes that its expanded work in narcotic addiction treatment and our related collaboration with The Howard Center are particularly relevant to domestic and sexual abuse in our community. By expanding and improving care for those suffering from addiction, we believe we can help improve the individual's quality of life and reduce instances of abuse.

Anticipated results from NMC Implementation Strategy

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

NMC's Intervention strategy is envisioned to include:

- Continue the work of NMC Sexual Assault Nurse Examiners
- Identification and referral from ED, Primary Care, Pediatrics, OB/GYN, etc
- Explore ways to support the work of key community partners

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

- Response to Do You Feel Safe in Home from NMC Emergency Department and Practices

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

- Incidents of Domestic Violence
- Incidents of Sexual Assault

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

Organization	Contact Name	Contact Information
Voices Against Violence	Kris Lukens	524-6575

Northwest Unit of Special Investigations	Robert White	524-7961
Vermont Department of Children and Families	Kristen Pryor	527-7741
Local Law Enforcement	Multiple	

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

Organization	Contact Name	Contact Information
Local Primary Care Providers	Multiple	Call 524-1280 for information

Other Needs Identified During CHNA Process

7. **Access / Availability to Healthcare & Physicians** 66% of Local Expert voted to continue from 2012 as Need; GRI 4th peer worse; GRI pop. to Dr. ratio 7 times VT avg. pop. to DDS ratio 4.4 times VT avg.; FRC pop. to Dr. ratio 1.8 times VT avg., preventable hospital stays adverse to VT avg., prevent hospital use 10th worse among peers
8. **Health Insurance / Uninsured** 62% of Local Expert voted to continue from 2012 as Need
10. High Blood Pressure 62% of Local Expert voted to continue from 2012 as Need; GRI 9th cause of death highest in VT
9. **Coronary Heart Disease** 69% of Local Expert voted to continue from 2012 as Need; #1 cause of death both Co.; FRC highest VT rate GRI 2nd highest; FRC deaths worst among peers
10. **High Blood Pressure** 62% of Local Expert voted to continue from 2012 as Need; GRI 9th cause of death highest in VT
11. **Diabetes** #6 cause of death both Co., FRC #2 worse in VT; FRC deaths 3rd worse among peers
12. **Need Undefined by Local Expert**
13. **Physical Environment** GRI park access peer 2nd worse, FRC 3rd peer worse, stressed housing FRC 4th peer worse, FRC 2nd worse in VT all metrics, GRI adverse air pollution; FRI housing cost 3rd peer worse
14. **Behavior/Social** GRI treatment compliance beneficial for 56%; FRC peer 12th worse for adequate social support; FRC elderly depression peer 4th worse; FRC & GRI low college attendance; FRC few involved in social clubs
15. **Violent Crime** FRC 1.3 times VT avg
16. **Chronic Lung Disease / Chronic Asthma** 66% of Local Expert voted to continue from 2012 as Need; #3 cause of death both Co., GRI highest VT rate & higher than expected
17. **Alzheimer's** #7 cause of death both Co., GRI lowest VT death rate, FRC 3rd lowest
18. **Stroke** FRC #5 cause of death, GRI #4 cause of death highest VT rate; GRI deaths peer worst
19. **ER / Urgent Care** use GRI beneficial 31%, FRC adverse for 25%
20. **Teen Births** FRC above VT avg.
21. **Cholesterol, chronic,** high GRI above avg. for 23.2%
22. **Kidney** both Co. 10th cause of death FRC #2 worse in VT, GRI #3
23. **Doctors prescribe small doses –** a need identified from Local Expert opinion and comments
24. **Fall related injuries for Vermont seniors age 65 and older** account for nearly 5,000 emergency department visits, 1,600 injuries and 120 deaths each year, a need identified from Local Expert opinion and comments
25. **Premature death** GRI 2nd best in VT, FRC avg.
26. **Accidents** FRC #4 cause of death GRI #5; FRC auto deaths and Unintentional injury death adverse among peers but better than US avg.
27. **Homicide** GRI beneficial death rate
28. **Sexual Disease** FRC syphilis 9th peer worse; FRC disease rate adverse in VT

29. **Back Pain, Chronic** GRI below avg. for 22%
30. **Transportation** a need identified from Local Expert opinion and comments
31. **Liver** lower than expected death rate GR
32. **Blood Poisoning** FRC beneficial death rate
33. **Flu/Pneumonia** FRC #9 cause of death, beneficial death rate both Co.

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[40]

1. Mental Health & Substance Abuse (including opiate addiction)
2. Obesity
3. Smoking
4. Cancer
5. Suicide
6. Domestic and Sexual Abuse

Significant needs where hospital did not develop implementation strategy[41]

- None

Other needs where hospital developed implementation strategy

- None

Other needs where hospital did not develop implementation strategy

7. **Access / Availability to Healthcare & Physicians** 66% of Local Expert voted to continue from 2012 as Need; GRI 4th peer worse; GRI pop. to Dr. ratio 7 times VT avg. pop. to DDS ratio 4.4 times VT avg.; FRC pop. to Dr. ratio 1.8 times VT avg., preventable hospital stays adverse to VT avg., prevent hospital use 10th worse among peers
8. **Health Insurance / Uninsured** 62% of Local Expert voted to continue from 2012 as Need
10. High Blood Pressure 62% of Local Expert voted to continue from 2012 as Need; GRI 9th cause of death highest in VT
9. **Coronary Heart Disease** 69% of Local Expert voted to continue from 2012 as Need; #1 cause of death both Co.; FRC highest VT rate GRI 2nd highest; FRC deaths worst among peers
10. **High Blood Pressure** 62% of Local Expert voted to continue from 2012 as Need; GRI 9th cause of death highest in VT
11. **Diabetes** #6 cause of death both Co., FRC #2 worse in VT; FRC deaths 3rd worse among peers

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

12. **Need Undefined by Local Expert**
13. **Physical Environment** GRI park access peer 2nd worse, FRC 3rd peer worse, stressed housing FRC 4th peer worse, FRC 2nd worse in VT all metrics, GRI adverse air pollution; FRI housing cost 3rd peer worse
14. **Behavior/Social** GRI treatment compliance beneficial for 56%; FRC peer 12th worse for adequate social support; FRC elderly depression peer 4th worse; FRC & GRI low college attendance; FRC few involved in social clubs
15. **Violent Crime** FRC 1.3 times VT avg
16. **Chronic Lung Disease / Chronic Asthma** 66% of Local Expert voted to continue from 2012 as Need; #3 cause of death both Co., GRI highest VT rate & higher than expected
17. **Alzheimer's** #7 cause of death both Co., GRI lowest VT death rate, FRC 3rd lowest
18. **Stroke** FRC #5 cause of death, GRI #4 cause of death highest VT rate; GRI deaths peer worst
19. **ER / Urgent Care** use GRI beneficial 31%, FRC adverse for 25%
20. **Teen Births** FRC above VT avg.
21. **Cholesterol, chronic,** high GRI above avg. for 23.2%
22. **Kidney** both Co. 10th cause of death FRC #2 worse in VT, GRI #3
23. **Doctors prescribe small doses –** a need identified from Local Expert opinion and comments
24. **Fall related injuries for Vermont seniors age 65 and older** account for nearly 5,000 emergency department visits, 1,600 injuries and 120 deaths each year, a need identified from Local Expert opinion and comments
25. **Premature death** GRI 2nd best in VT, FRC avg.
26. **Accidents** FRC #4 cause of death GRI #5; FRC auto deaths and Unintentional injury death adverse among peers but better than US avg.
27. **Homicide** GRI beneficial death rate
28. **Sexual Disease** FRC syphilis 9th peer worse; FRC disease rate adverse in VT
29. **Back Pain, Chronic** GRI below avg. for 22%
30. **Transportation** a need identified from Local Expert opinion and comments
31. **Liver** lower than expected death rate GR
32. **Blood Poisoning** FRC beneficial death rate
33. **Flu/Pneumonia** FRC #9 cause of death, beneficial death rate both Co.

APPENDIX

Appendix A – Written Commentary on Prior CHNA

Hospital solicited written comments about its 2012 CHNA.[42] 29 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, skip the indication and please continue to the next question.

Respondent Characteristics	Yes (Applies to Me)	Percent Responding YES	No (Does Not Apply to Me)	No Opinion	Total Participants
1) Public Health Expertise (public health dept volunteers / employees, one holding an MPH degree and/or employed in a capacity where one is required)	6	21%	15	8	29
2) Departments and Agencies Federal, tribal, regional, State or local agencies with relevant data/information regarding health needs of the community served by the hospital	11	38%	14	4	29
3) Priority Populations (represented by public elected officials, religious officials, long term care / work shelter executives; and/or members of LGBT community, medically underserved, low income, minorities)	6	21%	13	10	29
4) Representative of or member of chronic disease group or organization	4	14%	18	7	29
5) Broad Interest of the Community (school system exec's, employers, leadership of civic organizations, voluntary health groups, Chamber of Commerce, Industrial Development)	15	52%	10	4	29

2. Within the two Counties of Grand Isle and Franklin, do you perceive the local Priority Populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.

- Abenaki Indian population and under 50 self neglect patients.
- affordable housing for elderly, families and low/moderate income is desperately needed
- Domestic Violence survivor's and their children and drug addicts and their children. Collaboration between community partners.
- generational poverty, substance abuse, and domestic violence are creating perfect storms of mental and physical health problems...the ACE study clearly shows the long-term effects on the body and the correlating need for extensive health care i consider this a public health crisis in our community and would look to our Medical Center to take the lead in creating the public health response
- I really worry about the impact on rural poverty. Lack of transportation and services available for these individuals is a real problem. I'd like to see more outreach supports in our poorer towns such as Alburg and Richford in particular.
- I would identify people with unstable housing as a "priority population". Of course the issue goes much deeper than just housing. We see an increasing trend where people with serious socio-economic needs are being pushed to areas of the county where rent is very cheap which makes sense if you are just thinking about getting

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

a roof over a person's head for the lowest possible cost. Unfortunately these towns with low rent have very little in the way of employment opportunity and none of the social support systems required by this population. I just had an opportunity to meet a man who had been homeless until the middle of this past winter. He now is working with Pathways and has an apartment the size of a big bedroom and a $70/week allowance which he basically drinks. Though he lives in a building with other people he is basically isolated, lonely, and so depressed he burst into tears within minutes of the beginning of our conversation. This is one example, there are many other similar situations like re-entry from corrections, mental/behavioral clients, and patients with serious medical needs where people are "placed" in cheap or transitional housing with little or no support.

- low income, rural, children Outreach must be done by any service organization including health, education and government These folks can not get to the services they need and may not even know about services due to isolation
- Making treatment services available to everyone who suffer from addiction, I find that it is difficult for people to navigate the process in which to find and receive treatment services.
- n/a
- Obesity and Drug Addiction
- One issue I believe confronting priority populations is chronic disease management. We have many people attending our adult day who have diabetes, respiratory problems, heart disease and neurological health problems. A non-health need is safe housing that meets people's needs.
- Opiate addiction is out of control and we need other treatment options and long term residential treatment programs. We need to stop prescribing suboxone to most everyone who is addicted to opiates. Many people are diverting it and some people are getting addicted to suboxone as their first opiate.
- population with low health literacy non English speaking population of farm workers have difficulty accessing health care services. I would like to see leadership from the hospital and the farming community
- -substance abuse assistance -financial and housing assistance -legal assistance
- The elderly, minors, homebound
- The unchecked items are not unimportant, however, checks indicate highest priorities in my perception.
- There are free workshops available that address chronic conditions and how to deal with them. (The Healthier Living series sponsered by VT Health Dept). Many are canceled due to lack of sign ups. We need physicians on board and refering their patients to these workshops.
- There are groups of people placed in substandard housing in small communities with no support system. Corrections, community mental health and other social service agencies need to pool resources to work with this population.
- Transportation to and from hospital and medical appointments can be an issue for those situated in rural areas not served by bus line.
- Unique issues where we need a a social worker to get these patients to the respectable locations for special treatments; for example: dental social worker and nutritional Counselors to treat chronic dental problems outside ER. Prevention!

- unknown
- We need to focus on the individuals first. With good housing, food and work opportunities brings a healthier person. The list above are like silos and focusing on one will not bring the population to a higher standard of health.
- where can i find information on how these areas have been addressed in the last 3 years?
- YES
- Yes. A majority of the "priority populations" listed above are at greater risk for negative health impacts, as they have higher risk factors impacting health. Typically, priority populations use tobacco at higher rates, have poorer access for healthy food, have limited ability for regular physical activity and may be impacted by a variety of other factors. Supporting priority populations in achieving lifelong health requires an integrated and strong system as well as long-term commitment.

3. **Specific comments or observations about Mental Health & Substance Abuse as being among the most significant needs for the Hospital to work on to seek improvements?**
   - We must achieve better collaboration among providers (NCSS, NMC, NOTCH and private practices to provide these services.
   - Work with ncss and the Howard center
   - It seems that some people are falling through the cracks, especially with mental health needs. Current resources do not seem to be adequately meeting the needs of many individuals.
   - This issue is definitely at the root of many of the issues we face in Franklin and Grand Isle Counties. I would suggest adding "Behavioral Health" as well.
   - Although that topic is of utmost importance in our community and a major impact to good health, NMC has limited expertise in contributing to its solution. I believe NMC should be a partner in addressing MH & SA, but I don't think it is where we can be most impactful.
   - We need to get people away from substance abuse. I'm concerned that providing them legal drugs that they use seemingly forever is just replacing one drug addiction for another.
   - All narcotic prescribers should be required to used the states drug registry. All narcotic prescribers should be familiar alternative to opiates for pain management.
   - Medically assisted treatment and opiate addiction is one of our biggest societal woes in Franklin/Grand Isle county.
   - absolutely agree that this is one of the most significant needs love that there are medical social workers at NOTCH programs hate that the waiting list for a counselor through NCSS is almost 8 months hate that there are not enough therapists trained to work with mental health AND substance abuse problems hate that there are not enough therapists who understand the dynamics of domestic violence hate that the medical community doesn't see the underbelly of what the suboxone/methadone programs are doing to our community (diversion of medication, ongoing culture of addiction rather than recovery)

- Mental Health and substance abuse plague those involved and the community at large, costing many dollars if left unaddressed.
- Ability to identify patients and connect them with necessary resources.
- High on list
- Quick access to services including medication for mentally ill folks who are homeless. Focus on how to help opiate addicts get clean without using suboxone. Only use suboxone for detox.
- As long as we have increased numbers of addiction we will need continued resources applied to Mental Health and Substance Abuse.

4. **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Mental Health & Substance Abuse.**
   - Long term solutions have not succeeded at hospital leve.
   - NMC needs to support the agencies that are doing good work. There can not be douplication
   - Need more community supports. Housing seems to be a big issue.
   - Would suggest working closely with NCSS/Howard Ctr
   - Outreach into schools and local community is key.
   - we need more transportation for people to get to and from treatment
   - see above!
   - Stigma is prevalent and poses an obstacle to treatment and services
   - Need to find appropriate facilities for these patients
   - Target young- 16-29 year olds And target them with family counseling. "How to!" So they have ways to improve their situation.
   - I feel the additional resources being offered through the Comprehensive Pain Clinic are a good improvement towards a healther population of substance abusers and people with mental health issues.

5. **Specific comments or observations about Access/Availability to Healthcare & Physicians as being among the most significant needs for the Hospital to work on to seek improvements?**
   - I believe there is adequate access access/availability in St. Albans, particularly with the two new Urgent Care facilities. This issue is no longer significant.
   - There is an excess of Primary care. The walk in clinics do not support the patient center medical home and if it continues NMC should demonstrate that all patients information get back to the PCP. NMC must do better with reducing ED visits. There are models in this country that have proven it can be done.
   - There remains a shortage of primary care providers for adults in Franklin co.
   - We have done well with increasing our number of providers as well as the addition of the Urgent Care clinic, to provide access to healthcare.

- we need more and better transportation options for folks.
- absolutely agree that this is one of the most significant needs
- Organizations must be able to "bill" for services resulting in the wrong services or lack of services including preventive medical care.
- Signifivpcant improvements made, increased hours with practices and urgent care facilities.
- I do not see this as a significant need
- I think this continues to be an issue to address. Even as access/availability improved, changes in 1-2 large practices are major set-backs. I think a strong network with strong primary care relationships is how individuals begin maintain good health.
- Too many people in poverty don't get the medical attention they need - for a variety of reasons. More connection to local communities and transportation support are necessary.

6. Specific comments and observations about the implementation actions of the Hospital seeking improvement in Access / Availability to Healthcare & Physicians?

- I believe that NMC competes with private practices.
- There have been noticeable improvements!
- The hospital could encourage providers to offer more clinical rotation and experience for UVM health profession students - a great opportunity for students to learn about our community and the health needs/challenged therein as well as a great potential for future recruitment.
- more doctors and nurse practitioners are needed
- opening NOTCH clinics has been HUGELY helpful in improving health care for folks who have limited transportation
- This may be addressed as an outreach program.
- NMC has been instrumental and a leader. has assisted the transit of primary care practices and their patients to other pri ary care options.

4. Specific comments or observations about Obesity as being among the most significant needs for the Hospital to work on to seek improvements?

- Encourage community participation in the Diabetes Prevention Program, Heathier Living with Diabetes, and the other healthier living workshops. I will tell you, that, as much as I have heard it is not, eating healthy is expensive. We are on a rigid, managing diabetes with diet (no medication) plan - and it certainly costs more.
- Certainly this is a significant need
- Obesity continues to plague our region, from childhood through adulthood. It is a major risk factor in heart disease, diabetes, and cancer. We cannot make improvements on those aspects of health without working to

address the very complex issue that is obesity. It continues to be among the most significant needs in our region.

- Major problem in schools - especially in our poorer communities.
- it's big, but not as big as some of the other issues (pun intended)
- Continues to be a root cause of health concerns.
- Treatment should be moving. It should be high on the list.
- We offer plenty of healthy food choices in our cafe as well as access to CSA offerings and additional fitness offerings.

5. Specific comments and observations about the implementation actions of the Hospital seeking improvement in Obesity.

- RISE is probably a good activity.
- I have seldom eaten in the Courtyard Cafe, but know they do offer healthy choices. I do think the empty calorie choices should be very limited or eliminated. Gradually would cause less uproar.
- We need more access to a variety of activities that are free. This is a tough one. This is where the "Behavioral" component comes into play. Many of these Chronic Diseases can be greatly affected/avoided with behavior modification but this is more an art than science and requires people that are very good at motivating other people.
- NMC has stepped up its leadership in obesity prevention in the past two years as it supports its community-wide, evidence-based strategies both through large-scale funding of RiseVT, but its personnel support for community-based strategies and the Healthy Roots (farm to table) initiatives. Staff and expertise are more widely available within our community to make the sustainable changes that support more physical activity and healthy eating, the major components of obesity.
- public awareness on obesity as it related to certain cancers in addition to chronic disease. Provide Motivational Interviewing tool for all providers
- I LOVE the RISE program, more of this in more areas, not just st. albans proper
- from my work with families, i know that the energy for providing healthy meals for children is low cheap, pre-packaged food is tantalizing when you have a limited budget, limited time for cooking and cleaning, lmited mental availability for planning meals, and kids screaming in the grocery store so Hot Pockets and french fries and bug juice are a fabulous solution but the solution creates the obesity crisis getting under-privileged families to the exercise programs and nutrition programs outlined in your planned approach should be considered
- Rise Vermont is a key initiaitive Providing various workshops and programs
- Treatment should be walking with patients, and not sitting in a class or in a doctors office waiting.

6. **Specific comments or observations about Smoking as being among the most significant needs for the Hospital to work on to seek improvements?**

- Don't smoke, so no information. I do know that it is very difficult to get people to stop.
- Certainly this is a significant need
- Tobacco use continues to be the number 1 cause of death in VT and in our region. It is still the major risk factor in heart disease, cancer, COPD and acute childhood respiratory infections. Its impact is a major driver of health care costs. NMC cannot address many of its other significant needs without effectively addressing tobacco. Furthermore, although tobacco use rates among
- i appreciate the tobacco money, but i don't think it's a major area of concern lung cancer, however, IS a concern
- Should be a supportive role and not leading initiative
- Preventing kids from using E-cig. Lobbying for tougher laws.
- We have had continual representation in the business and professional community as well as public to provide ongoing education in the area of tobacco cessation.

7. **Specific comments and observations about the implementation actions the Hospital seeking improvement in Smoking**

- Work more closely with PCP's Blueprint staff to identify and target potential candidates for Quit activities. This is where the "Behavioral" component comes into play. Many of these Chronic Diseases can be greatly affected/avoided with behavior modification but this is more an art than science and requires people that are very good at motivating other people.
- NMC has supported the Franklin and Grand Isle Tobacco Prevention Coalition for nearly 15 years. Community norms around tobacco use are improving, but there is still more work to be done. NMC has been a strong model for reduced tobacco use as a hospital and as an employer which has provided good support for other organizations to follow the same path. Additionally, NMC has been a leader in pursuing strong and evidence-based strategies for our state which would decrease tobacco use, such as more smoke-free areas and higher tobacco prices.
- as Dr. Felitti would say, smoking is a solution to a public health crisis address the underlying reasons folk need to smoke (anxiety reduction, stress relief, appetite suppressant, anger management)
- There are various programs for smoking cessation. this should be an initiative advocated by primary care doctors.
- Lobbying for tougher laws.
- Chari Andersen does inpatient consults with smokers as well as sees patients on an outpatient basis 1:1 and also offers monthly classes throughout the community for the public as well as in corporations that express the need to have cessation representation on site. She also does 1 time information sessions at any location where a need is expressed or identified. Chari also does routine marketing in the community to keep offices and organizations up to date with proper advertising of available resources.

8. **Specific comments or observations about Cancer as being among the most significant needs for the Hospital to work on to seek improvements?**

- Cancer rates continue to be high in our region, as are cancer death rates. Many types of cancer are preventable or detectable at an early stage. There is more work to be done in these areas (see obesity and tobacco comments)
- as a woman, i'm ready to move out of VT just because of the god-awful number of breast cancer survivors here
- Cancer is prevalent in our Counties,
- Early screenings. Education and good systems to treat.

9. **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Cancer.**

- Although the hospital has been growing in its tobacco and obesity implementation leadership, our region still struggles with low cancer screening rates. There is more to be done in this realm.
- do more

10. **Specific comments or observations about Health Insurance / Uninsured as being among the most significant needs or the Hospital to work on to seek improvements?**

- Cost of insurance is a significant issue.
- Now on medicare. I do know that navigating VT Health Connect was very challenging - also more expensive than catamount. I have heard that some complanies are implementing standards, such as weight (not necessarily a healthy weight, but not obese,either)
- Those without health insurance or who are underinsured are less likely to access care - including primary care or cancer screenings (see above). That means that when they do access care, they may be more acute or further along in a disease state, with higher complexity and higher costs. Although ACA helps insure many more people, ensuring that high deductibles don't impact care is still essential.
- i'm not really sure how i feel about this one i think health care should be a right
- Not a primary issues. MPNMC has various programs to assist patients that need charity or financial assistance.
- Unsure numbers

11. **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Health Insurance / Uninsured.**

- I believe this is a mental health issue.
- I have no comments.
- i think the NOTCH clinics have made a big impact on the number of ED visits in spite of the excellent public awareness campaigns, many of the families i serve still see the ED as the place to go for immediate care where

is Vermont in getting a CVS Minute Clinic or Walgreen's Healthcare Clinic? those are freaking awesome resources

- NMC is well engaged in health care.

12. Specific comments or observations about Suicide as being among the most significant needs for the Hospital to work on to seek improvements?

- I have no specific comments.
- unless NMC sees suicide as an indicator of poor public health (which includes mental health) access, then yall should maintain your "not within our direct scope of expertise" stand but i think suicide is certainly a symptom
- We need to be a collaborative partner with all agencies. need to be a continued resource.

13. Specific comments and observations about the implementation actions of the Hospital seeking improvement in Suicide.

- I am impressed that NMC has participated in Mental Health First Aid courses.
- nothing to say
- NMC is engaged as an active partner.

14. Specific comments or observations about Domestic and Sexual Abuse as being among the most significant needs for the Hospital to work on to seek improvements?

- It is still a relevant issue faced by our community.
- goodness gracious, YES!! victims/survivors suffer chronic physical health concerns resulting from years (or a even a lifetime) of living in toxic environments the corresponding mental health issues are untreated due to the lack of appropriately-trained clinicians self-medicating is rampant among this population parents are often emotionally unavailable to their children and often less able to parent adequately
- We need to work with other agencies but can not be the lead.

15. Specific comments and observations about the implementation actions of the Hospital seeking improvement in Domestic and Sexual Abuse.

- I do not know how NMC has participated in actions to address this issue.
- we appreciate more than we can say the SANE program and the MOU that requires ED staff to contact us when domestic violence is suspected at UVMC, the SANE nurses screen for and document evidence of DV as well as SV they call us when a Grand Isle resident arrives (because GI is in our catchment area) in December, a forensic nurse there was able to document a victim's head trauma and interview her about previous assaults...the victim was terrified to make a statement to law enforcement about her husband, but not to talk to the nurse...because of the nurse's affidavit, he was arrested and has been held without bail since and is awaiting trial...the victim has "plausible deniabilty" and is able to say to her husband that she DID NOT speak to law enforcement and can

divert the blame to the ED staff and ultimately back to him because he assaulted her to the point of needing a medical transport..she will not need to testify against him in court..her future,whether he is released or not, is much safer because of the ED procedure at UVMC it would be great if we worked more closely with NMC to find areas where we can support the services you provide and the service providers in their work

- Always need to be able to identify abuse. assist and support primary care providers to identify and know how to assist patients.
- Giving patients reasons to improve. Resources to leave- Start with the youth.

16. Specific comments or observations about Coronary Heart Disease as being among the most significant needs for the Hospital to work on to seek improvements?

- Certainly this is a significant need
- Heart Disease is still the #1 killer of our community's residents. Its issue should receive high attention.
- if it's the #2 killer, then it is a significant need
- Heart disease is important to our community.

17. Specific comments and observations about the implementation actions of the Hospital seeking improvement in Coronary Heart Disease.

- This is where the "Behavioral" component comes into play. Many of these Chronic Diseases can be greatly affected/avoided with behavior modification but this is more an art than science and requires people that are very good at motivating other people. Using community collaboratives and the RCPC as a means to develop community wide protocols for dealing with specific chronic diseases so the patient hears the same message no matter where they go, theoretically if done right this should decrease duplication and overall utilization of services while improving health status. To be effective a true protocol would have to be developed and followed by all players and would need to include emergency and inpatient care and have a big focus on providing the right care at the right time in the right setting. This will affect the hospital's bottom line but if we are to be successful in improving the health of our communities the hospital needs to be OK with that.
- NMC has been a leader, and should continue to be, in addressing the risk factors of CHD - tobacco use and low physical activity/poor nutrition.
- no specific comment other than continue to look at it through a public health lens and focus on poverty and child welfare as being ground zero in your prevention efforts
- NMC CEO is a champion on heart disease.
- Education, awareness, dietary and nutritional counseling and exercise needs- Rise Vt moving more.

18. Specific comments or observations about Chronic Lung Disease and Chronic Asthma as being among the most significant needs for the Hospital to work on to seek improvements?

- Certainly this is a significant need

- Much like Heart Disease, COPD and Asthma continue to be major diseases of our community, causing death and disability, including low worker productivity and high health costs. It should continue to be a focus area.
- why is it so high in Grand Isle?

19. Specific comments and observations about the implementation actions of the Hospital seeking improvement in Chronic Lung Disease and Chronic Asthma.

- see Q 23
- NMC has been a leader, and should continue to be, in addressing the risk factors of CHD - tobacco use and low physical activity/poor nutrition.
- again, look at the root causes of smoking and address those needs in communities

20. Specific comments or observations about High Blood Pressure as being among the most significant needs for the Hospital to work on to seek improvements?

- Certainly this is a significant need
- High Blood Pressure is a major risk factor in Heart Disease, still our region's #1 killer. NMC should continue to be a focus area through an emphasis on obesity prevention and tobacco control.
- no specific comments
- Kidneys failure, high BP, stroke are all related. And is important in the community.

21. Specific comments and observations about the implementation actions of the Hospital seeking improvement in High Blood Pressure.

- I think that periodic blood pressure clinics are a good idea - don't know if you do them now or not.
- see Q 23
- NMC has been a leader, and should continue to be, in addressing the risk factors of HBP - tobacco use and low physical activity/poor nutrition.
- no specific comments
- Need t work with primary care.
- Awareness, nutrition - consistent high bp leads to kidney failure. Have availability of primary physicians to treat these patients when they need treatment.

22. Finally, after thinking about our questions and the information we seek, is there anything else you think important as we review and revise our thinking about significant health needs within the two Counties?

- nothing else

- The biggest thing is for everyone to work together. The new electronic records seem to be a great step in allowing all providers access to the same information. It might (hopefully) help with prescription abuse, since all providers know all prescribed medications.
- Healthcare is changing, it is no longer about just being there and being open or throwing money and resources at a problem. To make improvement in the needs mentioned in this survey we must truly engage people and somehow get Franklin and Grand Isle counties to want to be healthier. I know, easy to say, very difficult to do.
- not at this time.
- LGBQT sensitivity and support non-gendered restrooms, forms that allow for answers beyond the gender binary, etc
- Outreach and home visits are research based and proven to work. The Nurse Family Partnership is a good example of this.
- Are we prepared to meet the needs of our aging population?
- The more community involvement, the less you will see in all of the trouble categories. Keep people engaged and involve them in healthy and fun choices and families will strive. Also, I think we need to have a strong infrastructure on young women with drug problems. They need to be nurtured to prevent unplanned pregnancy and relapsing into depression and drug use.
- that we keep up what we are doing and continue to provide the support necessary in all areas of identified needs to better serve our poplulation in our community.
- Please carefully consider the cost of health care when taking on large scale construction projects. These projects are funded by increasing the costs of the services provided. There is a fine line and at some point we are going to tip over to the side where it's just too costly to get the services that folks need. I agree the hospital is an important piece in our community. I also see health care increasing becoming like college, going up at such a rate that only the top % earners can afford.

Appendix B – Identification & Prioritization of Community Needs

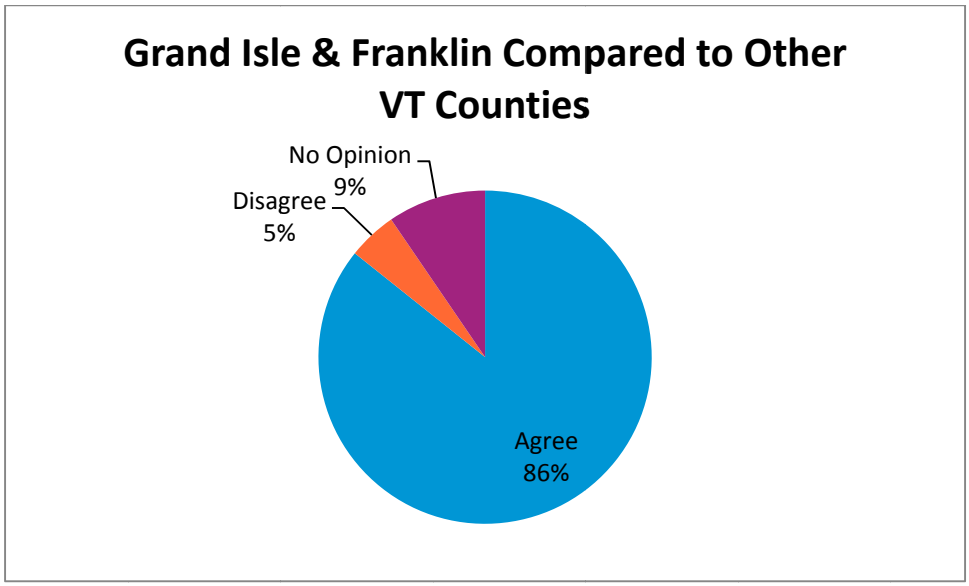
Identified Community Need	Votes	Voters	Cumulative Votes	Percent of total votes	Need Determination
MENTAL HEALTH & SUBSTANCE ABUSE inc. Opiate Addiction	485	16	485	30.3%	Significant Need
OBESITY	182	12	667	41.7%	
SMOKING	107	10	774	48.4%	
CANCER	92	9	866	54.1%	
SUICIDE	80	9	946	59.1%	
DOMESTIC AND SEXUAL ABUSE	78	10	1024	64.0%	
ACCESS / AVAILABILITY TO HEALTHCARE & PHYSICIANS	54	8	1078	67.4%	Other Identified Need
HEALTH INSURANCE / UNINSURED	51	7	1129	70.6%	
CORONARY HEART DISEASE	49	6	1178	73.6%	
HIGH BLOOD PRESSURE	48	6	1226	76.6%	
DIABETES	40	7	1266	79.1%	
Need undefined by Local Expert	40	1	1306	81.6%	
PHYSICAL ENVIRONMENT	32	5	1338	83.6%	
BEHAVIOR/SOCIAL	31	7	1369	85.6%	
VIOLENT CRIME	31	5	1400	87.5%	
CHRONIC LUNG DISEASE / CHRONIC ASTHMA	25	5	1425	89.1%	
ALZHEIMER'S	23	5	1448	90.5%	
STROKE	23	3	1471	91.9%	
ER / URGENT CARE USE	19	4	1490	93.1%	
TEEN BIRTHS	17	4	1507	94.2%	
CHOLESTEROL, CHRONIC, HIGH	14	4	1521	95.1%	
KIDNEY	11	2	1532	95.8%	
Doctors prescribe small doses	10	1	1542	96.4%	
Fall related injuries for Vermont seniors age 65 and older account for nearly 5,000 emergency department visits, 1,600 injuries and 120 deaths each year.	10	1	1552	97.0%	
PREMATURE DEATH	9	3	1561	97.6%	
ACCIDENTS	9	2	1570	98.1%	
HOMICIDE	8	2	1578	98.6%	
SEXUAL DISEASE	7	2	1585	99.1%	
BACK PAIN, CHRONIC	5	1	1590	99.4%	
Transportation	5	1	1595	99.7%	
LIVER	3	2	1598	99.9%	
BLOOD POISONING	1	1	1599	99.9%	
FLU/PNEUMONIA	1	1	1600	100.0%	

Individuals Participating as Local Expert Advisors[43]

Local Expert Characteristics	Yes Applies to Me	% of Local Experts Represented	No Does Not Apply to Me	No Reply	Total Responses
(1) **Public Health** - Persons with special knowledge of or expertise in public health	5	24%	9	7	21
(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	10	48%	6	5	21
(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.	9	43%	6	6	21
(4) **Chronic Disease Groups** - Representative of or member of Chronic Disease Group or Organization, including mental and oral health.	4	19%	9	8	21
(5) **Represents the Broad Interest of the Community** - Individuals, volunteers, civic leaders, medical personnel and others to fulfill the spirit of broad input required by the federal regulations.	14	67%	5	2	21

Advice Received from Local Expert Advisors

Question: *Do you agree with the observations formed about the comparison of Grand Isle and Franklin Counties to all other Vermont counties?*



Comments:

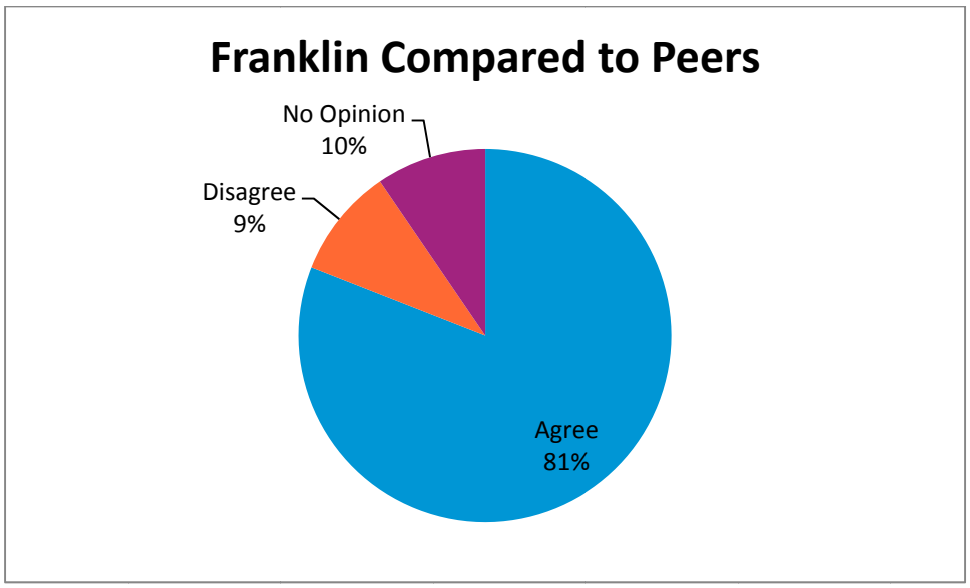
- Would be important to disaggregate populations within Franklin-Grand-Isle counties. The Abenaki, for instance, have not had an adequate needs assessment performed in several decades. Overall, there is a disjointed feeling whereas disparate agencies do their thing with little understanding of what others are doing which can only

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

contribute to the ongoing low ranking of folks living in Franklin County, in particular.

- As you identify, the Grand Isle data can be misleading because of the small numbers.

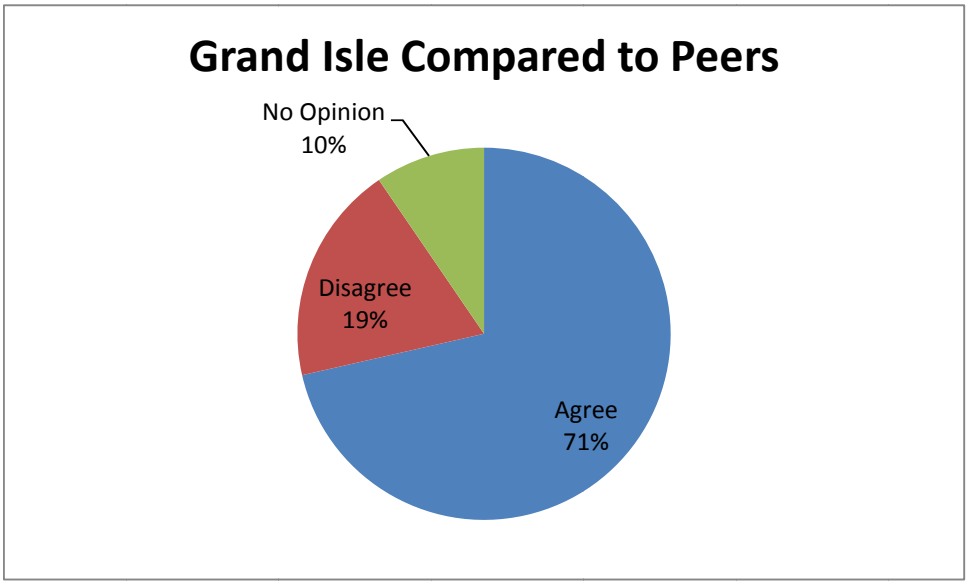
Question: *Do you agree with the observations formed about the comparison of Franklin County to its peer counties?*



Comments:

- Not sure if you saw this in case it helps: http://healthvermont.gov/research/documents/health_trends_vt_2010.pdf Broken down by HSA. For Health Behaviors: % reported not eating 5+ fruits & veg daily, (ST Albans HSA ranked last); again broken down by HSA, % with no physical activity in leisure time (St Albans HSA ranked last).
- Sobering information which indicates need for ongoing collaborative planning. I hope this is simply not an exercise that must be completed for regulatory purposes and then goes nowhere only to be resurrected the next time it must be pulled out for certification purposes....
- This data is unclear as to which County it refers.
- I question that we do better on in the uninsured category and worse on access to parks. Also, over the years I have heard repeatedly that our high school graduation rates are not good. I am not sure what the definition is of "on-time" high school graduation.

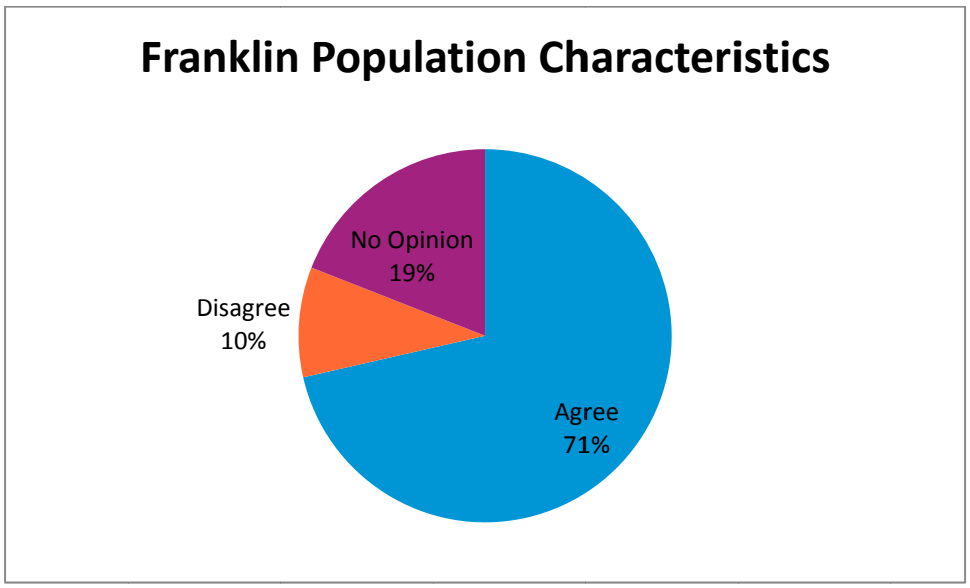
Question: *Do you agree with the observations formed about the comparison of Grand Isle County to its peer counties?*



Comments:

- The Social Factors do not seem better from the focal point of the school.
- housing and transportation are real barriers to better outcomes for those living in the islands
- It is difficult for me to discern certain data when I have little baseline information. There is a dizzying array of information that the rankings utilized do not clarify very well.
- I was unable to go back in the survey but I thought the previous page said we were doing better with strokes and this one says worse. I question that we are doing better with diabetes and pap tests. Also, question all the "better" under social factors and physical environment.

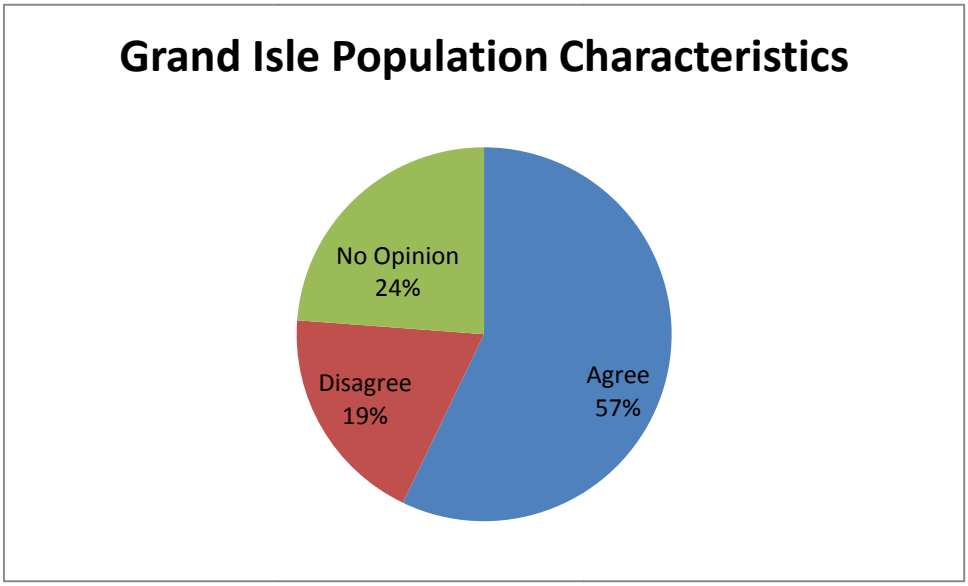
Question: *Do you agree with the observations formed about the population characteristics of Franklin County?*



Comments:

- That Franklin County is listed as a population with above average income figures is puzzling and goes against the prevailing wisdom which links income to all of the depressing statistics presented herein. I am unfamiliar with the Claritas Prizm customer segmentation data source which may reinforce a sense that the statistical ranking methodologies are neither valid nor reliable...
- The largest minority Hispanic? Really? What is the age group of the Claritas Prizm data? Over 18? I don't think we are doing better in consumed alcohol in past 30 days or use of tobacco.

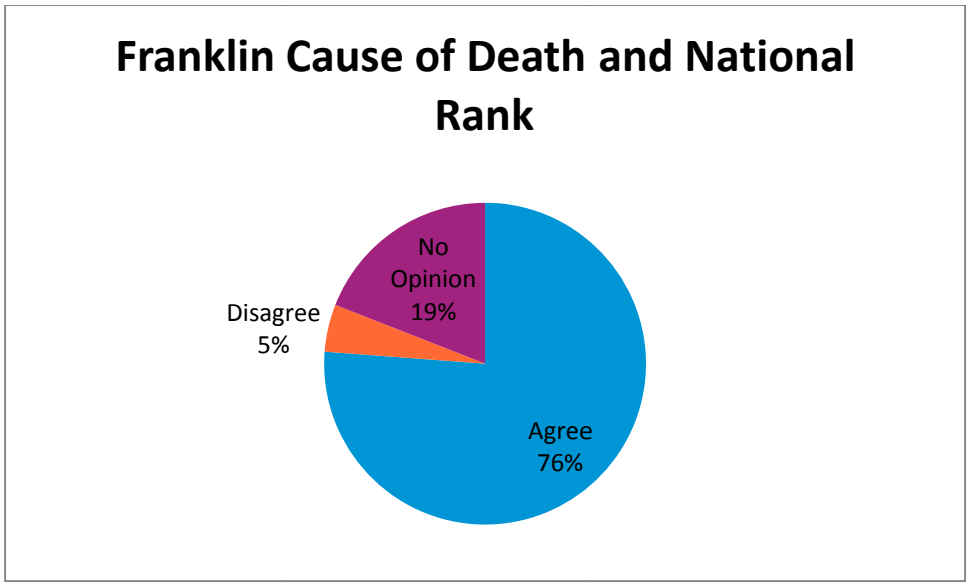
Question: *Do you agree with the observations formed about the population characteristics of Grand Isle County?*



Comments:

- Again, I have little baseline information nor good understanding of methodologies utilized to discern the information being presented.
- You state the median household income is 65k and is less than the VT median income which is 57k. 65k is greater than 57k.
- I have not looked at Grand Isle county data at this level so it is difficult to determine whether I agree or not.

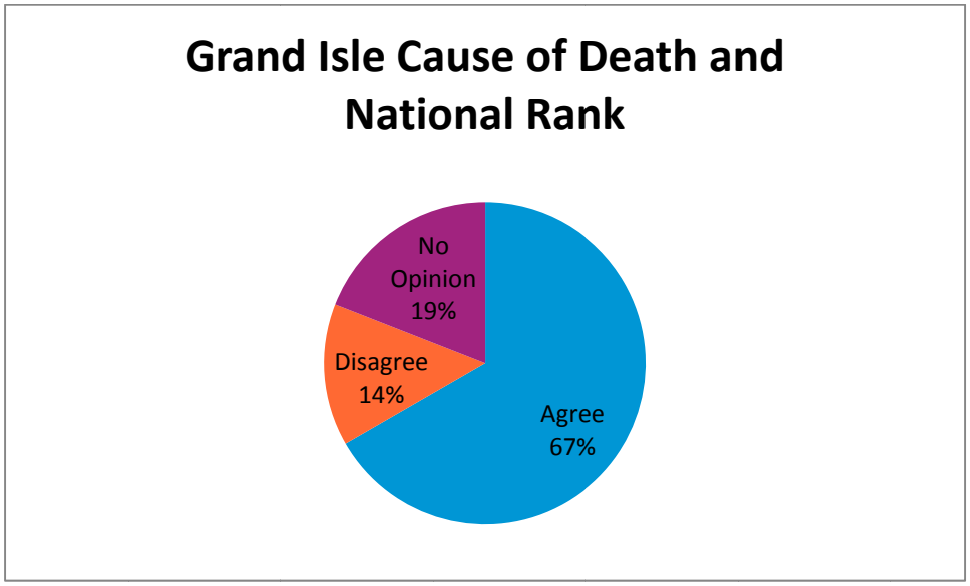
Question: *Do you agree with the observations formed about the cause of death and national ranking of Franklin County?*



Comments:

- The heart, diabetes, kidney, and cancer information appears accurate; I am surprised that the "stroke" ranking is lower than what I had previously understood. Further, I believed the Franklin County suicide rate to be highest in the State of Vermont so the ranking presented here was a surprise. The decline in smoking among men and women is not a surprise as here the County efforts have been well-coordinated and consistent over a steady and long period of time. NMC has run point here and done a very impressive job....

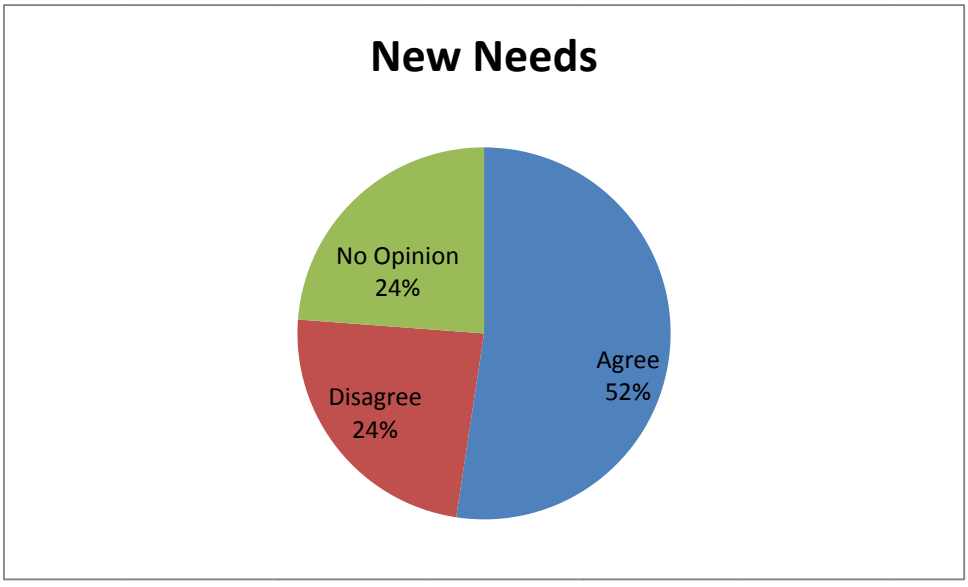
Question: *Do you agree with the observations formed about the cause of death and national ranking of Grand Isle County?*



Comments:

- As delineated earlier, I believe these data to be accurate and sobering, indeed. The only information that garners a sense of optimism is again the decline in rates of smoking for both men and women.
- There are 3 #1 causes of death.... Are they all tied?
- Unable to determine

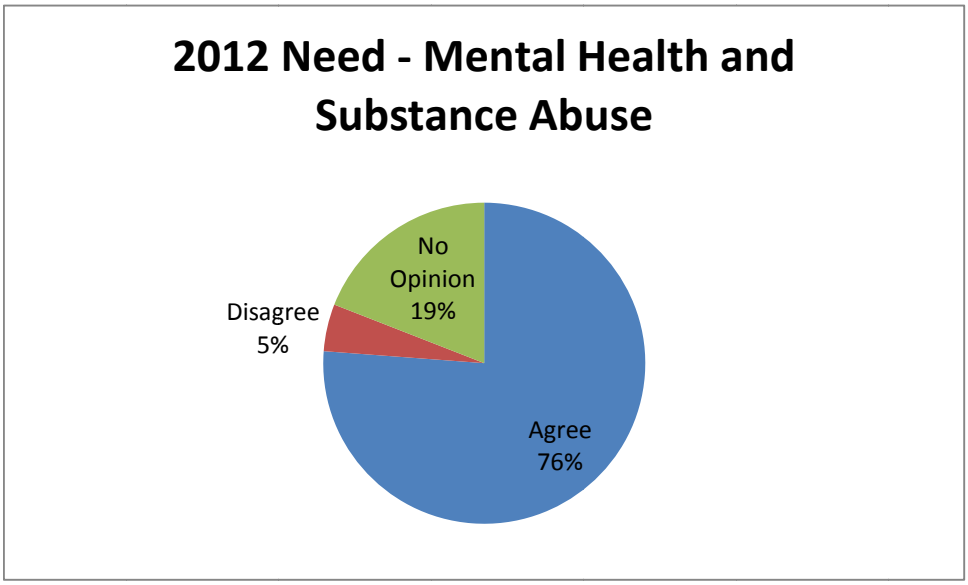
Question: *After reviewing comments about new needs to which the hospital could respond, do you agree?*



Comments

- EMR has reduced communication among medical providers leading to worse care. it is only used to "cover their @#$!" We need to reduce the stigma around getting assessment and treatment for mental health and substance abuse. Until we treat these like medical conditions rather than a lack of control or self regulation we will go nowhere! we are no where near where we need to be to address our aging population or youth in transition. we need halfway houses, affordable safe sustainable housing and teen centers.
- The comments appear to be consistent with overall sense that County health issues continue to border on tragic proportion. Despite the heroic and herculean efforts of some, the grim picture portrayed demands a call to action not for the faint of heart....As usual, it is NMC that typically coordinates yet there are signs that NCSS is picking up the slack in certain areas. The grassroots effort that is the only way to assure efficacy appears problematic....
- One of my assumptions is that medical health and healing is strongly influenced by positive and supportive human relationships. Community support and home health care are among the most significant factors in achieving priorities.
- I especially agree with the community-building approach to approaching the prevention of morbidity and mortality.
- I agree with the 2012 priorities but reserve judgement on a few of the opinions.
- continuing to work within health care reform and building partnerships/strengthening with agencies that work to improve overall well being of individuals and their families: families with young kids, pregnant moms, young pregnant teens., teens in general. working to improve referrals, consolidated plans of care and look at family vs individual.
- Attention needs to be given community wide regarding the epidemic of available, prescription (oxy for example) and illegally obtained (heroin for example), drugs at the street level abuse quantities. It is easier for the abusers to get these drugs on the street than it is by valid prescription.So what is happening is many of those who obtain "valid" prescriptions convert to street sales because it is so easy for them to get a "valid" refill once they are in the "valid" system. Someone needs 3 days of painkiller prescribed, they get 30 instead.....and sell the rest.... The hospital makes money, the pharmaceutical company makes money, the doctor makes money and the DRUG DEALER makes money... the street user increases their dependence and needs more and another "valid" user gets a bigger script next time.... There needs to be civil and possibly criminal accountability for the enormous amounts of drugs prescribed without a valid need by the "patients

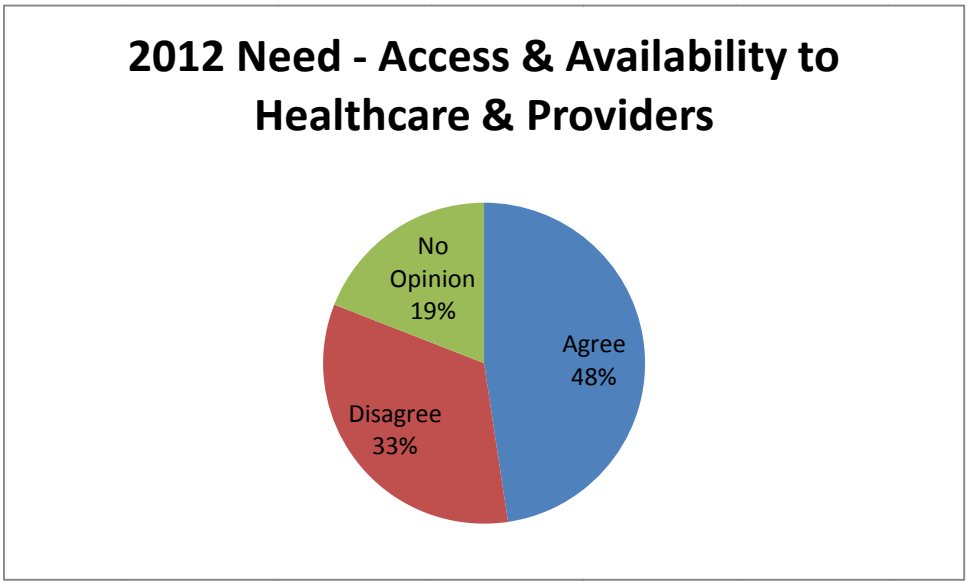
Question: *Do you agree with the specific comments or observations about Mental Health & Substance Abuse as being among the most significant needs for the Hospital to work on to seek improvements?*



Comments

- County frustration is palpable in the comments that are presented herein and which document the need for better collaboration. The NOTCH, NMC, and NC SS are presented as leaders so conspicuously absent is education and the public....
- Alternative and Complementary health practices will reduce dependence on the medical profession and the medical industry, and its prescriptions for addiction.
- I reserve judgement on a few of the opinions
- Must partner with teen and childrens services at these agencies in order to shift cost and try to support prevention and early intervention.
- MAT drugs and over prescribing of opiates is actually making more heroine addicts. This has to stop and we need long term residential treatment programs to address the opiate addiction problem. Suboxone should've given daily in clinics and should be last resort maintenance instead of the first mode of "treatment", which in my view is not treatment at all, just maintenance.
- Definitely agree that we need to continue to address access to mental health and substance abuse treatment. The long wait at NCSS has been a proverbial issue for years. I don't agree that medically assisted treatment is a "societal woe." NMC can take a leadership role in the area of mental health and substance abuse (which they have in this area). Much more to do and it will take time. Strong leadership is needed.

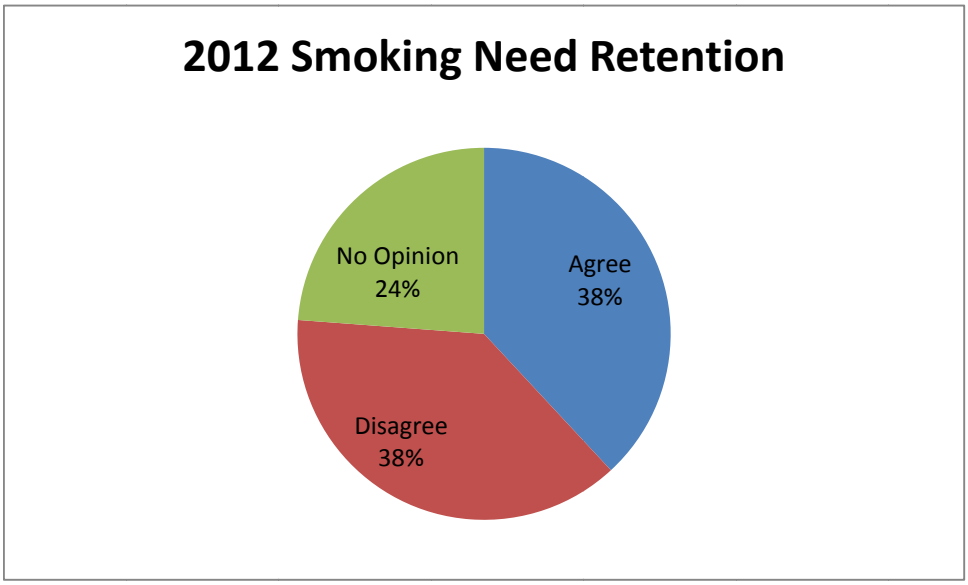
Question: *Do you agree with the specific comments or observations about Access and Availability to Healthcare & Providers as being among the most significant needs for the Hospital to work on to seek improvements?*



Comments:

- we need pediatric docs to start addressing substance abuse, depression and trauma in our children!
- I reserve judgement on a few of the opinions
- Whatever we ingest is a Substance available for Abuse.
- Mixed messages in the statements above....
- Access to care for the uninsured or under-insured continues to be an issue and still needs to be high on the radar. Also, oral health access is extremely challenging for anyone who does not have insurance and for children. Making the link between NMC, urgent care, and PCPs is important for patients.

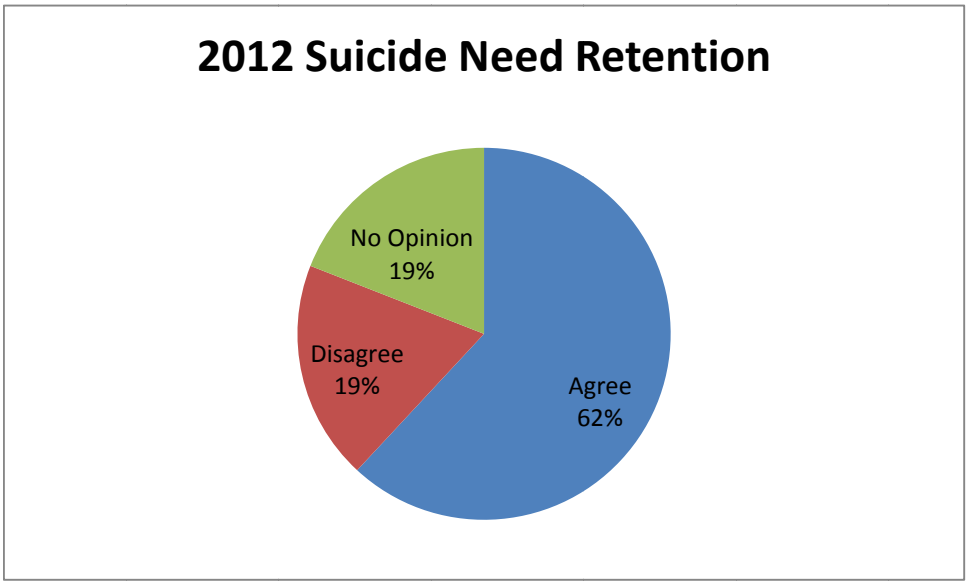
Question: *Do you agree with the specific comments or observations about retaining Smoking as being among the most significant needs for the Hospital to work on to seek improvements?*



Comments:

- The comments are hard to argue as they appear accurate. The passion in the words warrant further discussion as folks appear frustrated yet unwilling to throw in the towel....Need to engage in better overall strategic planning that involves as many stakeholders as possible....
- The hospital is a reaction, an intervention, a response to an emergency. Somehow we need to reward you for helping us avoid you, and reward ourselves safely and sufficiently as well.
- As for tobacco - we cannot address the top causes of death in F/GI if we do not prevent them by addressing tobacco use. The work there is NOT done. If cancer is a problem, then tobacco use and obesity are the solutions.
- I reserve judgement on a few of the opinions
- Again, mixed messages above.
- This is another area the NMC has taken a leadership role but seems to be less visible than previous years. All tobacco use is an ongoing concern in our two counties and should not be ignored because it is a large contributor to many diseases. VT Health Connect is not a "user friendly" system and so many people have to select high deductibles that it does not really help those who are financially strapped.

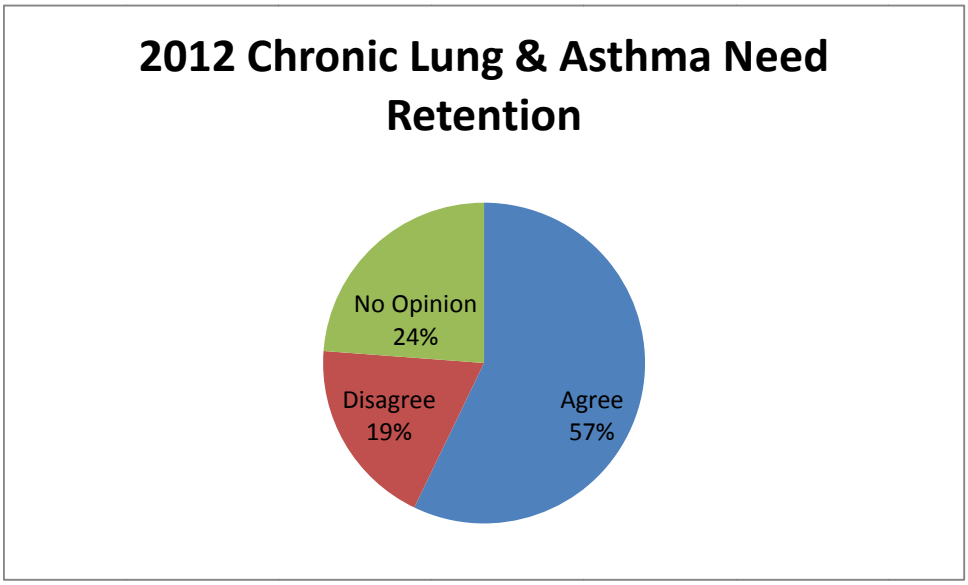
Question: *Do you agree with the specific comments or observations about retaining Suicide as being among the most significant needs for the Hospital to work on to seek improvements?*



Comments:

- The issues of suicide and sexual/domestic abuse are prevalent yet there is little coordination among agencies and this is upsetting. I believe Trauma is an umbrella for disparate abuse, suicide, and self-medication. In schools, teachers are facing concerns that are more pronounced and in other agencies, the same holds true. One comment asked about whether professionals are well-trained and I would offer they are not. Trauma therapy must be more than talk-therapy or cognitive insight therapy which are the prevailing modes of delivery because these are the therapies the therapists themselves feel most comfortable with. Yet, research tells us these are not the most efficacious yet it doesn't seem to matter.
- So, how are we going to heal a suicide?
- I reserve judgement on a few of the opinions
- All three areas need to continue be addressed.

Question: *Do you agree with the specific comments or observations about retaining Chronic Lung Disease and Chronic Asthma as being among the most significant needs for the Hospital to work on to seek improvements?*



Comments:

- I reserve judgement on a few of the opinions
- All important and I would certainly love to see the hospital take a lead on the LGBTQ issue!

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

Illustrative IRS Schedule h Part V Section B (Form 990)[44]

Community Health Need Assessment Illustrative Answers

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

   Suggested Answer –

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

   Suggested Answer –

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

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

      Suggested Answer –

   b. **Demographics of the community**

      Suggested Answer –

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

      Suggested Answer –

   d. **How data was obtained**

      Suggested Answer –

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

      Suggested Answer –

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

      Suggested Answer –

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

      Suggested Answer –

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

      Suggested Answer –

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

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

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

Suggested Answer –

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

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –

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

Suggested Answer –