Franklin & Grand Isle's 2019 Community Health Needs Assessment

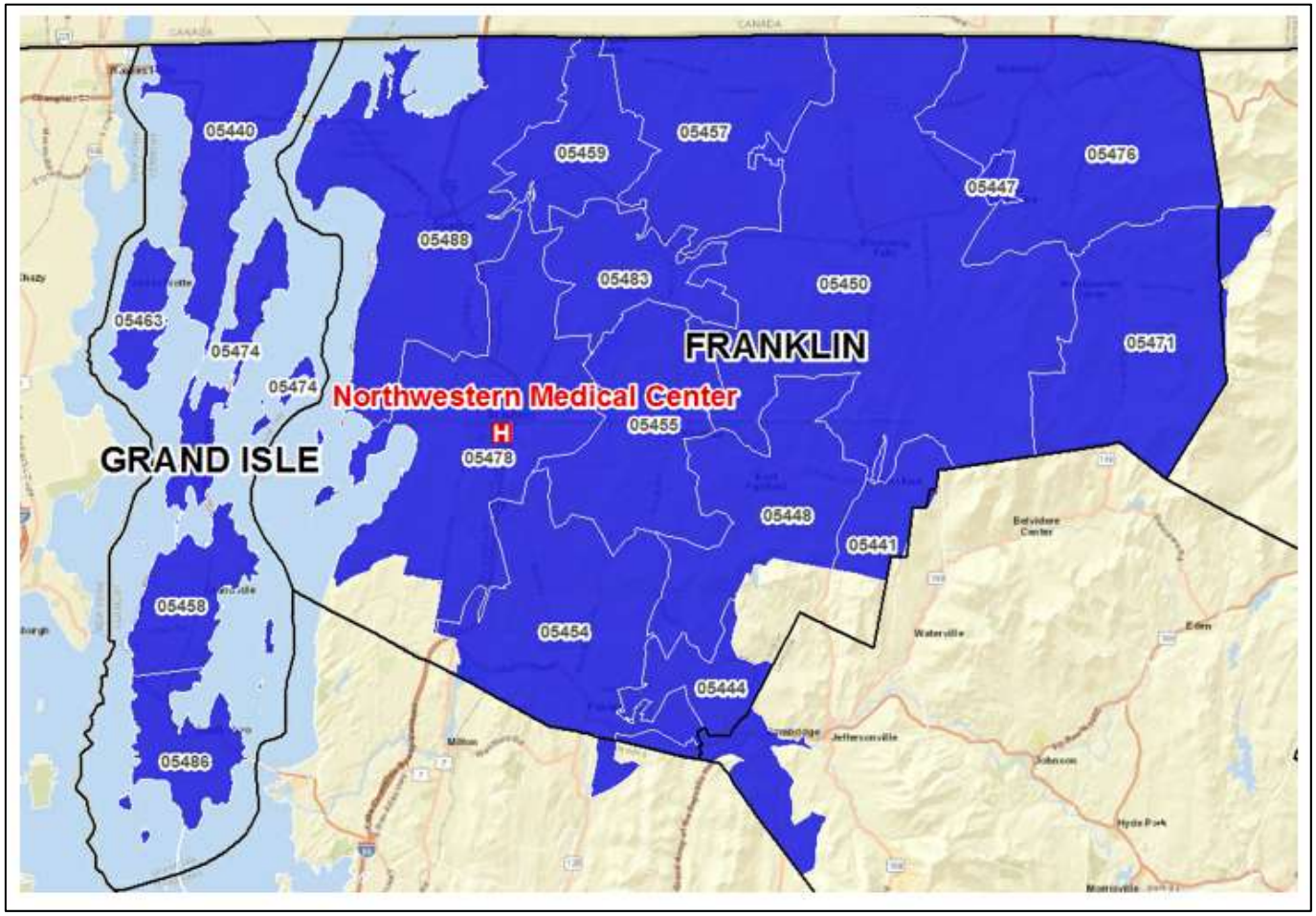
Overview Summary with Top Seven Priorities

May, 2019

NMC
Northwestern Medical Center

2019 Community Health Needs Assessment

Focused on the 55,000+ residents of Franklin & Grand Isle counties.



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2019 Community Health Needs Assessment

NMC's Process:

- Conducted every 3 years as per Federal regulations
- Facilitated by Quorum Health Resources with technical assistance from the Vermont Department of Health
- Informed by analysis of local, state, and national data as well as a general community online-survey
- Prioritized by a broad-based panel of local experts
- Informs NMC's implementation plan and strategic plan and is widely used by community partners

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2019 Community Health Needs Assessment

1

Inputs

- *Quorum, NMC, and VDH gather data on the community's health and demographics:*
  - *Local*
  - *State*
  - *National*
- *Conduct general community perceptions survey*
- *Engage local experts on data relevance and prioritization*
- *Identify priorities*

2

Implementation Plan Creation

- *NMC leaders and medical staff leaders review data and prioritization*
- *Create NMC action plan to respond to priorities*
  - *NMC's services and actions*
  - *Key partners*
  - *Key Indicators*

3

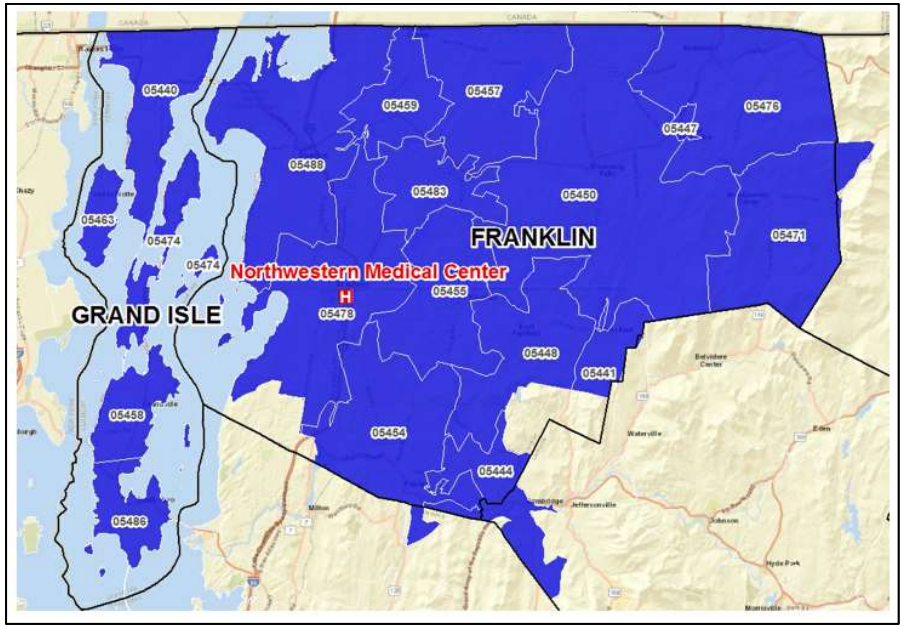
Finalizing & Sharing

- *Draft priorities and overview shared with Boards & Leadership of:*
  - *NMC*
  - *NCSS*
  - *FCHHA*
  - *NOTCH*
- *NMC Board approved final CHNA 05/01/19*
- *CHNA posted on NMC website and available at hospital*

VERMONT DEPARTMENT OF HEALTH · IBM Watson Health · CLARITAS · CDC · IHME Measuring what matters · NMC Northwestern Medical Center

2019 Community Health Needs Assessment

2019's Top Priorities Facing Franklin & Grand Isle:



1. Mental Health
2. Substance Abuse
3. Obesity
4. Suicide
5. Domestic/Sexual Assault
6. Food Insecurities
7. Smoking & Vaping

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2019 Community Health Needs Assessment

Additional Needs Ranked Outside Top Priority:

- Prevention & Wellness Education
- Access and Affordability of Care
- Cancer
- Physical Activity
- Dental Care
- Alcohol Use
- Chronic Pain Management
- ACES (Adverse Childhood Experiences) & Trauma
- Diabetes
- Housing
- Transportation
- Heart Disease
- Parent Education/Support
- Accidents
- Stroke
- Health Equity
- Women's Health
- Alzheimer's
- Kidney Disease

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Comparing 2016 and 2019:

2016 CHNA Top Priorities	2019 CHNA Top Priorities
1. Mental Health/Substance Abuse	1. Mental Health
2. Obesity	2. Substance Abuse
3. Smoking	3. Obesity
4. Cancer *	4. Suicide
5. Suicide	5. Domestic/Sexual Assault
6. Domestic/Sexual Assault	*6. Food Insecurities* *
	7. Smoking & Vaping

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Reflecting on 2016's Priorities & NMC's Work

1. **Mental Health and Substance Abuse – from 2016-19**
   1. Increase access to addiction services through recruitment and collaboration
   2. Embed Mental Health Care Managers into Primary Care—continue in the ED
   3. Partner even more closely with NCSS, the Howard Center, and others
2. **Obesity – from 2016-19**
   1. Continue RiseVT's evidence-based movement to embrace healthy lifestyles
   2. Expand the public offerings of the Lifestyle team
   3. Expand the Lifestyle team's business wellness services at worksites
3. **Smoking – from 2016-19**
   1. Continue primary prevention work of advocacy, Smoke Free Environments, Healthy Retailing, etc., and integrate into RiseVT
   2. Expand use of smoking cessation by primary care referral through Lifestyle Medicine and Blueprint

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Reflecting on 2016's Priorities & NMC's Work

4. **Cancer: – from 2016-19**
   1. Continue NMC's accredited Community Cancer Committee activities
   2. Expand mammography access through Breast Cancer Navigator
   3. Increase screening referrals through Vermont Blueprint for Health partnership
   4. Elevate primary prevention efforts in community through RiseVT & Lifestyle
5. **Suicide – from 2016-19**
   1. Continue embedded mental health care management in the ED
   2. Implement embedded mental health care management in Primary Care
   3. Explore ways to support the work of key community partners
6. **Domestic and Sexual Assault – from 2016-19**
   1. Continue the work of NMC Sexual Assault Nurse Examiners
   2. Identification and referral from ED, Primary Care, Pediatrics, OB/Gyn, etc.
   3. Explore ways to support the work of key community partners

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2019 CHNA Top 7 Priorities - NMC Actions

1. Mental Health – for 2019-22

- Key Stats: Adults with depressive disorder in St. Albans Health District is higher than VT average; Mental heath and substance abuse deaths are higher than VT average with related female deaths increasing 398.2% since 1980, related male deaths increased 130.8% since 1980
- Plan Highlights: Create interim safe room in the ED; conduct full renovation of ED to include safe rooms; increase visibility of outreach crisis clinicians; continue advocacy for statewide solutions;
- Indicators Include: 30-day follow-up after ED visit, 7-day follow-up after hospitalization with mental illness; Screening rate for clinical depression and follow-up plan;

2. Substance Abuse – for 2019-22

- Key Stats: Opioid-related deaths in St. Albans Health District is higher than VT average; Mental heath and substance abuse deaths are higher than VT average with related female deaths increasing 398.2% since 1980, related male deaths increased 130.8% since 1980;
- Plan Highlights: Continue to advance NMC addiction services; pursue plan for integrated site for NMC, Howard Center, and NCSSS services; expand partnerships and use of peer recovery coaching;
- Indicators Include: Rate of treatment initiation at first screening; Deaths from overdose.

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2019 CHNA Top 7 Priorities - NMC Actions

3. Obesity – for 2019-22

- Key Stats: Obesity higher than VT average; heart disease is the #1 cause of death in Franklin County and the #2 cause of death in Grand Isle County;
- Plan Highlights: Continue the RiseVT emphasis on embracing healthy lifestyles (and repeat measurement study in schools); expand Lifestyle Medicine offerings and infuse in diverse settings; enhance NMC's own 'lead by example' with HealthyU employee wellness;
- Indicators Include: School WellStat scores; NMC HealthyU rates; RiseVT measurement study; obesity rates.

4. Suicide – for 2019-22

- Key Stat: #8 leading cause of death in Franklin County & Grand Isle County, community leader priority
- Plan Highlights: Continue participation in state Zero Suicide initiative; work with Regional Clinical Performance Council relating to Adverse Childhood Experiences (ACEs); continue RiseVT's work within schools; financial support of related community initiatives (mentoring, etc)
- Indicators Include: Depression screenings; suicidality risk assessments; community suicide rates

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2019 CHNA Top 7 Priorities - NMC Actions

5. Domestic and Sexual Assault – for 2019-22

- Key Stat: Community leader priority
- Plan Highlights: Maintain Sexual Assault Nurse Examiners' work in ED; expanded use of screening tools in adult Primary Care offices, OB/GYN, and Pediatric offices; financial support of related community initiatives (Voices Against Violence – Laurie's House, etc).
- Indicators Include: Screening results in ED and offices; community incidence rates

6. Food Insecurities – for 2019-22

- Key Stat: Community leader priority
- Plan Highlights: Continue investment in Healthy Roots' work in community and with integration in RiseVT and Lifestyle Medicine; support healthy eating through demo kitchen at Congress & Main; expand partnership with Food Shelves and Martha's Kitchen; follow positive Food Insecurities Screening within NMC Primary Care practices with social work referral
- Indicators Include: Rate of food insecurity screening and referrals to Community Health Team

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2019 CHNA Top 7 Priorities - NMC Actions

7. Smoking & Vaping – for 2019-22

- Key Stats: Rate of adults who smoke cigarettes in St. Albans Health District is worse than VT average; lung disease #3 leading cause of death in Franklin County and Grand Isle County; community leader priority tied to emerging vaping statistics showing loss of gains in youth use of tobacco
- Plan Highlights: Continue RiseVT focus on policy change in worksites and municipalities and with state legislature in alignment with Franklin County Tobacco Prevention Coalition; clarify NMC policy to address e-cigarettes and vaping on campus; ensure providers are educated on appropriate interventions and timely referrals to NMC, local, state resources; expand tobacco use screening to ask about vaping and e-cigarettes; expand NMC Diagnostic Imaging lung screening program
- Indicators Include: Tobacco use assessment and cessation referral rates; Adult and youth rates of tobacco use and vaping.

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2019 Community Health Needs Assessment

These priorities are each bigger than any single entity or sector can address alone. Fortunately, collaboration runs strong in Franklin & Grand Isle counties. NMC is thankful for our many community partners.

Together, we can rise to a healthier future for all.

What questions do you have?

For the full CHNA document, please visit:
https://www.northwesternmedicalcenter.org/about-nmc/hospital-data/community-assessments/

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St. Albans, VT

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution May 1, 2019[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 the people of the greater Franklin and Grand Isle counties region has long been in alignment with the needs of our community. The "2019 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how NMC will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

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.

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

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

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

Thank You,

Jill Berry Bowen
Chief Executive Officer
Northwestern Medical Center

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

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

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

The 2019 Significant Health Needs identified for Franklin and Grand Isle Counties are:

1. Mental Health – 2016 Significant Need
2. Substance Abuse – 2016 Significant Need
3. Obesity – 2016 Significant Need
4. Suicide – 2016 Significant Need
5. Domestic Violence & Sexual Assault – 2016 Significant Need
6. Food Insecurities
7. Smoking – 2016 Significant Need

The Hospital will develop implementation strategies for these seven needs including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

APPROACH

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 helps the hospital identify and respond to the primary health needs of its residents.

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

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

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

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

Project Objectives

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 – Schedule H (Form 990)
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

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

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

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

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

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

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

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

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other (please specify)

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

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

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

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

existed in their portion of the county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
http://www.healthvermont.gov	Assessment of health needs of St. Albans Health District compared to all Vermont counties	December 4, 2018	2011-2015
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	December 5, 2018	2017-2018
http://svi.cdc.gov	To identify the Social Vulnerability Index value	December 10, 2018	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	December 10, 2018	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	December 11, 2018	2016

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

[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

- A CHNA survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 40 Local Expert Advisors was received. Survey responses started December 3, 2018, and ended with the last response on December 14, 2018.
- Information analysis augmented by local opinions showed how Franklin and Grand Isle Counties relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- 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
  - Low-income groups
  - Residents of rural areas
  - Children
  - Older adults

Additionally, the information and summary conclusions were put before the Hospital's Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need.[14] Consultation with 25 Local Experts occurred again via an internet-based survey (explained below) beginning January 14, 2019, and ending January 25, 2019.

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.[15]

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, most of the comments agreed with the findings. A list of all needs identified by any of the analyzed data was developed. The Local Experts then allocated 100 points among the list of health needs, including the opportunity to list additional needs that were not identified from the data.

The ranked needs were divided into two groups: "Significant" and "Other Identified Needs." The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least sixty percent (60%) of all points were included and to the extent possible, represented points allocated by a

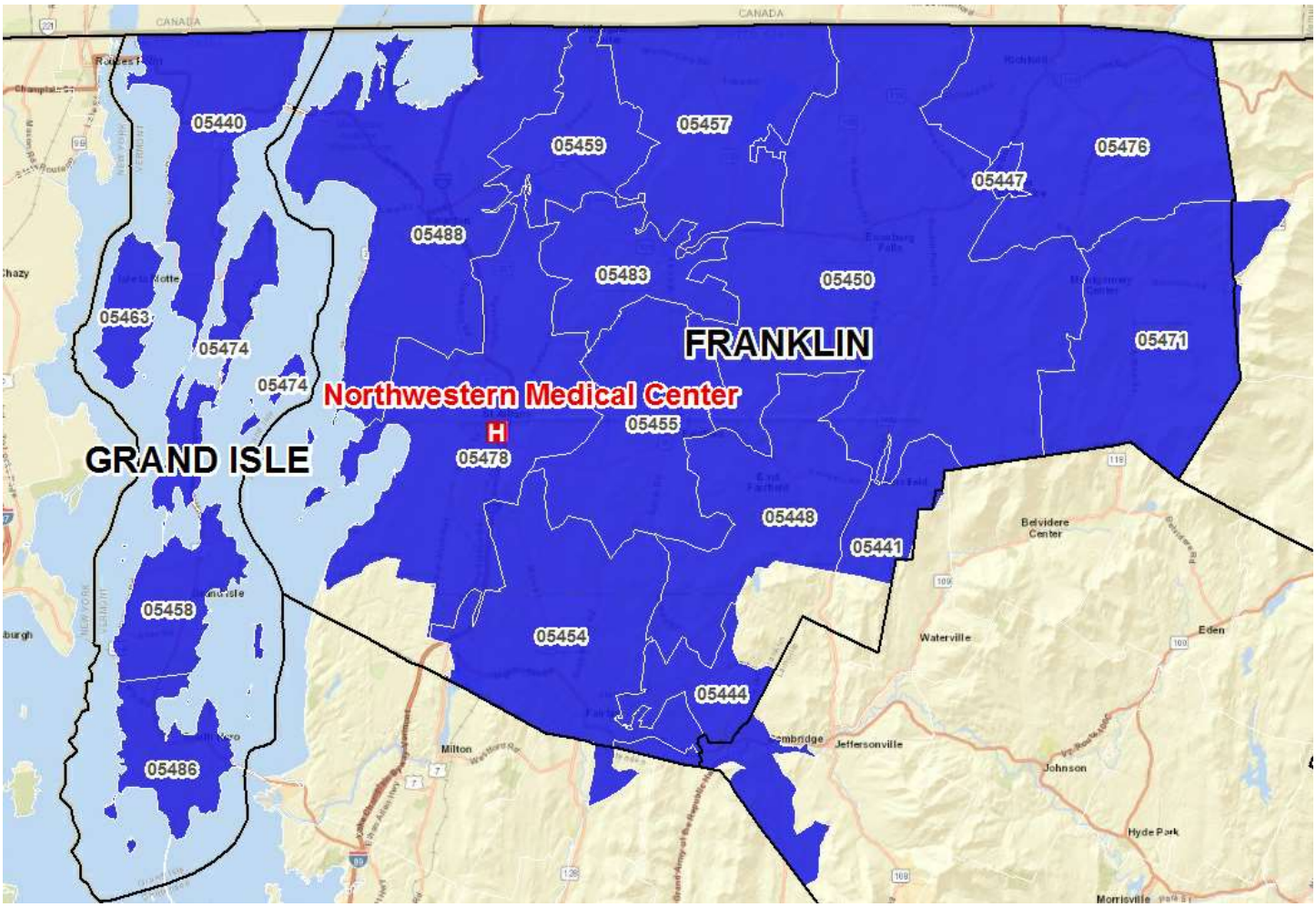
[12] Response to Schedule H (Form 990) Part V B 3 f
[13] Response to Schedule H (Form 990) Part V B 3 h
[14] Response to Schedule H (Form 990) Part V B 3 h
[15] Response to Schedule H (Form 990) Part V B 5

majority of voting local experts. The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation where a reasonable break point in rank order occurred.[16]

[16] Response to Schedule H (Form 990) Part V B 3 g

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



For the purposes of this study, Northwestern Medical Center defines its service area as Franklin and Grand Isle Counties in Vermont, which includes the following ZIP codes:[18]

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

(Zip codes 05460, 05470, 05479, 05481, 05485, and 05493 are included in the above zip codes.

During 2017, the Hospital received 89.0% of its Medicare inpatients from this area.[19]

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

Demographics of the Community[20] [21]

Variable	Northwestern Medical Center Service Area			State of Vermont			United States		
	2018	2023	% Change	2018	2023	% Change	2018	2023	% Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	54,421	55,073	1.2%	623,419	622,846	-0.1%	326,533,070	337,947,861	3.5%
Total Male Population	26,983	27,239	0.9%	307,262	307,006	-0.1%	160,763,265	166,448,961	3.5%
Total Female Population	27,438	27,834	1.4%	316,157	315,840	-0.1%	165,769,805	171,498,900	3.5%
Females, Child Bearing Age (15-44)	9,786	9,688	-1.0%	114,151	112,180	-1.7%	63,920,652	64,819,650	1.4%
Average Household Income	$78,803			$79,757			$86,278		
POPULATION DISTRIBUTION									
Age Distribution:									
0-14	9,631	9,378	-2.6%	94,478	90,577	-4.1%	61,041,768	61,251,682	0.3%
15-17	2,113	2,081	-1.5%	22,064	21,308	-3.4%	12,768,710	13,285,265	4.0%
18-24	4,450	4,649	4.5%	67,250	64,353	-4.3%	31,582,745	32,238,925	2.1%
25-34	6,291	6,220	-1.1%	71,122	72,396	1.8%	43,889,475	43,504,998	-0.9%
35-54	14,499	13,489	-7.0%	152,422	141,953	-6.9%	83,269,420	83,715,897	0.5%
55-64	8,459	8,643	2.2%	98,860	99,393	0.5%	42,205,344	43,372,380	2.8%
65+	8,978	10,613	18.2%	117,223	132,866	13.3%	51,775,608	60,578,714	17.0%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	21,817	22,234	1.9%	260,605	262,439	0.7%	123,942,960	128,512,580	3.7%
2018 Household Income:									
<$15K	2,099			25,140			13,503,937		
$15-25K	1,973			25,577			11,746,733		
$25-50K	4,330			57,132			27,363,816		
$50-75K	4,472			48,670			21,180,003		
$75-100K	3,174			36,166			15,192,282		
Over $100K	5,769			67,920			34,956,189		
EDUCATION LEVEL									
Pop Age 25+	38,227			439,627			221,139,847		
2018 Adult Education Level Distribution:									
Less than High School	1,625			12,560			12,392,218		
Some High School	2,158			23,904			16,363,680		
High School Degree	13,927			129,832			61,028,420		
Some College/Assoc. Degree	10,949			113,320			64,253,461		
Bachelor's Degree or Greater	9,568			160,011			67,102,068		
RACE/ETHNICITY									
2018 Race/Ethnicity Distribution:									
White Non-Hispanic	50,890			576,681			197,066,131		
Black Non-Hispanic	415			8,117			40,402,644		
Hispanic	957			13,183			59,581,729		
Asian & Pacific Is. Non-Hispanic	341			11,156			18,958,022		
All Others	1,818			14,282			10,524,544		

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

Consumer Health Service Behavior[22]

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

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

Health Service Topic	Demand as % of National	% of Population Affected
Lifestyle		
BMI: Morbid/Obese	101.3%	30.9%
Vigorous Exercise	101.4%	57.9%
Chronic Diabetes	95.4%	14.9%
Healthy Eating Habits	98.2%	22.9%
Ate Breakfast Yesterday	98.0%	77.5%
Slept Less Than 6 Hours	98.6%	13.4%
Consumed Alcohol in the Past 30 Days	92.1%	49.5%
Consumed 3+ Drinks Per Session	98.4%	27.7%
Chronic Conditions		
Chronic COPD	105.8%	5.7%
Chronic Asthma	99.1%	11.7%
Chronic High Cholesterol	96.3%	23.5%
Routine Cholesterol Screening	92.5%	41.0%
Chronic Heart Failure	104.4%	4.2%
Cancer Screen: Skin 2 yr	94.9%	10.2%
Cancer Screen: Colorectal 2 yr	100.2%	20.6%
Cancer Screen: Pap/Cerv Test 2 yr	95.7%	46.1%
Routine Screen: Prostate 2 yr	90.0%	25.6%
Chronic Lower Back Pain	91.5%	28.2%
Chronic Osteoporosis	102.4%	10.4%

Health Service Topic	Demand as % of National	% of Population Affected
Routine Services		
FP/GP: 1+ Visit	101.2%	82.3%
NP/PA Last 6 Months	109.6%	45.4%
OB/Gyn 1+ Visit	98.9%	37.9%
Medication: Received Prescription	98.9%	59.9%
Internet Usage		
Use Internet to Look for Provider Info	90.3%	36.0%
Facebook Opinions	91.4%	9.2%
Looked for Provider Rating	87.8%	20.6%
Emergency Services		
Emergency Room Use	105.3%	32.9%
Urgent Care Use	97.0%	32.0%
Behavior		
Search for Pricing Info	84.9%	22.8%
I am Responsible for My Health	102.0%	92.2%
I Follow Treatment Recommendations	99.9%	76.9%

[22] Claritas (accessed through IBM Watson Health)

Conclusions from Demographic Analysis Compared to National Averages

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

- 8% less likely to receive **Routine Cholesterol Screenings**, affecting 41%
- 5% more likely to use the **Emergency Room** (for non-emergent issues), affecting 33%

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

- 8% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 50%
- 9% more likely to have had a **Routine Visit with an NP/PA in the last 6 months**, affecting 45%

Leading Causes of Death[23]

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

Cause of Death			Rank among all counties in VT (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Franklin County Compared to U.S.)
VT Rank	Franklin Rank	Condition		VT	Franklin	
2	2	Cancer	2 of 14	158.4	191.5	Higher than expected
1	1	Heart Disease	1 of 14	158.8	212.1	Higher than expected
3	4	Accidents	5 of 14	54.8	46.8	As expected
4	3	Lung	7 of 14	41.3	48.9	Higher as expected
6	5	Stroke	11 of 14	29.2	35.5	As expected
7	6	Diabetes	2 of 14	20.5	28.8	Higher than expected
8	8	Suicide	8 of 14	17.3	14.9	As expected
11	11	Liver	8 of 14	8.8	7.4	As expected
5	7	Alzheimer's	13 of 14	35.8	22.8	Lower than expected
12	9	Flu - Pneumonia	7 of 14	7.0	12.4	As expected
15	15	Homicide	11 of 14	0.0	1.7	Lower than expected
10	12	Parkinson's	10 of 14	9.3	6.7	As expected
14	10	Kidney	2 of 14	3.7	8.3	Lower than expected
13	14	Blood Poisoning	8 of 14	3.4	4.5	Lower than expected
9	13	Hypertension	8 of 14	9.0	6.5	As expected

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

Cause of Death			Rank among all counties in VT (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Grand Isle County Compared to U.S.)
VT Rank	Grand Isle Rank	Condition		VT	Grand Isle	
2	1	Cancer	1 of 14	158.4	197.9	Higher than expected
1	2	Heart Disease	2 of 14	158.8	197.2	Higher than expected
3	5	Accidents	4 of 14	54.8	47.0	As expected
4	3	Lung	1 of 14	41.3	62.4	Higher than expected
6	4	Stroke	1 of 14	29.2	47.8	Higher than expected
7	6	Diabetes	10 of 14	20.5	20.6	As expected
8	8	Suicide	4 of 14	17.3	16.3	As expected
11	14	Liver	14 of 14	8.8	3.8	Lower than expected
5	7	Alzheimer's	14 of 14	35.8	18.9	Lower than expected
12	12	Flu - Pneumonia	14 of 14	7.0	6.8	Lower than expected
15	15	Homicide	13 of 14	0.0	1.1	Lower than expected
10	13	Parkinson's	12 of 14	9.3	6.2	As expected
14	10	Kidney	5 of 14	3.7	7.5	Lower than expected
13	11	Blood Poisoning	2 of 14	3.4	7.1	As expected
9	9	Hypertension	1 of 14	9.0	9.0	As expected

Priority Populations[24]

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

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

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[25]

- Low-income groups
- Residents of rural areas
- Children
- Older adults

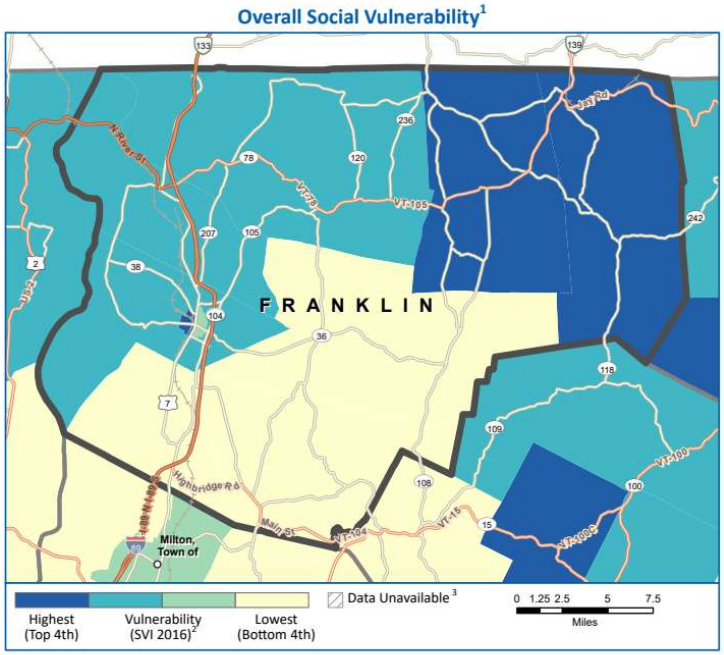
[24] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i

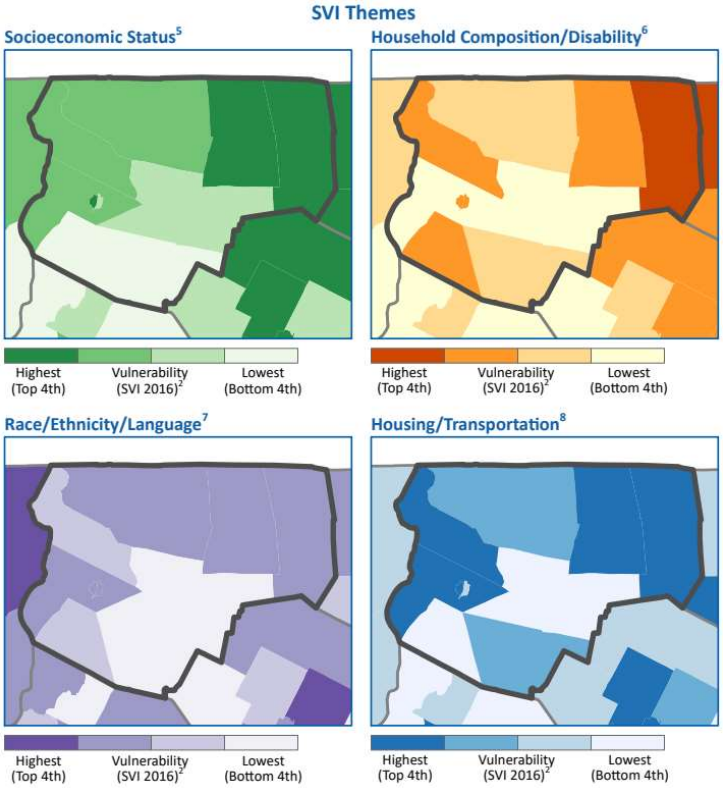
[25] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability[26]

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

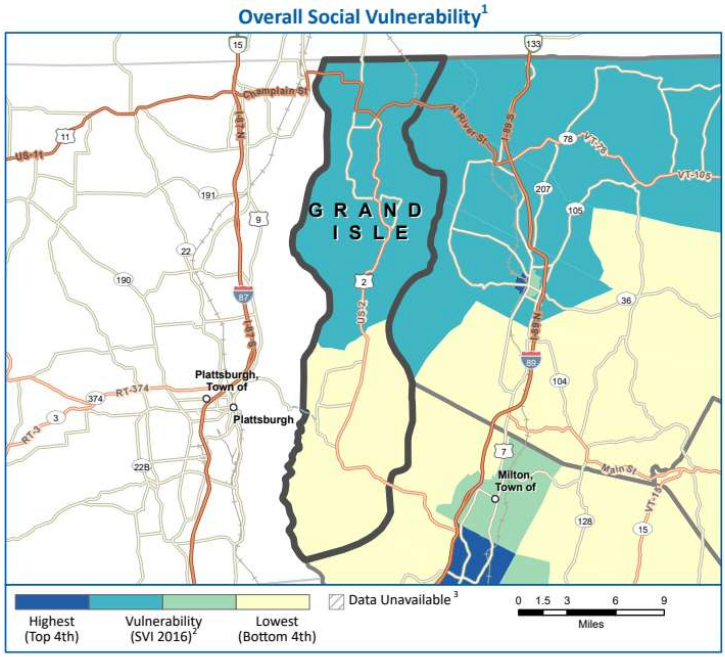
Franklin County's overall Social Vulnerability ranks fall into all four quartiles of vulnerability, the top half of the county fall into the top two quartiles (light and dark blue) making it more vulnerable than the lower half of the county:

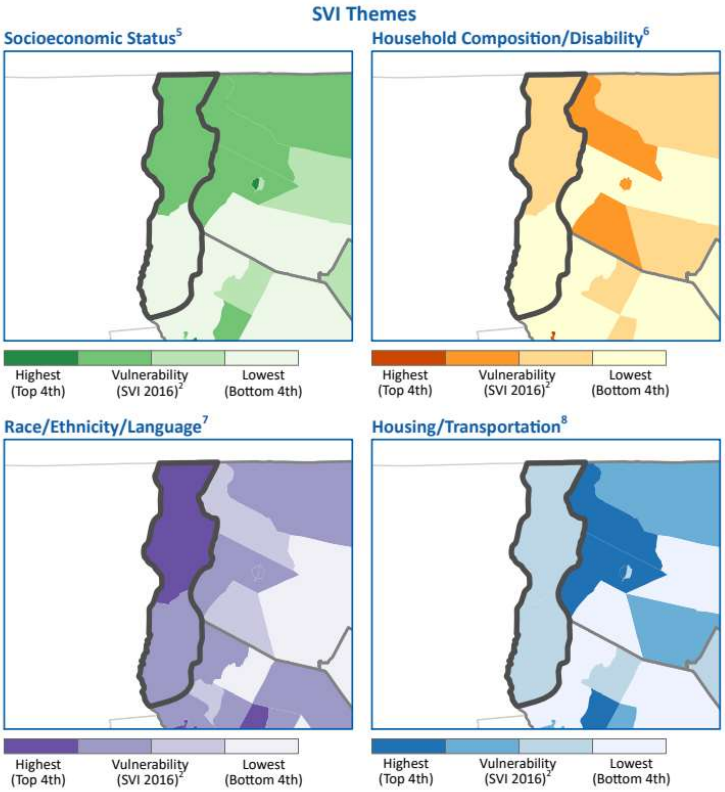




[26] http://svi.cdc.gov

Grand Isle County's overall Social Vulnerability ranks fall into the first and third quartile, the top half of the county in the light blue is more vulnerable than the lower half of the county in yellow:





Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 40 individuals provided feedback on the 2016 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	13	13	26
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	18	13	31
3) **Priority Populations**	19	7	26
4) Representative/Member of **Chronic Disease Group** or Organization	7	18	25
5) Represents the **Broad Interest of the Community**	21	6	27
Other			
Answered Question	**37**		
Skipped Question	**3**		

Priorities from the last assessment where the Hospital intended to seek improvement:

- Low-income groups
- Residents of rural areas
- Children
- Older adults

NMC received the following responses to the question: **"Should the hospital continue to consider the 2016 Significant Health Needs as the most important health needs currently confronting residents in the counties?**

	Yes	No	Response Count
Mental Health	34	1	35
Substance Abuse	36	0	36
Obesity	29	4	33
Smoking	33	2	35
Cancer	30	1	31
Suicide	34	1	35
Domestic & Sexual Assault	32	1	33

NMC received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2016 CHNA?"**

	Yes	No	No Opinion
Mental Health	35	1	36
Substance Abuse	36	0	36
Obesity	30	4	34
Smoking	34	1	35
Cancer	32	1	33
Suicide	34	1	35
Domestic & Sexual Assault	30	1	31

Comparison to Vermont[27]

To better understand the community, St. Albans Health District has been compared to the state of Vermont across six areas:

- Access to Health Services
- Mental Health and Substance Use
- Physical Activity, Nutrition and Obesity
- Immunizations
- Chronic Disease: Screening, Morbidity, Mortality and Associated Indicators
- Quality of Life

Health Topic	St. Albans Health District	Vermont Value
Access to Health Services		
Percent with health insurance	95%	94%
Primary Care Providers per 100,000 Population	51	75
Mental Health Professionals per 100,000 Population	194	341
Dentists per 100,000 Population	30	38
Mental Health and Substance Use		
Adults with a depressive disorder	24%	22%
Adolescents in grades 9-12 who made a suicide plan	12%	12%
Rate of suicide per 100,000	15.6	14.0
Adults who smoke cigarettes	19%	18%
Adolescents in grades 9-12 who smoke cigarettes	11%	11%
Adults who binge drank in the last month	15%	18%
Adolescents in grades 9-12 binge drinking in the past 30 days	16%	16%
Adolescents in grades 9-12 who used marijuana in the past 30 days	20%	22%
Accidental and undetermined opioid-related deaths per 100,000	16.1	15.2
Physical Activity, Nutrition and Obesity		
Adults age 20 and older who are obese	33%	28%
Adults age 20 and older who are overweight	33%	34%
Adolescents in grades 9-12 who are obese	16%	12%
Children age 2-5 (in WIC) who are obese	14%	14%
Adolescents in grades 9-12 meeting physical activity guidelines	25%	23%
Adults meeting physical activity guidelines	50%	59%
Immunizations		
Children age 19-35 months receiving recommended vaccines	72%	77%
Adults age 65 and older who receive annual flu shots	58%	59%
Adults age 65 and older who ever had pneumococcal vaccine	77%	77%
Chronic Disease: Screening, Morbidity, Mortality and Associated Indicators		
Adults with asthma	11%	11%
Adults with chronic obstructive pulmonary disease (COPD)	6%	6%
Female adults age 50-74 receiving breast cancer screening	76%	79%
Female age 21-65 receiving cervical cancer screening	87%	86%

[27] http://www.healthvermont.gov

Health Topic	St. Albans Health District	Vermont Value
Adults age 50-75 receiving colorectal cancer screening	72%	72%
Adults with cardiovascular disease	8%	8%
Adults with hypertension	28%	25%
Adults with a cholesterol check in past 5 years	79%	76%
Adults with high cholesterol	34%	34%
Adults tested for high blood sugar in last 3 years	53%	52%
Adults with diabetes	10%	8%
Coronary heart disease death rate per 100,000	134.2	114.8
Stroke death rate per 100,000	29.7	36.4
Quality of Life		
Adults whose health is fair or poor	14%	13%
Adults with poor physical health	11%	11%
Adults with poor mental health	13%	11%

Conclusions from Other Statistical Data[28]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Franklin and Grand Isle Counties statistics to the U.S. average, and lists the change since the last date of measurement.

Franklin County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Franklin county measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change		
- Female trachel, bronchus, and lung cancer*	54.5	66.4%
- Female skin cancer*	2.4	23.2%
- Female diabetes, urogenital, blood, and endocrine disease deaths*	55.3	7.1%
- Male diabetes, urogenital, blood, and endocrine disease deaths*	67.8	12.8%
- Male self-harm and interpersonal violence related deaths*	32.1	3.2%
- Female liver disease related deaths*	17.7	33.2%
- Male liver disease related deaths*	43.6	2.4%
UNFAVORABLE Franklin county measures that are **WORSE** than the U.S. average and had a **FAVORABLE** change		
- Female life expectancy	81	5.0%
- Female heart disease*	138.9	-55.1%
- Male tracheal, bronchus, and lung cancer*	75.7	-41.9%
- Female transport injuries related deaths*	9.2	-32.8%
- Male transport injuries related deaths*	23.9	-48.8%
DESIRABLE Franklin county measures that are **BETTER** than the US average and had an **UNFAVORABLE** change		
- Male skin cancer*	4.4	24.8%
- Female self-harm and interpersonal violence related deaths*	8.5	17.4%
- Female mental and substance use related deaths*	7.0	398.2%
- Male mental and substance use related deaths*	17.1	130.8%
DESIRABLE Franklin county measures that are **BETTER** than the US average and had a **FAVORABLE** change		
- Male life expectancy	77.4	10.6%
- Male heart disease*	190	-65.4%
- Female stroke*	33.4	-48.4%
- Male stroke*	26.6	-66.6%
- Female breast cancer*	22.8	-41.6%
- Male breast cancer*	0.3	-4.5%
- Female liver disease related deaths*	9.9	-26.9%
- Male liver disease related deaths*	15.1	-40.5%

*rate per 100,000 population, age-standardized

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

Grand Isle County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Grand Isle county measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE**		
- Female trachel, bronchus, and lung cancer*	53.9	43.7%
- Female skin cancer*	2.5	18.0%
- Male skin cancer*	5.0	26.5%
UNFAVORABLE Grand Isle county measures that are **WORSE** than the U.S. average and had a **FAVORABLE** change		
- Male tracheal, bronchus, and lung cancer*	69.0	-43.7%
- Female transport injuries related deaths*	10.4	-33.1%
- Male transport injuries related deaths*	20.5	-56.0%
DESIRABLE Grand Isle county measures that are **BETTER** than the US average and had an **UNFAVORABLE** change		
- Male diabetes, urogenital, blood, and endocrine disease deaths*	62	16.5%
- Female self-harm and interpersonal violence related deaths*	8.8	23.7%
- Male self-harm and interpersonal violence related deaths*	27.2	1.7%
- Female mental and substance use related deaths*	5.2	263.1%
- Male mental and substance use related deaths*	11.7	144.4%
DESIRABLE Grand Isle county measures that are **BETTER** than the US average and had a **FAVORABLE** change		
- Female life expectancy	82.3	6.0%
- Male life expectancy	77.8	10.6%
- Female heart disease*	107.2	-64.8%
- Male heart disease*	168.0	-68.4%
- Female stroke*	34.7	-49.5%
- Male stroke*	39.8	-61.1%
- Female breast cancer*	21.0	-49.1%
- Male breast cancer*	0.3	-13.6%
- Female diabetes, urogenital, blood, and endocrine disease deaths*	41.5	-9.1%
- Female liver disease related deaths*	8.9	-29.0%
- Male liver disease related deaths*	12.5	-42.6%

*rate per 100,000 population, age-standardized

Community Benefit

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

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

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

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

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

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

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

Activities reported by the Hospital in its implementation efforts and/or its prior year tax reporting (FY2017) included:

- The RiseVT community campaign to embrace healthy lifestyles which features prevention work with individuals, schools, businesses, and municipalities to raise awareness of the importance of wellness and help make the healthy choice the easy choice through community engagement, policy advancement, and infrastructure improvements.
- The expansion of care and service through NMC's chronic pain and addiction service, with a refocusing of pain management within Primary Care aligned with established protocols and the focusing of NMC's specialized practice on addiction treatment and recovery;
- Expanded partnerships in mental health care and the embedding of mental health in primary care offices, efforts that tie directly to the continued work to care for mental health patients safely in the Emergency Department which have led to the the construction of a safer holding room for mental health patients as well as plans for a comprehensive renovation of the Emergency Department;
- Continued emphasis on smoking prevention and succession in collaboration with Northwestern Counselling & Support Services, Blueprint for Health; and the Franklin Grand Isle Tobacco Prevention Coalition;
- Continued emphasis on the prevention of, early detection of, and coordinated care of cancer through NMC's nationally accredited community cancer program;
- Support of efforts relating to awareness and prevention of suicide, domestic abuse, and sexual abuse – with NMC's sexual assault nurse examiners in the Emergency Department and strong community partners including Voices Against Violence and Watershed Mentoring;
- Other strategies aligning with awareness, education, resource allocation, and collaborations relating to the identified priorities.

IMPLEMENTATION STRATEGY

Significant Health Needs

The methodology used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by NMC.[29] 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. NMC is an acute care medical facility located in St. Albans, Vermont. The next closest facilities are outside the service area and include:

- The University of Vermont Medical Center; 27.0 miles (30 minutes)
- Copley Hospital, Morristown, VT; 39.5 miles (59 minutes)
- Champlain Valley Physicians Hospital, Plattsburgh, NY; 38.4 miles (82 minutes)
- North Country Hospital and Health Center, Newport, VT; 60.7 miles (87 minutes)

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

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

1. **Mental Health – 2016 Significant Need; Adults with a depressive disorder in St. Albans Health District is worse than VT average; Suicide is the #8 leading cause of death in Franklin and Grand Isle counties**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

NMC services, programs, and resources available to respond to this need include:[30]

- Strong partnership with Northwestern Counseling and Support Services (NCSS), the local community mental health agency
- Social workers available for inpatient and outpatient services, including community health team structure
- Crisis clinicians and care management available within the emergency department from NCSS
- Addiction referral pathway embedded in the emergency department
- Psychiatry consultation available via tele-psychiatry when needed
- Existing process includes outreach crisis clinicians going to a clinic to see a patient and then providing a warm handoff for patient to access necessary services
- Embedded SBRT in the emergency department/Future embedded YSBRT's in Pediatrics

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

- Building downtown Lifestyle Medicine and increased low income housing
- Invest in mental and behavioral health ACO quality metrics
- Increase visibility of outreach crisis clinicians and integrated behavioral health
- Create interim safe rooms in the emergency department for short-term transitions
    - Full renovation of emergency department in the next 2 years
- Increase leadership role and advocacy statewide for emergency psychiatric offerings
- Advocacy with local legislators, VAHHS, UVMMC and the GMCB for extension of behavioral health services across state levels
- Advocacy of both inpatient acute and chronically ill patients is key
- Accountable Communities for Health
- Green Mountain Care Board (GMCB) committed to put $20MM toward inpatient psych beds
    - Increase activity with the organization and local legislators to help drive access to services
- Maintain continued investment in Regional Clinical Performance Council's Mental Behavioral Health subcommittee

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

- Participation in ACO collaboration
- Investment in prevention through lifestyle medicine offering and RiseVT (expanding statewide)
    - Building downtown Lifestyle Medicine and increased low income housing

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

- Increased access to addiction services through recruitment and collaboration
- Embedded Mental Health Care Managers into Primary Care, continue with embedded in ED
- Continued to sustain mental health managers in the emergency department
- Fully implemented RiseVT locally

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	✓	
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		

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

- 30-day follow-up after ED visit
- 7-day follow-up after hospitalization after mental illness
- Screening for clinical depression and follow-up plan

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

- Identification of undiagnosed depression
- Connection to community health teams with diagnosis of Major Depression Disorder
- PCMH quality metric for depression rate in office visits

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

Organization	Contact Name	Contact Information
Northwestern Counseling and Support Services	Todd Bauman	524-6554
VT Blueprint for Health	Candace Collins	524-1211
VT Department of Health	Judy Ashley	524-7970
Regional Clinical Performance Council	Amy Putnam	524-8435
RiseVT	Denise Smith	524-8825

Other local resources identified during the CHNA process that are believed available to respond to this need:[31]

Organization	Contact Name	Contact Information
Primary Care Practices	Numerous	
Community Psychiatrists and Mental Health Counselors	Numerous	

[31] 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

2. **Substance Abuse – 2016 Significant Need; Accidental and undetermined opioid-related deaths in St. Albans Health District is higher than the VT average; Female mental and substance use related deaths increased 398.2% from 1980 to 2014; Male mental and substance use related deaths increased 130.8% from 1980 to 2014**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- Dedicated addiction practice in the community
- Medicated Assisted Treatment (MAT) providers are embedded in primary care practices
- CMS Health Homes model for the hub and spoke (participating for opioid dependence). Partners include:
    - The Howard Center (adult)
    - NCSS (adolescent)
    - BAART – methadone clinic
- Employee Assistance Program
- Rise VT lifestyle medicine, which is prevention-focused
- Toxicology screening site – make it convenient for individuals to meet compliance
- Partner with Thresholds to offer group counseling services in the community
- Partner with Turning Point to provide Peer Recovery Coaches in the community

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

- Begin planning to integrate NMC, Howard Center, and NCSSS into one integrated site on NMC campus—existing space to be renovated
- Partner with ACO
- Continue and build upon partnership with previously-mentioned partners
- Expand use of peer recovery coaches

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

- Increased access to addiction services through recruitment and collaboration
- Embedded Mental Health Care Managers into Primary Care, continue with embedded in ED
- Continued to sustain mental health managers in the emergency department
- Fully implemented RiseVT locally

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	✓	
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	✓	

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

- 30-day follow-up after ED discharge for alcohol/drug dependence
- Initiate treatment at first diagnosis of alcohol or substance abuse disorder
- Engagement of 30 day follow-up following treatment

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
The Howard Center	Ed Williamson	524-7265
Northwestern Counseling & Support Services	Todd Bauman	524-6554
Turning Point	Karen Heinlein-Grenier	524-8455
VT Department of Health	Judy Ashley	524-7970
BAART Methadone Clinic	Jason Gougen	370-3545

Other local resources identified during the CHNA process that are believed available to respond to this need:[32]

Organization	Contact Name	Contact Information
Local Law Enforcement	Numerous	
Primary Care Practices	Numerous	
Alcoholics Anonymous		741-7100
Narcotics Anonymous		862-4516

[32] 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

3. **OBESITY – 2016 Significant Health Need; Obesity rate for adults and children is higher than the VT average; Heart disease is the #1 leading cause of death in Franklin county and #2 leading cause of death in Grand Isle county and are both higher than the VT and US average**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- Partner with RiseVT to promote a healthy lifestyle
    - NMC and RiseVT have come together and act as a firestarter across the community, giving rise to other similarly-focused health-related companies and offerings
- Lifestyle Medicine offering that includes nutrition education, dietician, clinic, and a physician—includes health coaching offering
- Primary care and pediatric offices are well-versed on a healthy lifestyle and make a point to educate patients and family members as much as possible
- Increased access to diabetes and nutrition education
- Healthy U offering with NMC employees

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

- Continue current services
- Embed health coaches in primary care practices
- With Rise VT, engage in a measurement study in local schools: 1st, 3rd, and 5th grades
    - BMI to be measured in 2019, 2021, and 2023
- Continue to increase awareness of the impact of overweight and obesity, as well as the notion of making the healthy choice the easy choice
- Infusing lifestyle medicine philosophy throughout community, with teaching kitchen and wellness space in a new development at Congress and Main in downtown St. Albans City
- Consider further developing NMC's leadership position in health by transforming NMC into a leading healthy organization with a wellness-focused culture
    - Healthy vending machines
    - Healthy food options only
    - Removal of soda on the campus
- Fitness Zone – space to embed health coaching and PT

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

- RiseVT efforts with municipalities, schools, and businesses to improve policy change and infrastructure

- RiseVT Active Play Campaign
- Advocacy of community walkability
- Lifestyle Health Coaching
- Expanded use of dieticians through primary care referral
- Increased WellStat scores in school system
- Continued primary prevention work of advocacy, Healthy Roots, community walkability, etc.
- Adopted EPODE best practice model

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		
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	✓	

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

- Fruit/veggie consumption
- Physical activity during leisure time
- Health Coach visits for employees (Healthy U)
- Health Coach visits for community

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

- RiseVT Measurement Study of 1st 3rd and 5th graders' healthy weights
- Childhood and adult obesity rates

- WellStat scores in schools (0-100) for school policies throughout region

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

Organization	Contact Name	Contact Information
RiseVT	Denise Smith	524-8825
VT Department of Health	Judy Ashley	524-7970
VT Blueprint for Health	Candace Collins	524-1211

Other local resources identified during the CHNA process that are believed available to respond to this need:[33]

Organization	Contact Name	Contact Information
Area Primary Care/Pediatrics	Numerous	
All area schools	Numerous	
All area workplaces	Numerous	
All area municipalities	Numerous	
Area Rec Departments	Numerous	
Area Fitness Facilities	Numerous	
Area Restaurants	Numerous	

[33] 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

4. Suicide – 2016 Significant Health Need; Suicide is the #8 leading cause of death in Franklin and Grand Isle counties

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- Zero Suicide initiative – state wide
- Partnership with Northwestern Counseling and Support Services (NCSS)
- All primary care office clinical care employees trained in Mental Health First Aid
- Offer a universal standardized validated suicide risk assessment framework and tool
    - Collaborative Assessment & Management of Suicidality (CAMS)
- Employee Assistance Program
    - Onsite presence once per week
    - Hotline available to those in need seeking counsel via phone
- RiseVT partnership focused on children and making positive life choices

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

- Participation in Zero Suicide Initiative: Statewide strategy for a process within the emergency department (screening and referral in the emergency department) through the state of Vermont
- Work with the Regional Clinical Performance Committee (RCPC) to enhance focus on adverse childhood experiences (ACEs), and how to more quickly get assistance to those children and prevent ACEs from occurring in the first place
- Continue work with schools, which include 21 total schools in the NMC service area (5 high schools, 16 elementary and junior high schools)
    - School-based clinicians in all community facilities
    - Involvement of schools with Rise VT

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

- Embedded mental health care in the emergency department and in primary care offices
- Expanded work with key community partners
- Expanded and Designated United Way gift from NMC to suicide-related organizations

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		
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	✓	

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

- Depression screenings from One Care VT

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

- Community suicide rate
- Successful suicidality risk assessment

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

Organization	Contact Name	Contact Information
Northwestern Counseling and Support Services	Todd Bauman	524-6554
RiseVT	Denise Smith	524-8825
Building Bright Futures	Liz Hamel	393-6634
Voices Against Violence	Kris Lukens	524-8538

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	Numerous	
Local private psychologists and mental health counselors	Numerous	
All area schools	Numerous	

5. Domestic Violence & Sexual Assault – 2016 Significant Health Need; Local expert concern

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- Universal screening for intimate partner violence and elder abuse across all adult primary care NMC practices (HITS—Hurt, insulted, Threatened with Harm and Screamed)
- Sexual assault nurse examiners (SANE) process in emergency department
- Pediatric SANE process in emergency department
- New Bright Futures questionnaires contain questions on safety for pediatrics (through the American Academy of Pediatrics)

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

- Continue investment in offering SANE
- Continue identification and referral of domestic violence and sexual assault within the emergency department, primary care offices, obstetrics/gynecology offices, and pediatric offices
    - With referral, embedded social work support will takes over (embedded care manager)
- Continued support of Laurie's House (and Voices Against Violence)—which provides crisis intervention, support and advocacy services to victims/survivors of domestic and sexual violence in Franklin and Grand Isle Counties
- Expand use of Bright Futures forms in pediatric visits
- Continue to implement the HITS (Hurt, insulted, Threatened with Harm and Screamed) domestic violence screening tool in adult primary care offices

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

- Created screening and referral processes
- Began financial support of Laurie's House
- Supporting partner and external programs through:
    - United Way corporate gift

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	✓	

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
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	✓	

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

- Positive screening of 'Do you feel safe at home?' within ED

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

- Incidence of domestic violence in community

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	524-8538
Northwest Unit of Special Investigations	Kelly Woodward	524-7989
VT Department of Children and Families	Kristen Pryor	524-7741

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

Organization	Contact Name	Contact Information
Primary Care/Pediatric Providers	Numerous	

6. Food Insecurities – Local expert concern

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

- The Healthy Roots Collaborative (HRC)
    - Community collaborative around diversified agriculture and healthy eating
        - Boost production of local food and get local food into schools, worksites, and peoples' homes
        - Work with farmers, merchants, schools, and businesses
    - Partner organizations include:
        - NMC
        - The South Hero Land Trust
        - FCIDC
        - Northwest Regional Planning Commission
        - Lake Champlain Islands Agriculture Network
        - Franklin/Grand Isle Workforce Investment Board
- Local food shelves
- Martha's kitchen, which provides restorative dignity to hungry individuals and families by providing nourishment and companionship in a safe, warm, and caring environment
- Universal screening for food insecurity in Primary Care
- Regional Clinical Performance Council (RCPC)—NCSS, Vermont Department of Health, NMC
    - Collaborators in an all-health service area common food insecurity project—via ACO
    - Integrated social needs screening
- Pediatrics Bright Futures
- Rise VT and Lifestyle Medicine—education/prevention/healthy eating
- Partner with schools to offer healthy foods options

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

- Continued work with schools—Vermont Universal School Lunch
- Support of healthy eating through cooking classes and demonstration kitchen in downtown St. Albans—Congress and Main development
- Explore expansion of relationship with food shelf – volunteerism, support, education

- Follow screening with intervention
    - Within NMC primary care practices, refer to social work for complete social needs screening after a positive Food Insecurities Screening—and connection to services
- Explore opportunity to begin food prescriptions
- Explore food insecurities of NMC employees
    - Free/reduced offerings in NMC cafeteria
    - Employee food pantry
    - Re-package leftover food to ensure it gets consumed

NMC evaluation of impact of actions taken since the immediately preceding CHNA: Normally this section is not included with a community health need not present in the preceding CHNA. However, much has been done in the past 3 years.

- [All of the current NMC services, programs, and resources available through its partners and highlighted in earlier Food Insecurities sections apply here]
- Food shelf vehicle to ensure gleaning of fresh fruit and vegetables are going where they need to
    - Out of an estimated 700,000 pounds of unused fresh fruit and vegetables in Franklin County in the past year, NMC has helped capture 10,000 pounds in past year—with goal of increasing this number

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	✓	
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	✓	

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

- Rate of food insecurity screening in NMC primary care practices

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

- Increase referral rate to community health team after determination of positive food insecurity screening

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

Organization	Contact Name	Contact Information
Health Roots Collaborative (HRC)	Jo Setta & Koi Boyton	524-8947
Northwest Family Foods	Robert Ostermeyer	527-7392
Martha's Kitchen	Bob Begley	524-9749
RiseVT	Denise Smith	524-8825
VT Department of Health	Judy Ashley	524-7970

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

Organization	Contact Name	Contact Information
All area food shelves	Numerous	
All area schools	Numerous	
Primary Care Practices	Numerous	

7. **Smoking – 2016 Significant Need; Rate of adults who smoke cigarettes in St. Albans Health District is worse than VT average; Lung disease is the #3 leading cause of death in Franklin and Grand Isle counties and higher than the VT and US average in both counties**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- RiseVT primary prevention efforts and tobacco prevention expert who works with worksites, schools, and municipalities on policies and prevention—and with legislature on state laws
- Lifestyle medicine smoking cessation classes in partnership with NCSS —individual and group
- Promotion of 802 Quits - free access to quitting smoking services through the Vermont Department of Health
- Screening, intervention, and referral available through primary care and pediatric offices

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

- Expand tobacco use screening to ask about vaping, e-cigarettes, and Juul use
- Continue to ensure providers are well-educated on appropriate and timely intervention
    - Prioritize with individuals with upper respiratory disorders
    - Ensuring there is a next step of referral—for team to reach out to the patient actively once referred
- NMC changing policy to address e-cigs and vaping on campus (already standard smoking ban in place)
- Diagnostic Imaging expanding lung screening program and marketing of the offering
- Expand smoking ban on NMC campus to include marijuana

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

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

Anticipated results from NMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
8. Available to public and serves low income consumers	✓	

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
9. Reduces barriers to access services (or, if ceased, would result in access problems)		
10. Addresses disparities in health status among different populations		
11. Enhances public health activities	✓	
12. Improves ability to withstand public health emergency		
13. Otherwise would become responsibility of government or another tax-exempt organization		
14. Increases knowledge; then benefits the public	✓	

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:

- Use of all tobacco products (cigarettes, vaping, Juul)

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

Organization	Contact Name	Contact Information
RiseVT	Denise Smith	524-8825
Northwestern Counseling & Support Services (NCSS)	Todd Bauman	524-6554
Vermont Department of Health	Judy Ashley	524-7970
Vermont Blueprint for Health	Candace Collins	524-1211

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

Organization	Contact Name	Contact Information
Area schools	Numerous	
Primary Care & Pediatric Offices	Numerous	
Local Merchants	Numerous	
Local Employers	Numerous	
Local Municipalities	Numerous	
Vermont Legislators	Numerous	

Other Needs Identified During CHNA Process

8. **Prevention/Wellness Education**
9. **Access and Affordability**
10. **Cancer – 2016 Significant Need**
11. **Physical Activity**
12. **Dental Care**
13. **Alcohol Use**
14. **Chronic Pain Management**
15. **ACES**
16. **Diabetes**
17. **Food, Housing and Transportation**
18. **Heart Disease**
19. **Parent Education/Support**
20. **Accidents**
21. **Stroke**
22. **Environmental Prevention**
23. **Health Equity**
24. **Housing Instability**
25. **Women's Health**
26. **Trauma – Intersection of domestic and sexual violence, mental health, and substance abuse**
27. **Alzheimer's**
28. **Kidney Disease**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[34]

1. Mental Health
2. Substance Abuse
3. Obesity
4. Suicide
5. Domestic Violence & Sexual Assault
6. Food Insecurities
7. Smoking

Significant needs where hospital did not develop implementation strategy[35]

1. None

Other needs where hospital developed implementation strategy

1. None

Other needs where hospital did not develop implementation strategy

1. None

[34] Responds to Schedule h (Form 990) Part V B 8
[35] Responds to Schedule h (Form 990) Part V Section B 8

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Round 1)

Hospital solicited written comments about its 2016 CHNA.[36] 40 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	13	13	26
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	18	13	31
3) **Priority Populations**	19	7	26
4) Representative/Member of **Chronic Disease Group** or Organization	7	18	25
5) Represents the **Broad Interest of the Community**	21	6	27
Answered Question			37
Skipped Question			3

Congress defines "Priority Populations" to include:

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

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

- *Transportation, dental care*
- *abuse/violence, poverty, less access to mainstream services*
- *Everyone needs to feel respected, valued, included and safe to pursue healthy and meaningful lives. Our services*

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

need to be accessible, affordable, coordinated, and culturally appropriate for all ages and abilities.

- *Transportation. access to care. treatment and stability to be successful in treatment (housing, social and behavioral change, connection to others for peer support) keeping older folks in their home, or home like environment.*
- *Health care provider diversity; empathetic caregiving supported by education and training in cultural issues and realities of rural living as a person with chronic health issues or mobility issues; reliable caregivers for homecare.*
- *Less likely to reach out to traditional services. Barriers include language, lack of transportation, etc.*
- *Affordable housing*
- *Transportation needs, prescription drug cost relief, nutritional concerns, education, mental health support, civil rights awareness, inclusion and respect, safety issues, jobs*
- *The Abenaki community is a poor one and folks suffer from diabetes, heart disease, and obesity. Prevention must be an ongoing priority....*
- *I work with the above groups on skill developments around parenting and self-care. More support around family/parental support would be a needed resource.*
- *Access to long term care facilities when needed, Continued increases in chronic health conditions, Ability to access home care*
- *Access to services, Social Determinant of Health, ACES, substance misuse, suicide*
- *Through our social outreach programs we attempt to address all of the above listed issues. Everything from spirituality to a food pantry*
- *transportation to work and medical care, access to/ability to pay for nutritious foods, access and time for exercise,*
- *Childhood Obesity, Obesity in general and chronic disease this represent 85% of our healthcare cost and there is minimal amount of dollar invested in prevention*
- *Access to affordable housing, transportation, social and community inclusive activities*
- *Substance abuse and Mental Heath issues*
- *Transportation to and from appointments or hospital for medical care. A system whereby they are offered/provided a live interpreter rather than just an iPad. The education level of some of this population is not very high, the iPad is not always reliable and it often makes them uncomfortable.*
- *lack of reliable transportation, lack of activities and a place to gather*
- *transportation and housing*
- *We have seven geriatric clients in our shelter currently. They all have significant health issues.*

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

1. **Mental Health**
2. **Substance Abuse**

3. **Obesity**
4. **Smoking**
5. **Cancer**
6. **Suicide**
7. **Domestic & Sexual Assault**

3. Should the hospital continue to consider the 2016 Significant Health Needs the most important health needs currently confronting residents in the county?

	Yes	No	Response Count
Mental Health	34	1	35
Substance Abuse	36	0	36
Obesity	29	4	33
Smoking	33	2	35
Cancer	30	1	31
Suicide	34	1	35
Domestic & Sexual Assault	32	1	33

Comments:

- *It is impossible to say we should NOT consider any of these needs as significant.*
- *I think with focusing on improving the health and wellness of the environment we live in, will help folks develop healthy behaviors. We can't expect real improvement unless we look at population level interventions.*
- *Lack of access for traditionally marginalized populations.*
- *nutritional education*
- *It is important to understand these issues within a cultural competency framework that is currently absent from any local discussion.*
- *It would be great to address the above needs while being conscience that they are all "symptoms" of larger support issues. Continue to address ACES and resilience in the community as a preventive measure.*
- *Need to work across the continuum of care. Need to continue to embed in primary care and at NMC.*
- *Our tribe faces these issues on a reoccurring basis.*
- *Substance abuse was separated from mental health in the list immediately above, yet combined in the first list. It is important to list these as separate issues so as not to conflate the two. Smoking is decreasing in prevalence, but due to the severe impact on health should still be on the list. Substance Abuse and Misuse?*
- *Primary prevention touch all these*

4. Should the Hospital continue to allocate resources to help improve the needs identified in the 2016 CHNA?

	Yes	No	Response Count
Mental Health	35	1	36

Substance Abuse	36	0	36
Obesity	30	4	34
Smoking	34	1	35
Cancer	32	1	33
Suicide	34	1	35
Domestic & Sexual Assault	30	1	31

Comments:

- *Yes, as much as the budget allows. Again, it is difficult to say that the hospital should not allocate resources to improve the health needs identified.*
- *I am wondering why homelessness is not on here. We have a crisis in Franklin County.*
- *Mental Health, Suicide Prevention and Domestic & Sexual Assault are somewhat out of the purview of NMC, and there are partners in our community who do this work well. We should continue to support their efforts.*
- *healthy living education and support - Rise Vermont for example*
- *I would like NMC to familiarize themselves more with Veterans and contact the Veteran assistance groups such as myself that are subject matter expects in this area to be able to assist more when needed.*

5. Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.

- *Smoking/ now vaping with youth with new laws and regs especially in schools and public places*
- *Dental Care, food security, healthy diet, mindfulness*
- *lack of safe and affordable housing severely impacts people's ability to access health care and a healthy life style.*
- *NMC should address issues of health equity across their systems and structures. As stated in the 2018 Vermont State Health Assessment, "health equity exists when all people have a fair and just opportunity to be healthy - especially those who have experienced socioeconomic disadvantage, historical injustice, and other avoidable systemic inequalities that are often associated with social categories of race, gender, ethnicity, social position, sexual orientation and disability."*
- *I would like NMC to help drive the idea of population level change as the highly successful prevention tool that it is. And to help put policy and practice into place that supports prevention in health and wellness long term; the outlook being 20-30 years for long term permanent change to happen.*
- *Additional resources for our homeless. A warming shelter... ?*
- *Housing and food security as social determinants of community health.*
- *I think this list is extremely important and remains relevant.*
- *Chronic Pain*
- *NMC employee has done great work in prevention work around tobacco use. NMC must take the lead in prevention initiatives that support other health issues as well.*
- *Prevention through early and strong supports in families.*

- *Need to work on childcare, resident care for elderly, need for health care professionals*
- *Adverse Childhood Experiences as an underlying factor for the above health issues. It is also critical to understand how the Social Determinants of Health play a role.*
- *school age bullying and suicide.*
- *Alleviating poverty, safe and affordable housing, child care and transportation are all important parts of solving these issues.*
- *Let's concentrate on those and not try to continuously add.*
- *Improve dental access for young children locally*
- *As described above, a dependable, site-wide system for offering live interpretation for patients speaking other languages. I'm sure the hearing-impaired population is provided with reliable interpretation services. If someone speaks no English it's quite like being deaf. They need someone who understands to be their ears and their voice.*

6. **Please share comments or observations about keeping <u>MENTAL HEALTH & SUBSTANCE ABUSE</u> among the most significant needs for the Hospital to address.**

- *I think you are working on this. I'm concerned patients have gone to the ER after repeatedly not shown for my dental appointments during the day or seeking drugs and the ER personnel prescribed opioids. I recommend no opioids and instead effective strengths of Tylenol and Advil. It should be the only option. I have called you on this as I hear my patients have had treatment with opioids. We need to learn to treat the underlying problems instead of pushing the drugs. And maybe you need training on real dental emergencies versus plain drug seeking emergencies. But you should also follow up with our dental offices as a curtesy to get the patient's treatment for underlying problem. Obviously, there are a few every year where the patients need true care and they need to be hospitalized and your care was wonderful. Also, FQHC do not need dental coverage on nights and weekends. I request that FQHC's have coverage on nights and weekends. I do not believe the hospital ED should be solely covering for simple questions or simple visits at the inflated ED price.*
- *It may be time to move away from a singular vision for the hospital and begin developing a system that is supported by NMC that is inclusive of the many agencies in the service area. I think it is being done in some ways now but it could be so much more. This comment is for all the health needs.*
- *Efforts to increase people's access to mental health and substance use treatment must continue to be a priority. Resources are still too limited. Also, efforts to address the intersectionality of substance use, mental health and domestic violence are essential.*
- *We need to separate out mental health from substance abuse. They are linked but not related. Adverse Family Experiences (AFEs) must be addressed in this section. About half (47%) of Vermont's children live in families that are stressed due to one or more of AFEs. Until we start working upstream we will continue to see a rise in the factors that contribute to mental health as well as substance abuse.*
- *Substance Abuse and Mental Health prevention works. There are no population level interventions listed. We know that about 20% of those who receive individual treatment for a chronic disease are successful, and when looking at population level change, that number is much higher. Let's get creative with our interventions. Also,*

we know that peer recovery is an intricate and important part of recovery form substance abuse and mental health problems. Let's support sustainable access to those who need support and recovery help to help social and behavior changes to be successful. Medication is a very small part of recovery. If you cannot help someone change how they interact with the world to help grow a solid foundation in recovery, and you believe medication is the treatment without behavioral intervention, we are a community that is not asking for recovery, but supporting a legal dealer. How do we help people change their lives so they can meet the expectations of society, rather than reject and eject them, and relegate them to a lifetime of daily dosing. Also, when someone is not medically qualified to be in the ED, but is clearly impaired, we need to do something. We cannot continue to harangue impaired people out the door, into the cold, and hope they get belligerent so they can be arrested (by the police officer waiting outside to do just that), or wander off and freeze to death or get hit by a car.

- *As it relates to my work, this would be important for NMC to continue to consider a priority of time and investment. There is still much work to be done in these areas.*
- *Both mental health issues and substance abuse drive social costs of homelessness, criminal behavior, and domestic violence. While here are agencies that address consequences of social instability, recidivism can best be prevented by managing the psychological and medical conditions that underscore these behaviors in concert with programs that promote housing stability and social integration.*
- *These issues continue to be prevalent in our community and impact physical health as well. There should be really strong coordination w/ the human service providers in the community who are also working with populations struggling with these issues (NCSS, DCF, DOC, VDH, PCP's, Howard Center, BAART, etc.) - working together and not in silos is most helpful.*
- *Mental Health and Substance Abuse continue to be both acute and chronic challenges for our communities impacting health, economic development, and families. Working to address root causes, provide support, and community changes to foster healthy decisions remains a high priority.*
- *Initiate programs in schools to address the health needs of the community. Involve school age children early as they soon will be adults in our community. Involving kids can change their behaviors and also those of their parents secondarily. Reach out and involve senior citizens in healthy living education and programs.*
- *My role in the community is education - Mental Health and Substance Abuse are the leading issues effecting the health, well-being and ability to educate our children. Our county has nowhere near enough resources to support the escalating needs our children have. We need mental health and substance abuse support for the parents of these children, and also the children.*
- *Without the treatment of MH & SA all of the other health care initiatives are ineffective.*
- *Over 90% of the families I work with in Northwest Vermont are also working toward or managing recovery.*
- *The need continues to support this group continues to grow.*
- *As a tribe, we attempt to address the issues that may be culturally specific to our tribal members. We would like to become more involved with the hospitals on a range of issues: education for better eating, child birth and end of life situations.*
- *We are seeing significant improvements in the wait list for individuals seeking MAT and that should remain a*

focus, however we should be working to direct these folks to recovery support services outside of the treatment model. Treatment may be for a lifetime or season but Recovery practices are required to create a healthy environment..

- *Again, these should be listed separately. Substance abuse and misuse treatment has gotten a great deal of attention. Community based prevention strategies are now needed. Continued de-stigmatization of mental health issues is a priority.*
- *I don't feel qualified enough to elaborate on this topic, with that being said I feel that with substance abuse comes a need for mental health counselling. Getting beyond the abuse and into treatment requires a huge amount of evaluation to determine why and how a person abuses anything.*
- *Again, let's focus on prevention. Adding support as secondary help is important but we need to eliminate the cause first.*
- *Mental Health and Substance Abuse issues affect more than the individual who is afflicted with these conditions-the psychosocial trauma on family members, especially young children can be vast and damage can be long-term. We do not have enough clinicians to care for individuals with these conditions, shifting responsibility back on to Primary Care providers who may be less equipped (due to lack of training) to help. This can be very draining on the provider and the system-time constraints, lack of resources for referral, high turnover and burnout of support staff/clinicians-and ultimately leads to suboptimal care.*
- *It is very important to be able to provide the community with these resources and have crisis intervention at all times for this. I deal with crisis situations regularly in my job and there is not enough help in our area.*
- *Given the state of the world, it seems more important than ever to keep these issues at the forefront of your concern.*
- *access to these varied services is not always easy for those in need.*
- *Mental health and substance abuse issues continue to be the most prevalent problems in dealing with the criminal population in franklin county. It is a daily struggle for many people.*

7. Please share comments or observations about the actions the Hospital has taken to Reducing the <u>MENTAL HEALTH & SUBSTANCE ABUSE</u>.

- *Still need to work on this.*
- *New partnerships have been successful. Increase in MAT and other substance use treatment has been great.*
- *The hospital has taken some bold action around reducing access to medications, getting medications out of circulation, and supporting community efforts to do so. Additionally, the hospital recognizes the idea of stability in the community as a cornerstone to any successful interventions for chronic disease. It is a pleasure to work with many hospital employees to support the community to reduce chronic disease, adversity and build successful outcomes for chronic disease intervention, prevention and recovery.*
- *As it relates to my work, I appreciate your MAT clinic and embedded mental health care initiatives.*
- *Addressing substance abuse through the efforts of the Pain Clinic and the MAT program, the hospital has shown*

leadership in the community, impacting on the issue both through direct client services and as partners in various community planning meetings. It has taken an more prominent and visible role than in the past.

- *SBIRT for substance abuse at the ED. Crisis screening through the DA at the ED occurs. We need more communication and collaboration and a safe place to house people waiting for mental health beds - perhaps a small psychiatric wing and/or detox wing.*
- *Continuing working with partners (Howard, NCSS, VDH, SBIRT, etc.) to integrate, cross-train, and identify/address/treat our community's mental health and substance abuse needs is of utmost importance. We've done work in this realm, and there's more to accomplish. Our actions are in the right arena, and we need to continue and expand.*
- *AA meetings are well attended.*
- *NMC's initiative to collaborate with Howard Center and NCSS has had a significantly positive outcome on the health of ore community.*
- *I do not have/witnessed enough personal knowledge to comment on the actions taken.*
- *Education and awareness - Incorporating into primary care*
- *we would like to see the hospital make referrals to our Treat the Heart, Heal the Soul, Women's Elder's group. At these meetings women are welcomed and a lot of issues are addressed.*
- *The hospital has offered more primary care doctors for stable MAT patients. I feel it may still be falling short on the education and understanding of some Docs to understand the science of addiction.*
- *I am not aware of what of the above actions the hospital has undertaken.*
- *I'm not familiar with what is happening here. sorry*
- *The only prevention model I know is Risevt. Having provided, social workers embedded is good. It helps to stabilize the situation. But we need to work on how to prevent these to happen first.*
- *Participation in local projects to improve access and recruiting Pain clinic/substance use specialists. Partnering with NCSS. Crisis clinicians in the ED. Communication between NCSS and providers has improved markedly, but still could use a bit more work.*
- *I feel that Healthy Roots and Lifestyle Medicine are great programs as long as the community is willing to get on board. Healthy body, healthy mind. There's a saying in Spanish- "mejor prevenir que lamentar". It means "better to prevent than lament".*
- *well considering that I have just learned about these things, more information should be made to the general public. It would help if those who are in contact with people with needs new of the resources available and how to contact them*
- *The comprehensive pain clinics administering of suboxone and vivitrol has been a tremendous help to the criminal populations opiate addiction issues.*

8. Please share comments or observations about keeping <u>OBESITY</u> among the most significant needs for the Hospital to address.

- *1. Increased use of healthy food and exercise options in the schools. 2. Rise Vermont expanding 3. More road intersection availability to walk, run and bike safely from rural communities to city 4. Continue to work on obesity measures of helping incorporate physical therapist and movement coaches - available... if you hurt you don't move - pain management without drugs. 5. Walking indoor availability. Indoor track, indoor swimming for obese or overweight and aging populations especially in winter months*
- *We know that overweight and obesity are increasing nationally, statewide and locally. However, the underlying causes of overweight and obesity lie in three fundamental behaviors: lack of physical activity, poor diet, and tobacco use which result in 4 disease (cancer, heart disease/stroke, Type 2 diabetes, and lung disease) which results in more than 50% of all deaths in Vermont.*
- *The EPODE model is an excellent example of population level intervention. The hospital has been building capacity for that intervention. RISE VT has also be helpful with building health and wellness in a variety of settings. The understanding of population health interventions of those who make decisions is key to moving in this direction. That and the close connections the hospital has with many organizations and agencies. It is to be applauded, I am so lucky our hospital sees the long term changes necessary to turn the curve.*
- *I am not familiar enough with this issue to comment.*
- *I cannot comment knowledgeably on this topic.*
- *preventative outreach, build more sidewalks, have more community based health and wellness activities, in partnership with VDH or BBF or the PCC at NCSS.*
- *Obesity continues to be one of the leading causes of death and disability, and driver of health care costs for our region's residents - including contributing to heart disease, diabetes, cancer, etc. Because it is a complex problem, it involves long-term and ongoing strategies to begin to reverse the problem. Obesity should remain on NMC"s significant needs list for a long time.*
- *Cardiac Rehab includes weight data Tuesday/Thursday open gym area is great for cardiac patients to continue exercise after Cardiac Rehab. Cardiac Rehab program is great.*
- *Obesity and its health impact is well understood. It is clearly effecting our community.*
- *I do not have/witnessed enough personal knowledge to comment.*
- *Population Health should be the center and need to address from childhood to seniors. RIseVT has been the catalyst*
- *Proper education.*
- *While opening the door to MAT, we see many folks with obesity issues that came along with their medications.*
- *As a driver for many other health issues, this remains important.*
- *I strongly feel working with our youth to educate them and the families on obesity is an important part of a communities overall health.*
- *As the Medical director of Lifestyle Medicine and RiseVt I am familiar with the measurement study that has demonstrated a 41% of overweight and Obesity in our kids population (grade 1-3-5). Knowing the correlation with chronic disease it is important that we continue our effort in helping people to adopt healthy lifestyle.*

- *Obesity leads to multiple other chronic conditions-if we can improve health/lifestyles, we can prevent many of these chronic conditions.*
- *Oops! That's answered above also!*
- *more exercise in more areas...Rise VT is a great thing' ed's to be expanded into other communities*

9. Please share comments or observations about the implementation actions the Hospital has taken to address <u>OBESITY</u>.

- *Through RiseVT NMC continues to make an effort to address overweight and obesity.*
- *Many employees are involved in different aspects of community change. What I like most is that all the people in the community come from a "let's do it" place, and work to get things done. The hospital has been a great driver and support of some initiatives that have been successful, and are at the table for many other population level change forums.*
- *RiseVT, Healthy Roots, and support of the Safe Routes to School Program in our region have been among NMC's most visible and comprehensive obesity-prevention initiatives. Having funded team-members in place to create, support, partner with, and accomplish policy, environmental, and community-level changes will allow for evidence-based initiatives to be implemented and "completed" far faster than the alternative. That means that the benefits will be realized more completely and for a greater number of communities and individuals. These efforts are outstanding!*
- *Healthy food choices in the Cafe.*
- *RISE VT has been a wonderful resource provided for our community.*
- *I do not have/witnessed enough personal knowledge to comment on the actions taken.*
- *We serve the entire community, not just Abenaki citizens, with our food shelf. Point the community our way and we will work with the hospital to help educate people on how to avoid obesity.*
- *Rise VT gets a great deal of publicity, and it will be interesting to see if the data shows results.*
- *The Rise VT movement is a huge step in this process.*
- *Rise Vt is a Community Based Intervention working on Childhood Obesity. RIseVt also has an impact at school, business, Family and Community. NMC innovate with LM clinic in order to support our population and PCP to educate our patients on how to improve their health and reduce Obesity.*
- *RISE VT is thriving-and now going STATE-WIDE!!*

10. Please share comments or observations about keeping <u>SMOKING</u> among the most significant needs for the Hospital to address.

- *Non smoking zones, Need more with vaping and pot along with tobacco*
- *It is important to keep smoking cessation efforts in the forefront especially about youth.*
- *As mentioned above, smoking is one of the three behaviors that results in major diseases.*
- *If we don't keep it a priority it will come back. Juuling is a great example of why we need to continue to push prevention.*

- *Yes, please as emphasis for supporting healthy life style choices.*
- *I believe that the hospital should continue to support smoking cessation and concentrate on prevention of use with youth.*
- *Smoking, and greater tobacco/nicotine use, continues to be the #1 cause of death and disability for our residents. It is also a driver of health care costs as tobacco users suffer disproportionately from heart disease, cancer, respiratory diseases, and so much more. Our region's adult tobacco use rate continues to remain high, and with the invent of vaping devices, it is possible youth use of cigarettes may increase in the future. This deadly topic continues to be of the utmost importance for NMC to address.*
- *The majority of my clients are smokers - contributing to health and financial concerns.*
- *Not as apparent but embedded with primary care COPD*
- *smoking should always be a top priority. Along with smokeless tobacco*
- *Continued lifestyle messages promoted in local advertising creates the buzz needed to address the issue.*
- *While less and less people smoke, the health impact of this behavior is significant.*
- *Smoking and vaping are big concerns with our youth. more education needs to happen here on the effects of vaping.*
- *Major cause of cardiovascular disease, pulmonary disease, cancer to name a few. WE need to continue helping people. Again, primary prevention is the best.*
- *Non-smoking campus/classes*
- *People will quit when they want to quit or when they have a health scare.*

11. Please share comments or observations about the implementation actions the Hospital has taken to address <u>SMOKING</u>.

- *cessation classes, public awareness efforts, Tobacco Coalition*
- *NMC has placed an emphasis on smoking cessation, however, there is more to be done in order to address the area of health equity. NMC could increase visibility of smoking cessation offerings (include smoking cessation on list of services offered on webpage?)*
- *Amy Brewer is a rock star! She has great connections to everyone, and has been successful in making positive change on so many venues. She also is not reactive to the issues, but proactive and thoughtful. She has a whole host of them. See her work plan, it's fabulous!*
- *I appreciate your mini grant and classes. Thanks to your grant process we were able initiate several new initiatives with our clients to support these cessation efforts.*
- *Our agency has partnered with the Tobacco Cessation program to offer cessation classes to our clients; they have educated our staff about how to approach cessation conversations with clients and kept us informed about new tobacco products that have come on the market and how they are pitched to youth.*
- *NMC has added lung cancer screening to its resources and continues to support the Franklin Grand Isle Tobacco Prevention Coalition. There is so much more that can be done to prevent youth use, protect everyone from*

secondhand smoke, and to help motivate and support adults in quitting for good. For example, there is still so much work that can be done by NMC and its providers/systems that will motivate and support more quit attempts. This area is almost completely unexplored by NMC.

- *I do not have/witnessed enough personal knowledge to comment on the actions taken.*
- *I've seen posters in several locations.*
- *Amy does and amazing job.*
- *The Tobacco Coalition is a needed part of this battle.*
- *No smoking in the hospital and outside of building. We have a health advocate dedicated on working with policies with smoking cessation*

12. Please share comments or observations about keeping CANCER among the most significant needs for the Hospital to address.

- *Prevention, Education and motivate patients*
- *Goes without saying*
- *Cancer is one of the leading diseases that cause death in Vermont and our area. It is important to expand focus on the root causes.*
- *Cancer is important, we know chronic adversity leads to all kinds of health issues, can we support reducing adversity and supporting early interventions, I love paying people to show up for early interventions, a few dollars for a long way.*
- *Yes, important.*
- *I don't feel qualified to comment.*
- *Franklin County's lung cancer rates continue to be higher than the rest of the state. Colorectal cancer remains the top 1 or 2 cancers as well. Both are preventable through addressing tobacco, healthy diet, and early screening (colorectal cancer and breast cancer screenings).*
- *I do not have/witnessed enough personal knowledge to comment on the actions taken.*
- *Not evident as an initiative*
- *Cancer should remain a top priority*
- *Prevention, early detection, and treatment remain priorities.*
- *Not familiar with this.*
- *At this moment we do screening (colon, breast etc.) not much prevention on these.*
- *I do not have as much experience in this area b/c my patients are children and go to UVM for care.*

13. Please share comments or observations about the implementation actions the Hospital has taken to address CANCER.

- *Preventive measures*

- *NMC has made improvements to screening, education, and care navigation.*
- *Regular exams, gently reminding folks, looking to educate for change. You do a lot.*
- *I'm afraid I do not know enough to comment on this.*
- *I support continuing with our healthy eating and tobacco control efforts as cancer control initiatives. Beyond that, we have not been strong leaders in cancer prevention/early detection. There is more we can and should do, including supporting DI in its mammogram initiatives and its growing lung cancer screening initiatives (which have been proven to save lives).*
- *I do not have/witnessed enough personal knowledge to comment on the actions taken.*
- *Support groups*
- *again, I've seen posters*
- *continued messages in local media and awareness activities.*
- *Walk in mammography is outstanding- increasing access.*
- *Detection and again primary prevention. Helping people to understand that cancer is correlated highly with our lifestyle (specially our diet)*

14. Please share comments or observations about keeping SUICIDE among the most significant needs for the Hospital to address.

- *Suicide is increasing especially among youth*
- *Doing screening and intervention is important. 60% of people go to the doctor with a physical complaining, and are really there for depression. Can we look at early intervention and prevention practices as a driver for change. We recently lost a young man in our community to suicide, can we find ways to support our children through difficult times. This may mean showing up at non-traditional tables. The number of young people we lose in the this community to suicide and overdose is astounding. What are the root causes of that?*
- *Yes, especially given recent and tragic suicide*
- *I believe that with suicide increasing in the general population and among seniors in particular that this should be a focus of the hospital.*
- *Suicide remains and important issue for our region, especially for teens and isolated individuals. I believe it ties in with mental health and substance abuse priorities. I am unsure how NMC would act to address it.*
- *I do not have/witnessed enough personal knowledge to comment on the actions taken.*
- *We are losing our next generation from both substance abuse and suicide. Need to increase our presence in schools.*
- *Hot button topic, social media helps to promote assistance.*
- *Its unfortunately on the rise, young and old.*
- *I'm not exposed to this part of our health issues.*
- *Prevention need to make the young people feeling that they are part of our community*

- *Seems like we are seeing more and more young people committing suicide in our community*
- *Suicide among young people is a rampant and frightening thing. Seems like people only have relationships with electronics nowadays. There seems to be an inability to build in-person, face to face, interpersonal relationships. Something is missing when someone who appears to be successful, healthy, put together, good family, friends, etc.... takes their own life suddenly. What makes them feel SO isolated? SO alone? Why do they feel as though they can't talk to anyone?*

15. Please share comments or observations about the implementation actions the Hospital has taken to address <u>SUICIDE</u>.

- *supporting increased mental health supports*
- *They did a study around suicide coding. They work with our county Mental Health.*
- *Please tell me more, I would love to learn.*
- *Working with NCSS to embed mental health professionals in clinics and practitioners offices is an obvious and effective tactic.*
- *I am not aware of any actions the hospital has taken to address suicide outside of its mental health and substance abuse actions.*
- *I do not have/witnessed enough personal knowledge to comment on the actions taken.*
- *Cannot name specifics*
- *don't know*
- *Offering awareness activities.*
- *Same*
- *Not sure there is any action done.*
- *Crisis clinicians in the ED. NCSS partnership. Would like to see some community forums.*
- *Don't know.*

16. Please share comments or observations about keeping <u>DOMESTIC & SEXUAL ASSAULT</u> among the most significant needs for the Hospital to address.

- *Safe houses and resources to prevent or allow patients to move on safely and without retaliation from the abuser*
- *The numbers keep going up along with increased risk. Lethality assessments are imperative as we address strangulation and other high risk abuse*
- *Healing is the most important part of DV and SA. How do you support recovery. People who commit domestic violence and sexual assault are a product of the environment they are raised in. how do we change that environment. And how can the hospital maintain equity for both parties in this issue? There is a 100% plea out rate in our county for all crimes. That means people are admitting guilt, not always because they are guilty, but*

because they cannot pay lawyers, do not have the mental health to endure years in the court system, and when accused, you are vilified by you community, so pleading out seems the easier softer way. so what happens to the children in these cases? Their fathers are vilified, they children have no dad, there is no healing, and the cycle continues. If you are convicted of a sex crime, you will never, ever get a job in the legal economy, and you will forever be marginalized by this community. How do we stop the generational cycle without looking at both sides, equity is the key.

- *Yes. Important.*
- *DV and SA are issues appropriate for the hospital to address. They affect children as much as adult victims and often are driven by MH issues as well as substance abuse.*
- *Mental Health and Substance Abuse are partner issues to domestic and sexual assault. They are definitely community needs and we should address it within our abilities.*
- *Working for Prevent Child Abuse Vermont, this is a daily conversation topic for me. The referrals for program due to domestic abuse or risk of continues to be significant in the area.*
- *Supporting community initiatives*
- *Domestic violence is a concern for our tribal citizens. We participate in the STOP grant and work with victims of domestic violence monthly*
- *Continue to educate those in the medical profession in the treatment of individuals and family members.*
- *I'm not exposed to this part of our health issues.*
- *Not sure what is done other than service offer in the community*
- *Affects more than just the immediate victim.*
- *Another rampant issue in our community and often looked at as an ugly secret. If we are going to support and uplift women (because the majority of cases are against women) in our community then this issue ALWAYS needs to be a significant one.*

17. Please share comments or observations about the implementation actions the Hospital has taken to address <u>DOMESTIC & SEXUAL ASSAULT</u>.

- *Partnership with Voices Against Violence. Willingness to see the connection to safe and affordable housing and support financially*
- *Trained nurses.NO shortage of police at the ED, not good but they are there.*
- *I believe the hospital should consider support to increase the number of shelter beds and transitional housing units available to DV victims.*
- *I am unsure of specific actions NMC has taken to address these issues. I would like to ensure that NMC provider staff have strong training to support, protect, and refer victims. I also hope that NMC actively supports efforts led by partners within our community to address this topic.*
- *I do not have/witnessed enough personal knowledge to comment on the actions taken.*

- *As prior law enforcement I've worked closely with hospital staff to address domestic violence in the past. great staff*
- *I am not aware of the actions the hospital has taken, so cannot comment.*
- *Universal screening.*

18. Finally, after thinking about our questions and the information we seek, is there anything else you think is important as we review and revise our thinking about significant health needs in the county?

- *absolutely limit ER dispensing opioids*
- *Keep thinking about more innovative ways to partner with community organizations to increase impact.*
- *When you start unpacking a lot of the listed issues, history plays a big part in our health. How do we develop equity for those who are marginalized of vilified by our community, and how to we look at past experience of adversity, toxic stress and trauma as root causes of mental health, substance abuse, suicide and every other chronic disease there is. None of us gets better unless all of us get better.*
- *I'm guessing you already have a community advisory committee? This might be a great way to gather on-going information from area stakeholders. Thank you for all you do.*
- *I believe that the hospital ought to take advantage of the existing network of cooperating agencies who serve the needs of low income households by directing support which allows them to execute existing strategies with a full compliment of resources necessary to match and even anticipate rising service demands and, perhaps, sufficient even to implement innovations that are sitting on drawing boards across the county.*
- *Being a 71 year old, I have taken advantage of many services at NMC. I feel it is wonderful health facility. The only suggestion I can think of now is that there needs to be a communication via technology between UVM med center and NMC. The two networks don't share info.*
- *I think NMC has established itself as a prevention champion. I think our strong point is addressing healthy eating, physical activity and tobacco control through environmental, policy, and community-wide interventions. Addressing these topics- all of which are important components to preventing obesity, substance abuse, and cancer - will, over time, give our community the biggest and most positive return (healthy, health care savings, economic development, etc.). I think our priority should be on primary prevention with complementary efforts in secondary prevention (early detection, screening, integration, training of providers) and a strong support of our community partners who are addressing mental health, substance abuse, suicide prevention and sexual/domestic assault.*
- *Prevention please!*
- *Define the role for NMC in our community; Identify challenges with access to specific care; What does NMC do, well and where can we have more concerted efforts? Where can NMC have the most impact on the care in our community*
- *I think these issues are a worthy goal. Managing any one of them would be a great accomplishment.*
- *I think we need to remember the ""Regular Patient's needs and focus on a healthy community"". On the note of*

the healthy community, we must address our children and keep them in the forefront of building A Healthy Community. (find ways to fund physical activities, theater and arts free of charge to All area children) :)

- *The list is a mix of behavioral actions and diseases/medical conditions. Is it helpful to separate those out when planning actions? Please separate mental health from substance abuse.*
- *I have nothing else to add.*
- *We need to continue our effort in primary prevention and RiseVt. We need to continue to educate our Physicians partner the importance of teaching people how to stay healthy. At this moment we are still to much in the sick care business. If we are planning to be value based model... we have a lot or work to do. I really do not think that we are prepare for this new medicine.*
- *I think there should be a new protocol when it comes to helping young youth that are struggling with substance abuse. They should not have had to have been gotten in trouble in order to do drug testing if a parent brings them in to see if they are abusing drugs if they are under the age of 18. Drug and alcohol abuse among young youth is very high in this region.*
- *A lot of it is all tied in together. Mental health, drug abuse, suicide, sexual assault, even obesity... Education seems to be the key there but finding a good way to make people WANT to learn to live a happier, healthier life is the key. How to get people to listen and desire a better way of life?*
- *outlying rural areas need transportation and information sharing so they know what services are available and how to access them*

Appendix B – Identification & Prioritization of Community Needs (Round 2)

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health – 2016 Significant Need	370	20	18.50%	18.50%	Significant Needs
Substance Abuse – 2016 Significant Need	314	19	15.70%	34.20%	
Obesity – 2016 Significant Need	183	15	9.15%	43.35%	
Suicide – 2016 Significant Need	113	14	5.65%	49.00%	
Domestic Violence & Sexual Assault – 2016 Significant Need	104	11	5.20%	54.20%	
Food Insecurities	98	10	4.90%	59.10%	
Smoking – 2016 Significant Need*	86	10	4.30%	63.40%	
Prevention/Wellness Education	98	10	4.90%	68.30%	Other Identified Needs
Access and Affordability	90	11	4.50%	72.80%	
Cancer – 2016 Significant Need	75	10	3.75%	76.55%	
Physical Activity	71	8	3.55%	80.10%	
Dental Care	70	10	3.50%	83.60%	
Alcohol Use	59	7	2.95%	86.55%	
Chronic Pain Management	52	9	2.60%	89.15%	
ACES	50	2	2.50%	91.65%	
Diabetes	25	3	1.25%	92.90%	
Food, Housing and Transportation	25	1	1.25%	94.15%	
Heart Disease	23	4	1.15%	95.30%	
Parent education/supports	20	1	1.00%	96.30%	
Accidents	10	1	0.50%	96.80%	
Stroke	10	2	0.50%	97.30%	
Environmental Prevention	10	1	0.50%	97.80%	
Health Equity	10	1	0.50%	98.30%	
Housing Instablility	10	1	0.50%	98.80%	
Women's Health	9	2	0.45%	99.25%	
Trauma - intersection of domestic and sexual violence, mental health	8	1	0.40%	99.65%	
Alzheimer's	5	1	0.25%	99.90%	
Kidney Disease	2	1	0.10%	100.00%	
Total	2000		100.00%		

**Although Smoking was initially rated below Prevention/Wellness Education and Access and Affordability, recent increases in the use of e-cigarettes continues to create a significant health problem in the community. Thus, NMC agrees to work toward addressing this challenge.*

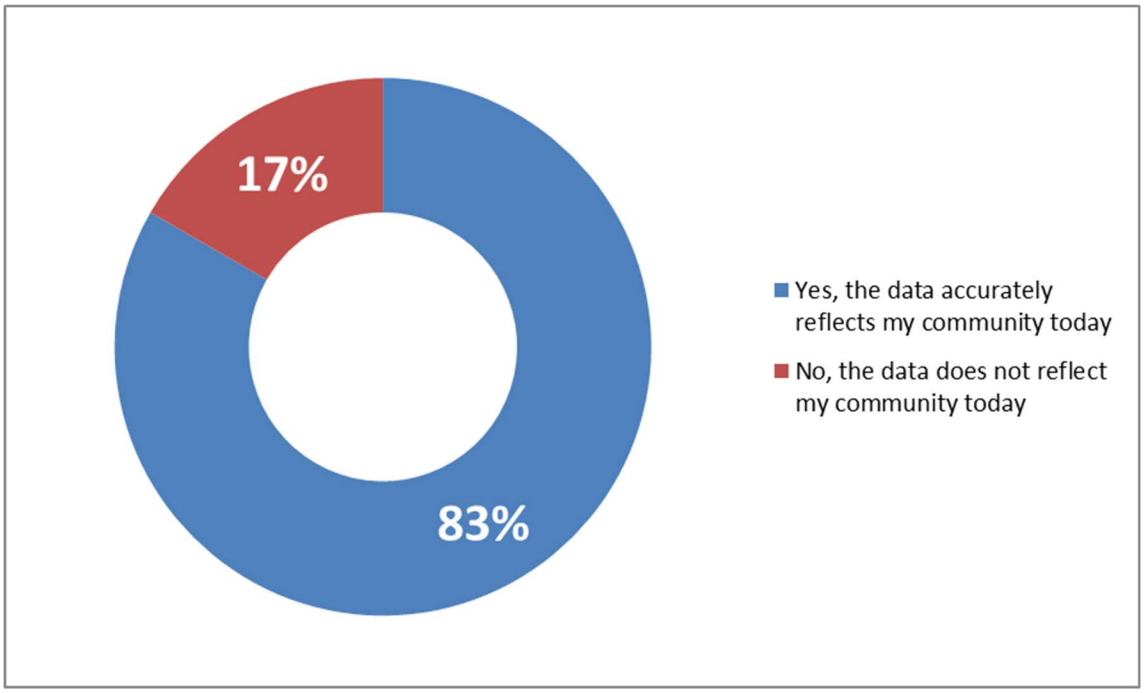
Individuals Participating as Local Expert Advisors[37]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	13	8	21
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	11	8	19
3) **Priority Populations**	7	7	14
4) Representative/Member of **Chronic Disease Group** or Organization	3	11	14
5) Represents the **Broad Interest of the Community**	15	2	17
Other			5
Answered Question			25
Skipped Question			0

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

Advice Received from Local Expert Advisors

Question: Do you agree with the comparison of St. Albans Health District to all other Vermont counties?

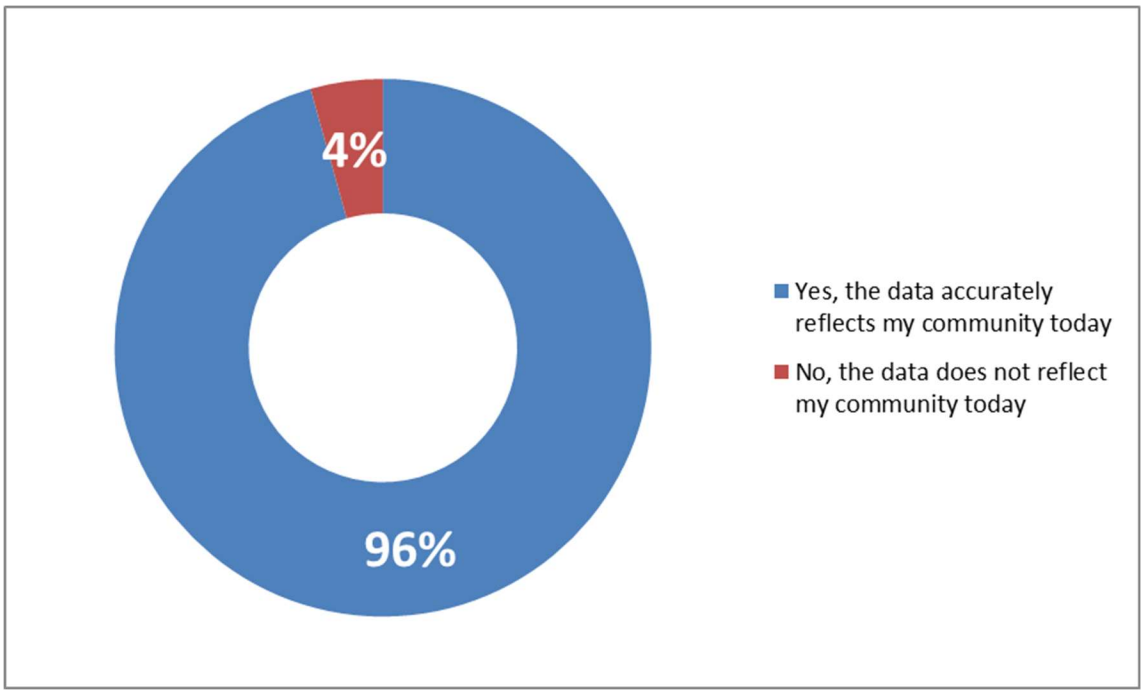


Comments:

- *Would prefer a 3rd option of 'unsure'*
- *I would have to assume this information is accurate.*
- *My real answer on the access numbers would be 'not sure' because I don't know if the South Hero Community Health Center location is included in the provider numbers? If it isn't, Grand Isle would be skewing the numbers down - and it would be good to understand that.*
- *YRBS Data 2017 for Franklin and Grand Isle County, separately, I don't have it by hospital district: Adolescent, grades 9-12*
    - *- who made a suicide plan FC=12% GI= 15% VT=11%*
    - *- who ever smoked a cigarette FC=24% GI=27% VT 24% or a better one is*
    - *- who ever smoked a cigarette or cigar or used smokeless tobacco or electronic vape products, last 30 days FC=21% GI=22% VT=19%*
    - *- who ever binge drank past thirty days FC=19% GI=20% VT=17%*
    - *- who ever used marijuana past 30 days FC 22% GI= 18% VT 24%*
- *I am surprised with the low percentage of adults with poor mental health and physical health*
- *I am surprised with how low so many of the %'s are.*

- *There is a high percentage of NOTCH patients with hypertension and diabetes then the St Albans Health District but in the most part I can agree with the document.*
- *Question the access to Health Services for St. Albans vs Vermont Value. Is the Vermont Value a fair indication for us to compare to in this process.*
- *Would have expected our numbers to be higher based on general observation.*

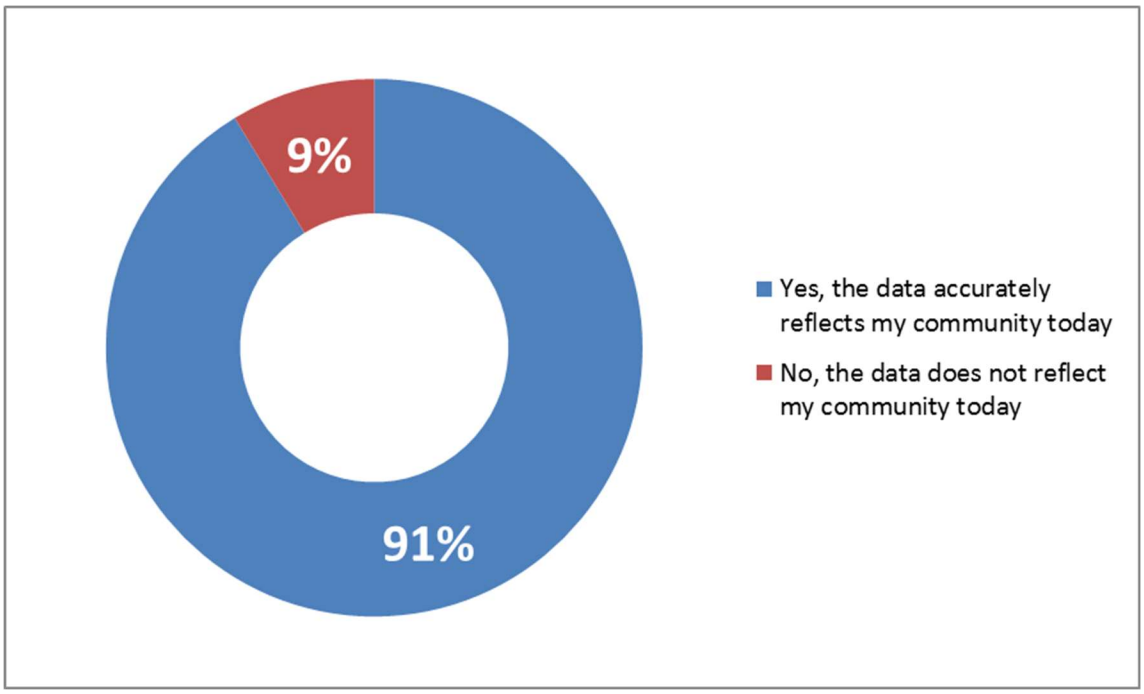
Question: Do you agree with the demographics and common health behaviors of NMC's Service Area?



Comments:

- *We lag behind Vermont and the nation as a whole on bachelor's degree +.*
- *How do I know if it really is representative??*
- *I have no way to evaluate this data*
- *I have to trust that it does. I am not sure.*
- *I have no way of validating the accuracy of these data.*
- *Seriously disheartened to see the longest surviving inhabitants of the state, the Abenaki, being lumped in with "All Others". Even Asian & Pacific Is. Non Hispanic are more recognized*

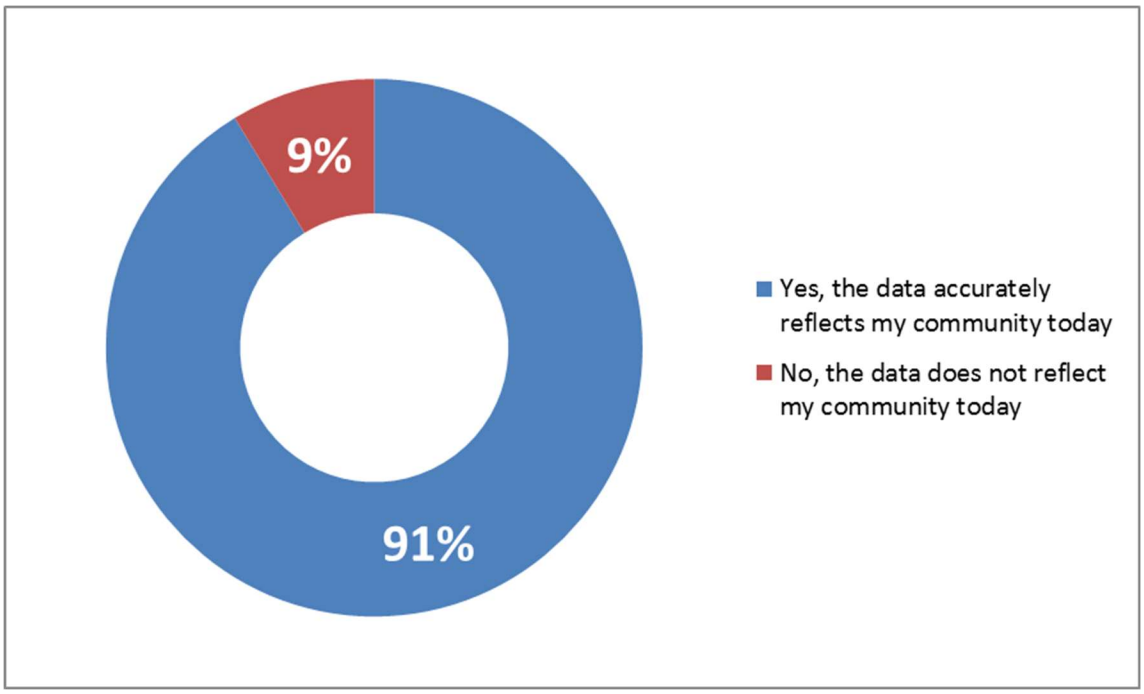
Question: Do you agree with the overall social vulnerability index for Franklin and Grand Isle Counties?



Comments:

- *If I remember correctly, this index counts a household as more vulnerable if they live in a rental property with 30+ units. That's not an accurate reflection of vulnerability in Vermont, as larger complexes tend to be newer and in better condition - and often more frequently inspected. And I'm not convinced that the cluster of tenants means that the tenants are more susceptible to spreading of diseases. But otherwise, I think the data is accurate.*
- *This is not clear how do I really know if it is representative???*
- *I am supposing it is correct*

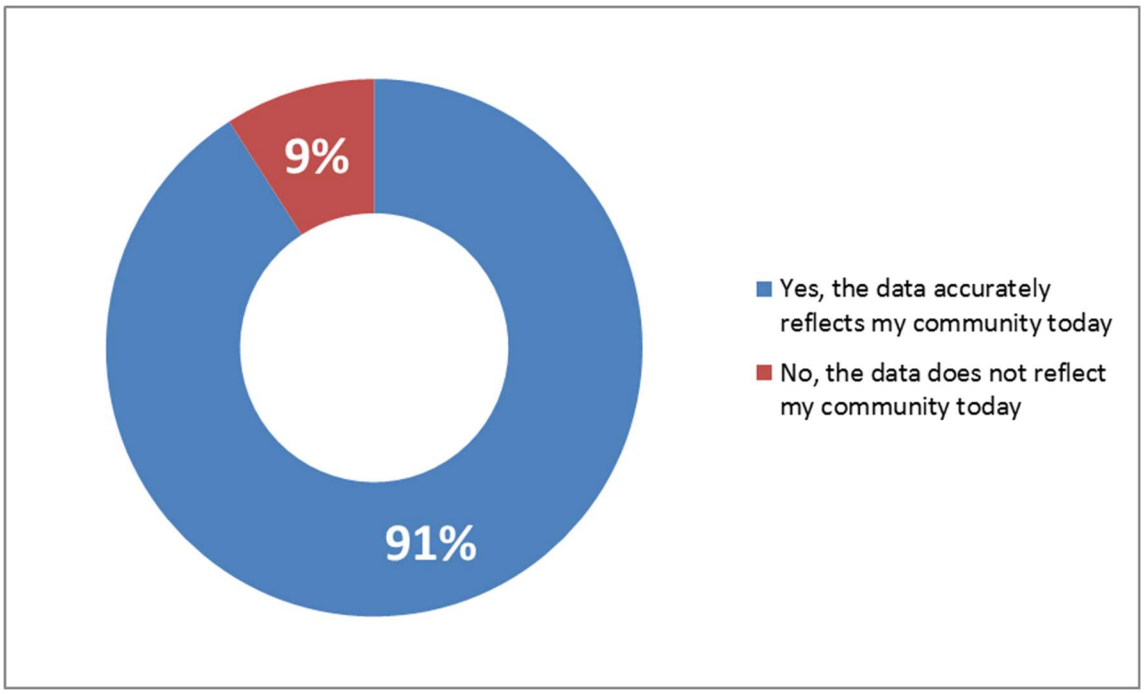
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *Yes I believe the data is accurate and would wonder how statistically significant the value is compared to other counties?*
- *unsure, not area of expertise*
- *I really do not know of the accuracy of the data*
- *It's distressing to see suicide in the top 10 in both counties.*
- *Where does substance use related disorders fall in the ranking, and what percent of the above listed illness are attributable to substance use?*
- *I think there's an error in the GI data - do you meant to say that GIC has the #1 rank of cancer deaths in the state? (It says FC...)*
- *Obesity has a strong correlation with most of the above including Cancer*
- *Is Franklin County #1 for cancer or is it Grand Isle?*
- *I am unsure as to 'higher than expected rates' are fined in terms of ranking, are those rankings also reflected in higher than average rates?*
- *I am concerned with sample size.*

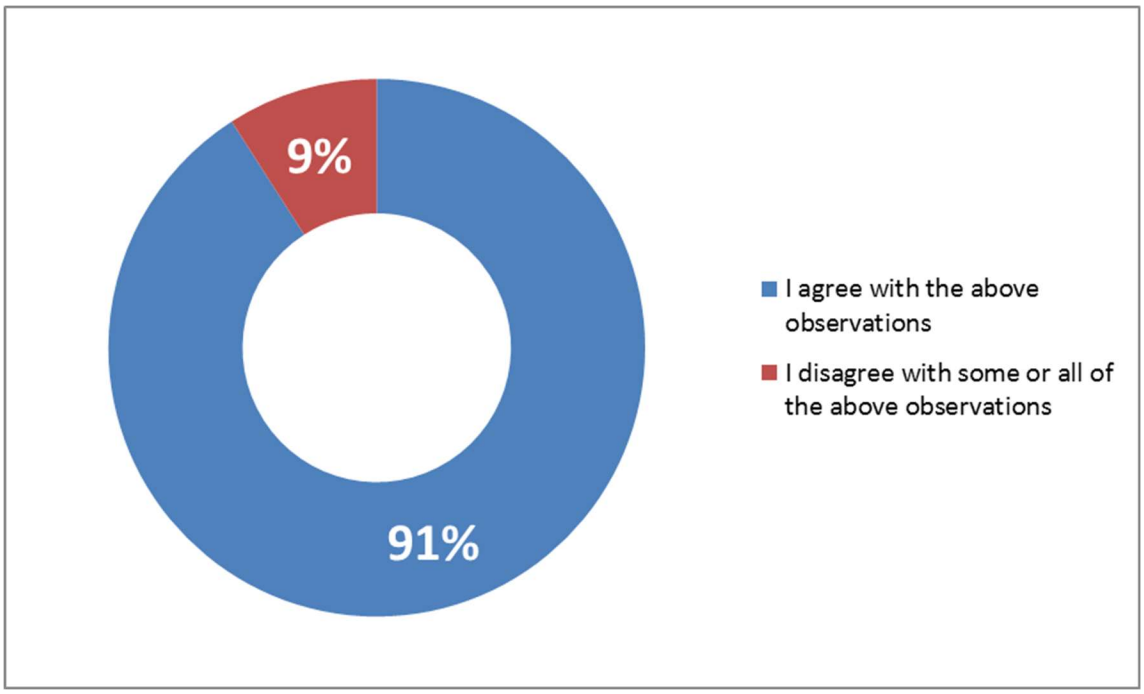
Question: Do you agree with the health trends in Franklin and Grand Isle Counties?



Comments:

- *No surprise around substance abuse, but still distressing. Looks like there may be work to do around women and smoking?*
- *Again, I have no way of validating the accuracy of these data.*

Question: Do you agree with the written comments received on the 2016 CHNA?



Comments:

- *Although I believe the above are important, I am not 100% confident the hospital can play a meaningful role in addressing some of them - they may be out of the hospital's sphere of influence.*
- *Good work with prevention as an example RiseVt*
- *BUT----- there are many agencies in this Health service area doing this good work. NMC needs to consider not so much taking the lead but supporting work that is being done. Collaboration and integration are two good words to consider in this process.*
- *The challenge is who has responsibility in addressing these items.*
- *It should be the responsibility of a non english speaking person / group to learn the language and culture now that they are here. Not the other way around.*

Appendix C – Community Survey Results

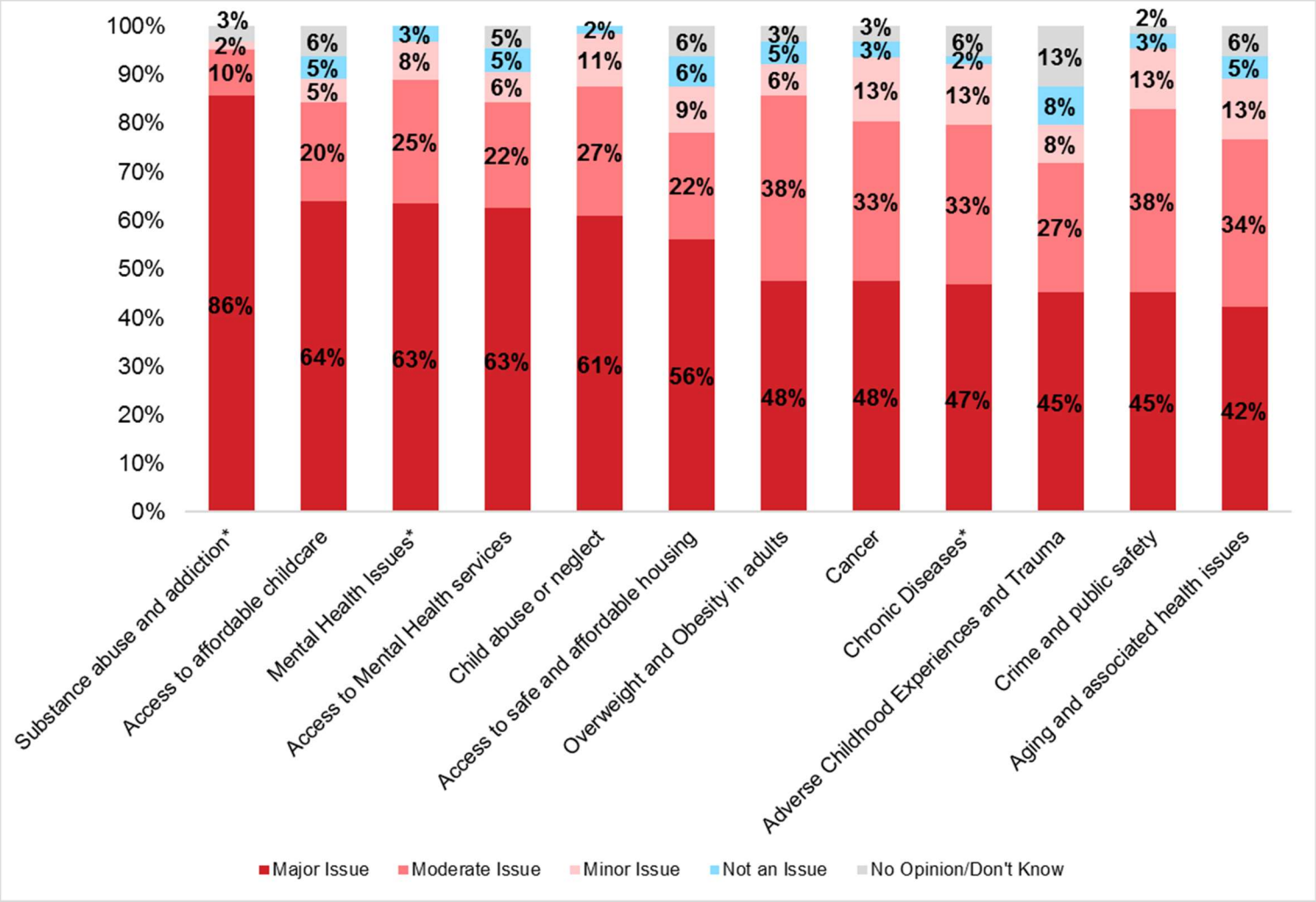
NMC also solicited a survey to its service area's residents to help understand the health needs and challenges facing the local population to ensure the appropriate health needs were identified for the 2019 CHNA.

This survey was open to any area resident over 18 years of age. 64 surveys were completed.

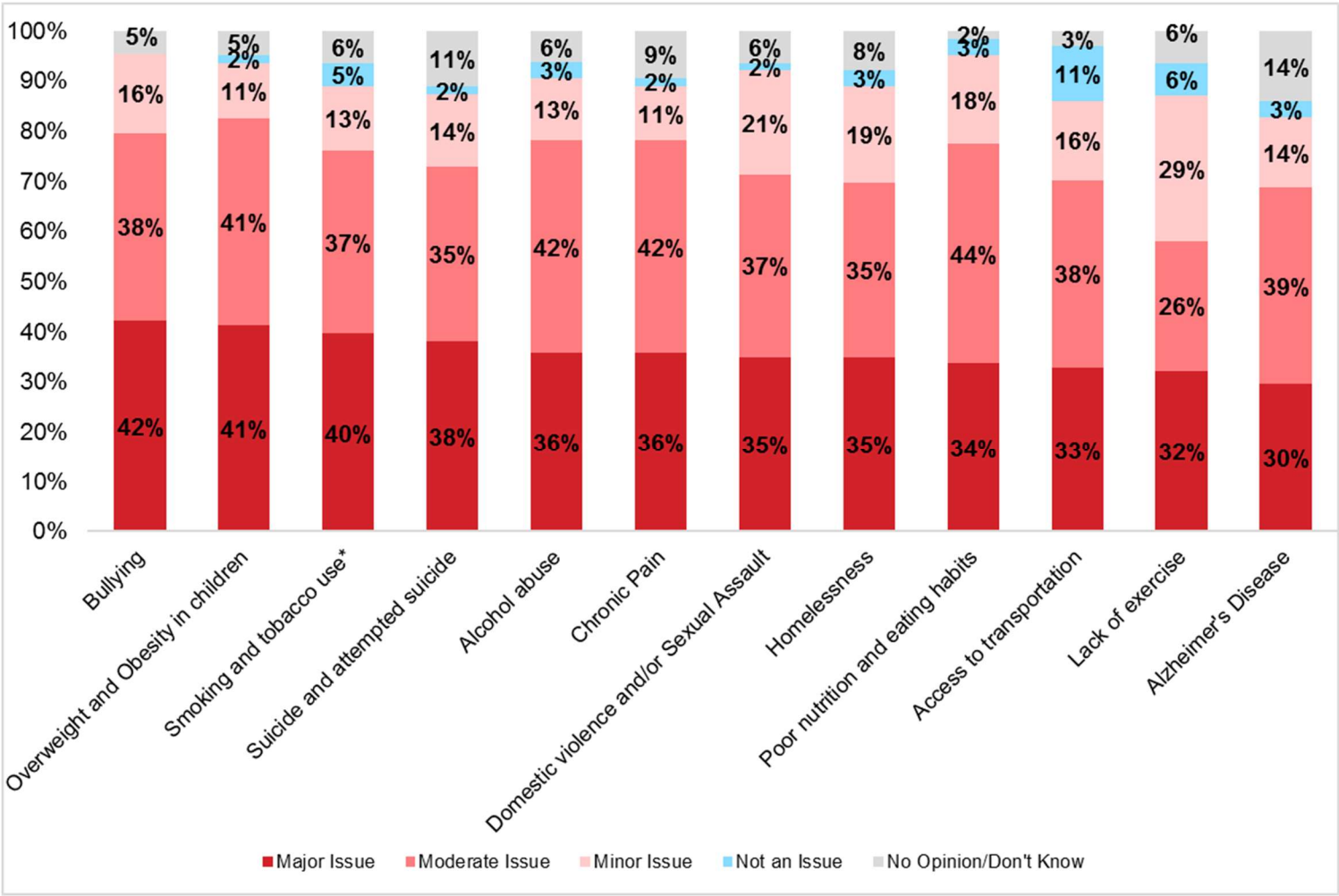
The following presents the information received in response to the solicitation efforts by the hospital.

Question: What is your perception of the level of concern of these Community Health Issues? Use the following definitions to prioritize each issue:

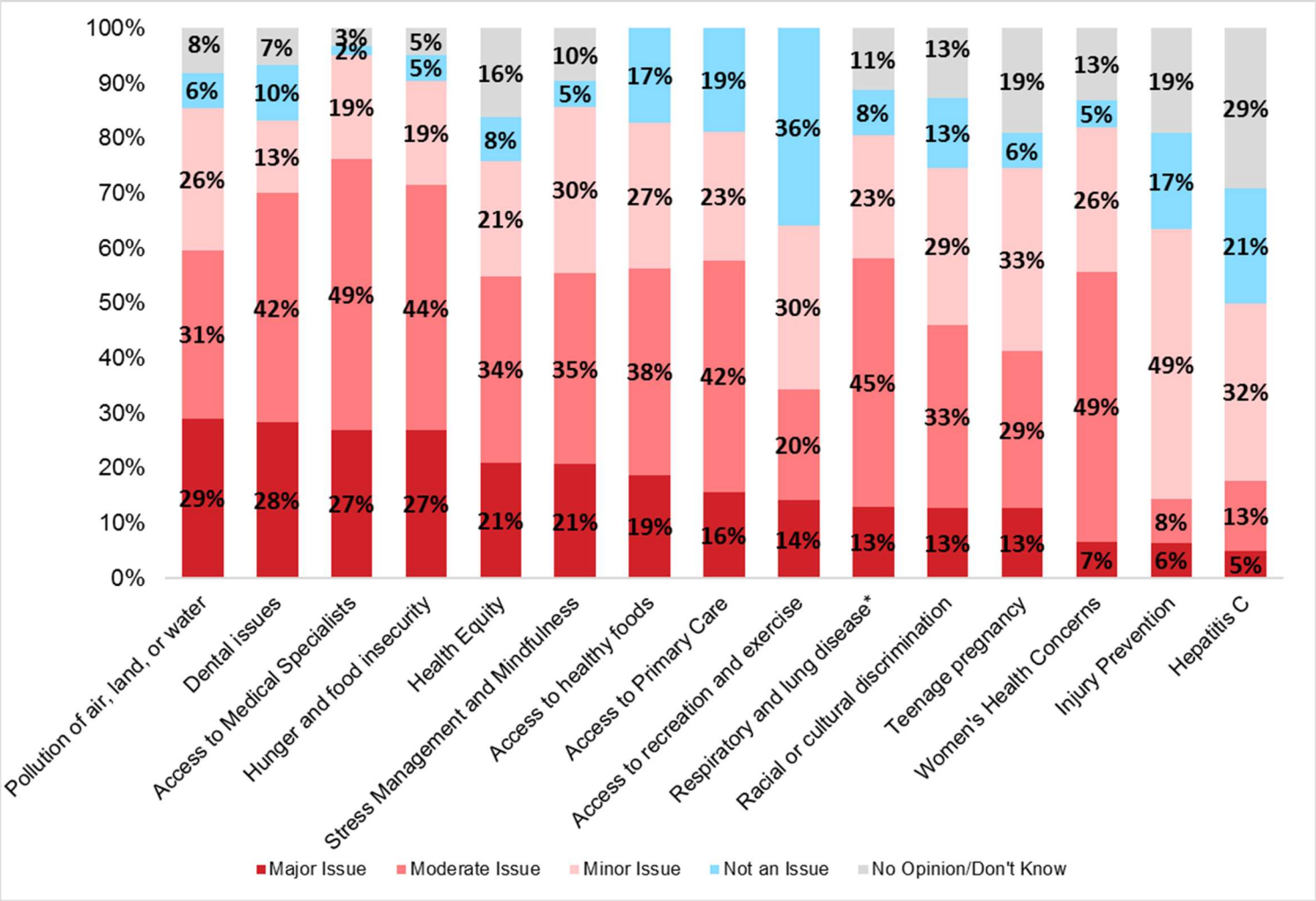
Minor Issue - A concern, but of less importance than other issues
Moderate Issue - A concern of average importance compared to other issues
Major Issue - Among the top three to five concerns needing prompt attention



** Substance abuse and addiction includes illegal or prescription*
** Mental Health Issues includes depression, anxiety, stress, bipolar, etc.*
**Chronic Disease includes diabetes, heart disease, high blood pressure, high cholesterol, stroke*

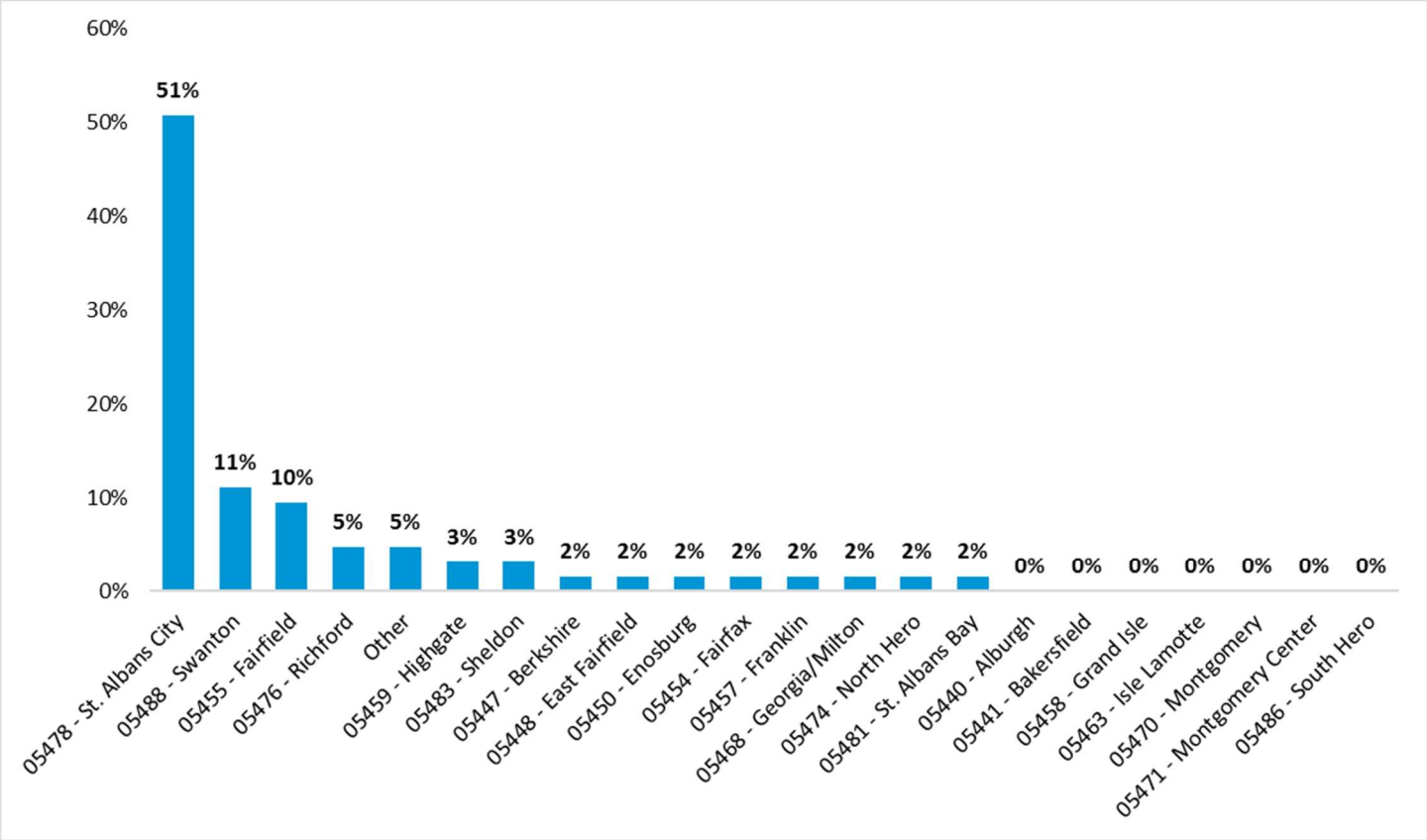


**Smoking and tobacco use includes vaping*

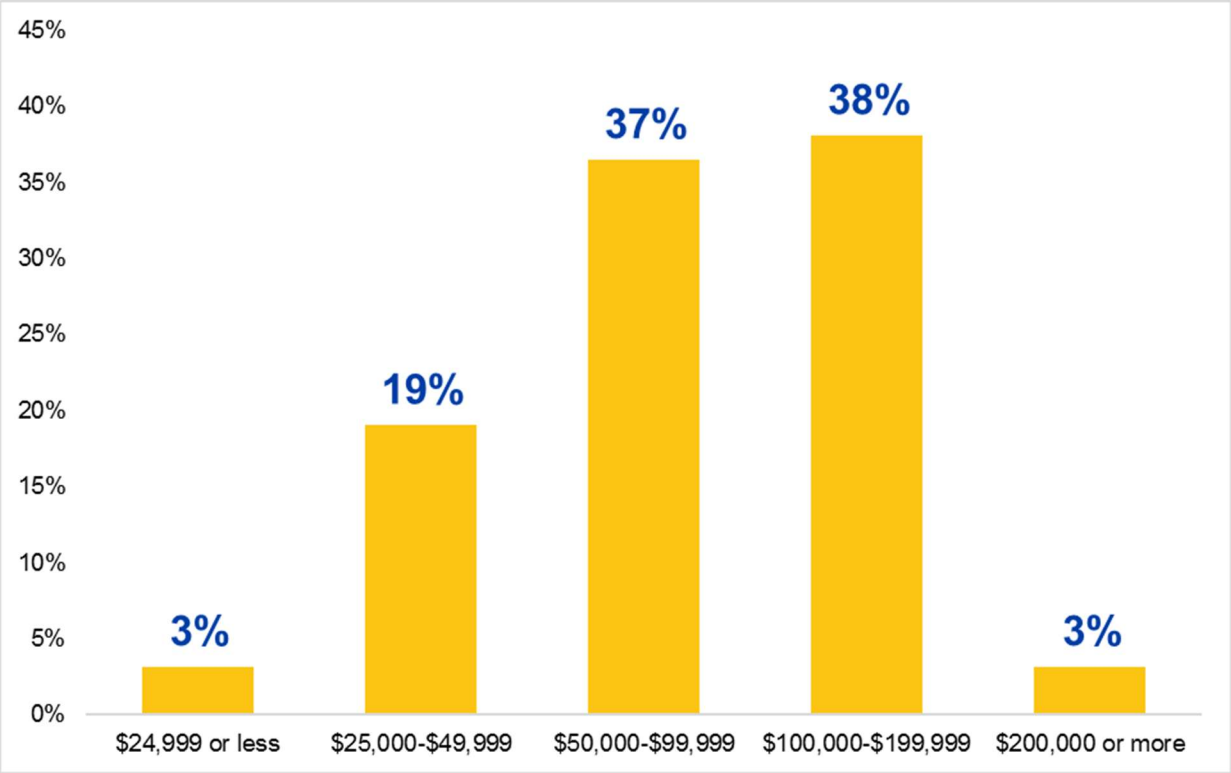


**Respiratory and lung disease includes asthma, COPD, etc.*

Question: What is your ZIP code?



Question: Counting income from all sources (including all earnings from jobs, unemployment insurance, pensions, public assistance, etc.) and counting income from everyone living in your home, which of the following ranges did your household income fall into last year?



Appendix D – National Healthcare Quality and Disparities Report[38]

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

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

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

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

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

Key Findings

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

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

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

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

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

Trends

- Trends show that about 55% percent of quality measures are improving overall for Blacks.[39] However, most recent data in 2014-2015 show that about 40% of quality measures were worse for Blacks compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Asians. However, most recent data in 2014-2015 show that 20% of quality measures were worse for Asians compared with Whites.
- Trends show that almost 35% of quality measures are improving overall for American Indians/Alaska Natives (AI/ANs). However, most recent data in 2014-2015 show that about 30% of quality measures were worse for AI/ANs compared with Whites.
- Trends show that approximately 25% of quality measures are improving overall for Native Hawaiians/Pacific Islanders (NHPIs). However, most recent data in 2014-2015 show that nearly 33% of quality measures were worse for NHPIs compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Hispanics, but in 2014-2015, nearly 33% of quality measures were worse for Hispanics compared with non-Hispanic Whites.
- Variation in care persisted across the urban-rural continuum in 2014-2016, especially in access to care and care coordination.

Looking Forward

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

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

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

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

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

Link to the full report:

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

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

Illustrative IRS Schedule h Part V Section B (Form 990)[40]

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?**

   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**

   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**

      *See footnote ** on page ***

   b. **Demographics of the community**

      *See footnote ** on page ***

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

      *See footnote ** on page ***

   d. **How data was obtained**

      *See footnote ** on page ***

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

      *See footnote ** on page ***

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

      *See footnote ** on page ***

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

      *See footnote ** on page ***

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

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

*See footnotes ** and ** on page ***

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

*See footnote ** on page **, footnotes ** and ** on page **, and footnote ** on page ***

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

N/A

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

2016

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

*Yes, see footnote ** on page ** and footnote ** on page ***

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**

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

*See footnote ** on page ** and footnote ** on page ***

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

Answer

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

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

Answer

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

Answer

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

Answer

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

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

Answer

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

2016

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

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

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

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

*See footnote ** on page **

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)?

Answer

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

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?

Answer