Northwestern Medical Center

2012 Community Health Assessment For Franklin & Grand Isle Counties

Summary Overview – September, 2012
Approved by the NMC Board October 3, 2012

Introductory Letter from Complete Assessment Document:

Dear Community Member:

Northwestern Medical Center (NMC) welcomes you to review this document as we strive to help meet the health related needs in our community.

As we have traditionally, NMC continues to play a collaborative role in the broad-based "Bridges to Well Being" Community Needs Assessment produced by the Franklin Grand Isle Community Partnership and the Franklin Grand Isle United Way. Now, in addition, all not-for-profit hospitals are required to develop a specified "Community Health Assessment" in compliance with the Federal Accountable Care Act which we must file with the Internal Revenue Service. As mandated, this "2012 Community Health Assessment" identifies local health and medical needs, describes NMC's anticipated role in each and how we plan to respond to such needs. It also identifies opportunities for continued collaboration with local providers, organizations as we work to achieve desired improvements. NMC will conduct the required assessment effort at least once every three years. Since this report is a response to a federal requirement of not-for-profit hospital to identify the community benefit it provides in responding to documented community need, footnotes are provided to answer specific tax form questions.

Understandably no single organization, including the hospital, has the resources to solve all the community challenges identified in a comprehensive assessment of this nature. Some issues are beyond our mission so are 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 to help guide how we can collaborate with others to help address the more pressing identified needs.

This report was developed with guidance and assistance from Quorum Health Resources to help ensure compliance with the Federal requirements. It is based on quantifiable health data and informed by a community perceptions survey as well as input on prioritization from experts and leaders within our community. We hope you will agree with the priorities identified and with NMC's planned approach to them. As you review it, please think about how to help us all improve the health of our community. We all live and work in this community together and our collective efforts can make living here more enjoyable and healthier. To share input on this document, please contact our Community Relations Office at 524-1044.

Higher Priority Needs

1. MENTAL HEALTH & SUBSTANCE ABUSE Mental Health was one of three top concerns by +60% of residents, expressed as access problem; Substance Abuse was a problem expressed by +70% of residents, prescription drug abuse and youth drug use are major problems;

Problem Statement: There is a shortage of available, affordable mental health resources. There is a need for a comprehensive, integrated approach to the care of individuals suffering from specialty substance abuse, often times associated with Chronic Pain or abuse of narcotics and prescription medication.

NMC's planned approach: NMC will work collaboratively with Northwestern Counseling & Support Services to support their efforts regarding expanding access to mental health care in our community, including efforts to integrate into the Vermont Blueprint for Health. NMC is establishing an Interventional Pain Management service. NMC will work collaboratively with The Howard Center and other providers, agencies, and organizations in the community to help create a comprehensive, integrated approach to chronic pain management and narcotic addiction. This effort will be aligned with the patient-centered medical home effort being fostered through the implementation of the Blueprint for Health.

Investment Dollars Allocated in FY'13 NMC Budget: $117,875

Key community resources include:

- Howard Center
- Northwestern Counseling & Support Services
- Maple Leaf Farms
- Northwestern Medical Center: Interventional Pain Service
- Community Forum on Chronic Pain & Narcotic Addiction
- Turning Point
- Center Point
- Alcoholics Anonymous
- Narcotics Anonymous
- Vermont Department of Health

2. ACCESS / AVAILABILITY TO HEALTHCARE & PHYSICIANS 2/3 of residents cite a problem; primary care access and specialty medicine access is the most important issue to resolve; visits to primary care from the two counties are 9% above the U.S. average; Pediatrician use is 12% above the U.S. average; parts of Franklin County are designated MEDICALLY UNDERSERVED; community residents did not report difficulty in having a physician;

Problem Statement: Access / Availability to primary and specialty care needs to increase to ensure an adequate supply of practitioners to meet identified needs in the community.

NMC's planned approach: NMC will continue implementation of its Medical Staff Development Plan which outlines the necessary recruitments of practitioners to meet the community's need for primary care and specialists. This plan will be updated during NMC's next round of strategic planning efforts, expected to be complete in May of 2013. Included in this will be NMC's continued support of the implementation of the Vermont Blueprint for Health, ongoing collaboration with NOTCH (Northern Tiers Centers for Health) and private practice physicians, and pursuit of appropriate medical clinics for specialists.

Investment Dollars Allocated in FY'13 NMC Budget: $374,750

Key community resources include:

- Northwestern Medical Center: Physician Recruitment & Referral
- Northwestern Walk-In Clinic
- Northern Tiers Centers for Health (NOTCH)
- Private Physician Practices
- Franklin County Home Health Agency
- Ladies First Program
- Healthcare Ombudsman Program

3. OBESITY a top resident concern; HEALTHY EATING HABITS 10% below U.S. average; MORBID OBESE rates 5% above U.S. average; number of FAST FOOD restaurants is high; LOW INCOME ACCESS TO HEALTHY FOOD a minor concern;

Problem Statement: Additional obesity reduction efforts, including an emphasis on health eating are needed.

NMC's planned approach: NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community. This will include: investigation of a collaborative opportunity in a larger-scale community-based approach to obesity; continued participation in the Fit & Healthy Community initiatives; expansion of the Better U pilot program into the community; and work with employers to replicate NMC's successful Healthy U program in other worksites. NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding obesity.

Investment Dollars Allocated in FY'13 NMC Budget: $35,545

Key community resources include:

- Northwestern Medical Center: Registered Dietitians & Better U
- Vermont Department of Health
- Primary Care Providers & Pediatricians
- Center For Health & Wellness
- Municipal Recreation Departments
- Fit & Healthy (Swanton & Enosburg)
- Collins Perley Sports Complex & Private Facilities
- Mississquoi Valley Rail Trail
- Walk & Bike St. Albans

4. SMOKING Grand Isle rate is below the VT average, Franklin rate is above the VT average

Problem Statement: The number of local residents who smoke needs to decline.

NMC's planned approach: NMC will continue to take a leading role in the Franklin Grand Isle Tobacco Coalition's efforts regarding reduction in the use of tobacco. NMC will also play an active role in tobacco cessation efforts in the community and will help incorporate these efforts into the implementation of community care team of the Blueprint for Health.

Investment Dollars Allocated in FY'13 NMC Budget: $7,720

Key community resources include:

- Franklin Grand Isle Tobacco Coalition

- Vermont Department of Health
- Primary Care Providers
- Fit & Healthy (Swanton & Enosburg)
- Northwestern Medical Center: Smoking Cessation

5. CANCER is the #1 VT cause of death, Grand Isle rate is the highest in VT and greatly above U.S. average; Cancer SCREENING TEST usage is 9% below average; PROSTATE SCREENING testing rate is 6% below average; deaths from BREAST & COLON CANCER is a Franklin concern, no Grand Isle data exists; LUNG CANCER is a cause of death is a concern for both counties;

Problem Statement: Early detection of cancer and coordination of treatment should be increased.

NMC's planned approach: NMC will build upon its accredited cancer program to improve awareness of cancer related issues, promote early detection, and expand oncology case management. Special emphasis will be placed on improving the early detection of colon cancer and streamlining the treatment of breast cancer. We will continue to work collaboratively with the Vermont Center for Cancer Medicine and Fletcher Allen Health Care on the treatment of cancer patients. NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding cancer. NMC's collaboration in the work regarding tobacco reduction will contribute to the effort to reduce cancer in our community.

Investment Dollars Allocated in FY'13 NMC Budget: $26,870

Key community resources include:

- Vermont Center for Cancer Medicine
- Northwestern Medical Center: Cancer Program
- American Cancer Society
- Center for Health & Wellness
- Vermont Department of Health
- Jim Bashaw Fund

6. HEALTH INSURANCE / UNINSURED second of top three major concerns by over 60% of residents, COST PROBLEMS present as being 5% above the U.S. average;

Problem Statement: Healthcare costs are a potential barrier to access to care in the community.

NMC's planned approach: NMC will continue to take an active role in the implementation of healthcare reform activities focus on or in part on bending the cost curve, including: the implementation of the Blueprint for Health to better manage chronic conditions; the expansion of the NMC Emergency Department Pilot to reduce avoidable ED visits; participation in the "One Care" Accountable Care Organization with Fletcher Allen & Dartmouth; etc. NMC will also continue our charity care program and maintain our internal organizational focus on cost containment. NMC will work collaboratively with the Green Mountain Care Board as the State works to restructure the healthcare system to provide enhanced access to lower cost high quality care to all Vermonters.

Investment Dollars Allocated in FY'13 NMC Budget: $102,000

Key community resources include:

- Green Mountain Care Board
- Vermont Department of Health
- Northwestern Medical Center: Charity Care Program
- Northern Tiers Centers for Health (NOTCH): Sliding Fee Scale

7. SUICIDE Franklin County has the highest VT rate and the death rate in Grand Isle County is above the VT average;

Problem Statement: An enhanced strategy is needed to implement proven Suicide Prevention techniques.

NMC's planned approach: As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to suicide prevention and look for appropriate opportunities to assist. NMC's collaboration in the work regarding narcotic addiction could contribute to the effort to reduce suicide in our community.

Investment Dollars Allocated in FY'13 NMC Budget: None Specified

Key community resources include:

- Northwestern Counseling & Support Services
- Vermont Department of Health
- Voices Against Violence
- Private Practice Psychologists & Counselors

- Law Enforcement Professionals
- Teen Centers
- Churches

8. DOMESTIC AND SEXUAL ABUSE many physicians and even mental health workers are not trained to either identify domestic violence or even treat patients adequately.

Problem Statement: Expansion of community response is needed in relation to the education, prevention, diagnostics, and treatment of domestic and sexual abuse.

NMC's planned approach: NMC will continue to support and encourage the community efforts relating to domestic and sexual abuse led by Voices Against Violence. We will continue our active role in the detection and treatment of abuse victims through the Sexual Assault Nurse Examiners service in our Emergency Department.

Investment Dollars Allocated in FY'13 NMC Budget: $1,750

Key community resources include:

- Voices Against Violence
- Northwest Unit of Special Investigations
- Northwestern Medical Center: Sexual Assault Nurse Examiners
- Prevent Child Abuse Vermont
- Vermont Department of Children & Families
- Safe At Home Program

9. CORONARY HEART DISEASE is the second leading VT cause of death; Franklin County has the highest rate in VT, its coronary death rate is worse than its peer counties and somewhat worse than U.S. average, older data has heart disease death rates in second lowest U.S. quartile; CARDIAC STRESS TESTING is 9% below U.S. average

Problem Statement: The number of heart related deaths needs to decline. Diagnostic and medical treatment resources need to increase. Prevention efforts should be pursued on a broader scale.

NMC's planned approach: NMC will continue to grow Northwestern Cardiology, our new successful medical cardiology collaboration with Fletcher Allen. We will continue to expand our diagnostic resources as necessary to support community need relating to that initiative. NMC will collaborate with efforts within the Blueprint for Health to

increase primary care focus regarding heart disease. NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community. This will include: investigation of a collaborative opportunity in a larger-scale community-based approach to obesity which will impact heart disease longer term; continued participation in the Fit & Healthy Community initiatives; expansion of the Better U pilot program into the community; and work with employers to replicate NMC's successful Healthy U program in other worksites. NMC's collaboration in the work regarding tobacco reduction will contribute to the effort to reduce heart disease in our community.

Investment Dollars Allocated in FY'13 NMC Budget: $86,820

Key community resources include:

- Northwestern Cardiology
- Primary Care Providers
- American Heart Association
- Northwestern Medical Center: Better U & Cardiac Rehab
- Center for Health & Wellness
- Vermont Department of Health
- Franklin Grand Isle Tobacco Coalition
- Fit & Health Communities (Swanton & Enosburg)

10. CHRONIC LUNG DISEASE AND CHRONIC ASTHMA Chronic lung disease is the third leading VT cause of death, Grand Isle County has the highest death rate in VT and this rate is greatly above U.S. average; the rate for chronic asthma is 12% below average;

Problem Statement: The number of pulmonary related deaths needs to decline. Diagnostic and medical treatment resources need to increase. Prevention efforts should be pursued on a broader scale. Enhancement of services relating to chronic Asthma should be included in these efforts.

NMC's planned approach: NMC will continue to pursue the establishment of a Pulmonary service similar in nature to our successful establishment of the medical cardiology service. NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding lung disease and asthma. NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community, including continued leadership in the Franklin Grand Isle Tobacco Coalition.

Investment Dollars Allocated in FY'13 NMC Budget: $500

Key community resources include:

- Primary Care Providers
- American Lung Association
- Vermont Department of Health
- Northwestern Medical Center: Respiratory Therapy
- Franklin Grand Isle Tobacco Coalition

11. HIGH BLOOD PRESSURE related deaths in Grand Isle County are the highest in VT, both counties have incident rates placing them in the highest U.S. quartile

Problem Statement: More residents need blood pressure awareness including condition management education and treatment.

NMC's planned approach: NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding high blood pressure. NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community. This will include: investigation of a collaborative opportunity in a larger-scale community-based approach to obesity which will impact high blood pressure; continued participation in the Fit & Healthy Community initiatives; expansion of the Better U pilot program into the community; and work with employers to replicate NMC's successful Healthy U program in other worksites.

Investment Dollars Allocated in FY'13 NMC Budget: $9,940

Key community resources include:

- Primary Care Providers
- American Heart Association
- Vermont Department of Health
- Center For Health & Wellness

Lower Priority Needs

12. STROKE is the fifth leading cause of death in VT; Grand Isle County has the highest death rate in VT, while Franklin County has the lowest VT death rate;

Problem Statement: The number of local residents having strokes should decline and Franklin success should be evaluated for adoption in Grand Isle.

NMC's planned approach: NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding stroke. NMC will continue our direct involvement through the clinical stroke protocol. NMC's collaborative health promotion and wellness initiatives regarding obesity, heart disease, high blood pressure, and high cholesterol will positively impact stroke risk in the community.

Investment Dollars Allocated in FY'13 NMC Budget: $4,970

Key community resources include:

- Primary Care Providers
- Northwestern Cardiology
- American Heart Association
- Vermont Department of Health
- Northwestern Medical Center: Stroke Protocol Initiative

13. DIABETES prevalence rates are among the lower rates observed in the US;

Problem Statement: Diabetic education and treatment resources should be expanded to continue to reduce the impact of this disease.

NMC's planned approach: NMC will continue its diabetes education and counseling service, expanding access as needed to continue to meet community need. NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding diabetes. NMC's collaborative health promotion and wellness initiatives regarding obesity, heart disease, high blood pressure, and high cholesterol will positively impact diabetes risk in the community.

Investment Dollars Allocated in FY'13 NMC Budget: $12,770

Key community resources include:

- Primary Care Providers & Pediatricians
- Specialists: Podiatrists, Ophthalmologists, etc
- Northwestern Medical Center: Diabetes Counseling
- Northwestern Medical Center: Diabetes & You
- Northwestern Medical Center: Diabetes Fund
- Vermont Department of Health
- Center for Health & Wellness

14. HOMICIDE Grand Isle County has the highest death rate from homicides in VT although it has the lowest violent crime rate; Franklin County has the second highest homicide rate in the State and a violent crime rate 50% above the Vermont average;

Problem Statement: Violent crime and Homicide rates must be reduced.

NMC's planned approach: As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to suicide prevention and look for appropriate opportunities to assist. NMC's collaboration in the work regarding narcotic addiction could contribute to the effort to reduce violent crime and homicide in our community.

Investment Dollars Allocated in FY'13 NMC Budget: None Specified

Key community resources include:

- Law Enforcement Professionals
- Voices Against Violence
- Northwest State Correctional Facility

15. JOBS develop job opportunities which pay a living wage and are considered worthwhile occupations; the unemployment rate in Grand Isle exceeds the Vermont average by about 0.3% while Franklin County unemployment is below the Vermont average by about 0.8%

Problem Statement: Reduce the unemployment rate to not exceed the State average.

NMC's planned approach: As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to job development and look for

appropriate opportunities to assist. NMC will continue to actively participate in, support, and encourage the work of the Franklin County Industrial Development Corporation, the Franklin County Regional Chamber of Commerce, and the Franklin Grand Isle Workforce Investment Board. NMC's Scholarship Work Experience Program will facilitate access to the professional training necessary for local students to obtain healthcare careers.

Investment Dollars Allocated in FY'13 NMC Budget: $26,200

Key community resources include:

- Franklin County Industrial Development
- Franklin Grand Isle Workforce Investment Board
- Champlain Valley Office of Equal Opportunity
- VocRehab Vermont
- Area High Schools & Technical Centers
- Vermont Adult Learning
- Vermont Associates for Training & Development
- Champlain Valley Area Health Education Center
- Northwestern Medical Center: Health Professions Scholarships

16. PALLIATIVE CARE programs exist in Franklin County.

Problem Statement: Palliative care services should expand as appropriate into both Counties.

NMC's planned approach: NMC will develop a more formal approach to palliative care within the hospital setting, drawing upon expertise from the Medical Staff and community partners.

Investment Dollars Allocated in FY'13 NMC Budget: $9,200

Key community resources include:

- Franklin County Home Health Agency
- Northwestern Medical Center: Palliative Care Initiative
- Primary Care Providers

17. BABY DEATHS - INFANT MORTALITY & NEONATAL INFANT MORTALITY worse than peers and U.S. average; LOW BIRTH WEIGHT & PREMATURE BABIES & POSTNEONATAL INFANT MORTALITY a Grand Isle concern, favorable Franklin rates; VERY LOW BIRTH WEIGHT a Grand Isle concern, somewhat a Franklin concern; WHITE NON HISPANIC INFANT MORTALITY worse than peers and U.S. average.

Problem Statement: Efforts are needed to reduce infant mortality.

NMC's planned approach: NMC's Family Birth Center and the Northwestern Obstetrics & Gynecology practice will collaborate to implement a "Centering Pregnancy" program, an innovative evidence-based approach to prenatal care which has been shown to improve clinical outcomes. NMC will continue to work collaboratively with the Vermont Department of Health and other providers on other issues relating to healthy childbirth: including special services for opioid dependent mothers, breastfeeding in the workplace, etc.

Investment Dollars Allocated in FY'13 NMC Budget: None specified

Key community resources include:

- Pediatricians
- Northwestern Obstetrics & Gynecology
- Vermont Department of Health
- Safe Kids Vermont

18. BIRTHS - TO WOMEN AGE 40 TO 54 a Grand Isle concern, somewhat a Franklin concern; TO UNMARRIED WOMEN somewhat a concern in both counties; TEEN BIRTHS most recent data suggests a Franklin concern, but further analysis shows teen births concentrated in the 18-19 range whereas the 13-17 range is typically the greater cause for concern;

Problem Statement: Target critical populations should have increased availability to prenatal care educational programs;

NMC's planned approach: NMC's Family Birth Center and the Northwestern Obstetrics & Gynecology practice will collaborate to implement a "Centering Pregnancy" program, an innovative evidence-based approach to prenatal care which has been shown to improve clinical outcomes. NMC will continue to work collaboratively with the Vermont Department of Health and other providers on other issues relating to healthy childbirth: including special services for opioid dependent mothers, breastfeeding in the workplace, etc.

Investment Dollars Allocated in FY'13 NMC Budget: $3,300

Key community resources include:

- Northwestern Obstetrics & Gynecology
- Northwestern Medical Center: Family Birth Center
- Vermont Department of Health
- CareNet Pregnancy Center

19. PHYSICAL ENVIRONMENTAL FACTORS do not appear a concern as it has a positive influence on health status.

Problem Statement: A community-based determination is needed to identify and implement actions to continue to improve the local physical environment.

NMC's planned approach: As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to our physical environment and look for appropriate opportunities to assist. There may be opportunities within the Fit & Healthy Communities Initiatives for NMC to play a supportive role in developing resources to promote increased health status, as NMC did with the establishment of the walking path in Swanton.

Investment Dollars Allocated in FY'13 NMC Budget: $1,100

Key community resources include:

- Northwest Regional Planning Commission
- Friends of Northern Lake Champlain
- Habitat for Humanity
- Samaritan House
- Municipal Parks Departments & Hardack Association
- Missisquoi Valley Rail Trail
- CIDER & Green Mountain Transit Authority

20. ACCIDENTS while the fourth leading cause of VT deaths, do not present as a problem; MOTOR VEHICLE INJURY rates are favorable in Franklin; SPORT INJURY is 6% below national average; UNINTENTIONAL INJURY rates are better than peer and U.S. values

Problem Statement: A community-based determination is needed to identify and implement actions to reduce the number of accidental injuries.

NMC's planned approach: As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to suicide prevention and look for appropriate opportunities to assist.

Investment Dollars Allocated in FY'13 NMC Budget: None specified

Key community resources include:

- Law Enforcement Professionals
- Vermont Department of Health
- Franklin County Home Health Agency
- Community Emergency Response Team
- Northwestern Medical Center: Emergency Department

21. CHRONIC HIGH CHOLESTEROL rate is 8% below the U.S. average;

Problem Statement: More residents need cholesterol awareness including condition management education and treatment.

NMC's planned approach: NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding high cholesterol. NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community. This will include: investigation of a collaborative opportunity in a larger-scale community-based approach to obesity which will impact high cholesterol; continued participation in the Fit & Healthy Community initiatives; expansion of the Better U pilot program into the community; and work with employers to replicate NMC's successful Healthy U program in other worksites.

Investment Dollars Allocated in FY'13 NMC Budget: $4,970

Key community resources include:

- Primary Care Providers
- American Heart Association
- Center For Health & Wellness

22. CHRONIC OSTEOPOROSIS rate is 6% below the U.S. average;

Problem Statement: Continued efforts relating to osteoporosis awareness including condition management education and treatment are needed to further reduce the impact of the condition.

NMC's planned approach: NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding osteoporosis. NMC will continue our direct involvement through our bone density screening service. NMC's collaborative health promotion and wellness initiatives regarding senior exercise will positively impact osteoporosis risk in the community.

Investment Dollars Allocated in FY'13 NMC Budget: $6,970

Key community resources include:

- Primary Care Providers
- Northwestern Obstetrics & Gynecology
- Vermont Department of Health
- Center for Health & Wellness
- Northwestern Medical Center: Bone Density Screening
- Northwestern Medical Center: Strong Women Program

23. SEXUALLY TRANSMITTED DISEASE not a concern; Chlamydia in Grand Isle occurs at a rate of 168 per 100,000 and Franklin County has an occurrence rate of 121, both of which are below the Vermont statewide average

Problem Statement: More residents need awareness of sexually transmitted diseases including condition management education and treatment.

NMC's planned approach: As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to suicide prevention and look for appropriate opportunities to assist.

Investment Dollars Allocated in FY'13 NMC Budget: None specified

Key community resources include:

- Primary Care Provider
- Northwestern Obstetrics & Gynecology
- Vermont Department of Health
- Planned Parenthood

- Area High School Health Programs

24. PREMATURE DEATHS Grand Isle favorable but Franklin unfavorable; LIFE EXPECTANCY for females is 81.5 years, for males 77.4 years, both about 4 years behind top U.S. values solutions however, may lie with other needs;

Problem Statement: A community based determination is needed to identify and implement actions to reduce the number of residents dying prior to age 75.

NMC's planned approach: As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to suicide prevention and look for appropriate opportunities to assist.

Investment Dollars Allocated in FY'13 NMC Budget: None Specified

Key community resources include:

- Primary Care Providers
- Law Enforcement Professionals
- Vermont Department of Health
- Center for Health & Wellness

Community Members Assisting in Prioritization:

Special thanks go out to the community members who assisted in the prioritization of the community health priorities identified through the quantitative and qualitative research. They were able to confirm the appropriateness of the items and put them into priority within the context of our community. The composition of this this group of community members aligns with the Federal regulations for the involvement of community leaders with specified skills or representing specified constituencies or professions.

Participating in this assessment were:

- Elizabeth Gamache, Mayor of St. Albans
- Sonya Rochon, Voices Against Violence
- Leonard Stell, Swanton Chief Of Police
- Kelly Woodward, Northwest Unit for Special Investigations
- Deb Grennon, Franklin Grand Isle Bookmobile
- Diana I. Langle, All About Kids Supervised Visitation Center
- Beth Crane, Franklin County Caring Communities
- Robin Way, C.I.D.E.R.
- Ruth Wallman, Lake Champlain Islands Chamber
- Odessa Kilby, Champlain Valley Agency on Aging
- Linda Ryan, Samaritan House
- Dorey Myers, Vermont Department of Health
- Sue Chase, CarePartners Adult Day Center
- Pamela Polhemus, Planned Parenthood of NNE
- Tim Smith, Franklin County Industrial Development Corporation
- Sally Bortz, Franklin-Grand Isle United Way
- Judy Ashley McLaughlin, Vermont Dept of Health
- Kristin Prior, Agency of Human Services
- Janet McCarthy, Franklin County Home Health Agency
- Kris Lukens-Rose, Voices Against Violence
- Helen Riehle, Champlain Valley Area Health Education Center
- Amy Brewer, Franklin Grand Isle Tobacco Coalition

NORTHWESTERN MEDICAL CENTER
ST ALBANS, VERMONT

2012 COMMUNITY HEALTH NEEDS ASSESSMENT

ADOPTED BY BOARD OCTOBER 3, 2012[1]

[1] Response to Schedule H (Form 990) Part V B 2

QHR | Consulting Services

Dear Community Member:

Northwestern Medical Center (NMC) welcomes you to review this document as we strive to help meet the health related needs in our community.

As we have traditionally, NMC continues to play a collaborative role in the broad-based "Bridges to Well Being" Community Needs Assessment produced by the Franklin Grand Isle Community Partnership and the Franklin Grand Isle United Way. Now, in addition, all not-for-profit hospitals are required to develop a specified "Community Health Assessment" in compliance with the Federal Accountable Care Act which we must file with the Internal Revenue Service. As mandated, this "2012 Community Health Assessment" identifies local health and medical needs, describes NMC's anticipated role in each and how we plan to respond to such needs. It also identifies opportunities for continued collaboration with local providers and organizations as we work to achieve desired improvements. NMC will conduct the required assessment effort at least once every three years. Since this report is a response to a federal requirement of not-for-profit hospitals to identify the community benefit it provides in responding to documented community need, footnotes are provided to answer specific tax form questions.

Understandably no single organization, including the hospital, has the resources to solve all the community challenges identified in a comprehensive assessment of this nature. Some issues are beyond our mission so are 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 to guide how we can collaborate with others to help address the more pressing identified needs.

This report was developed with guidance and assistance from Quorum Health Resources to help ensure compliance with the Federal requirements. It is based on quantifiable health data and informed by a community perceptions survey as well as input on prioritization from experts and leaders within our community. We hope you will agree with the priorities identified and with NMC's planned approach to them. As you review it, please think about how to help us all improve the health of our community. We all live and work in this community together and our collective efforts can make living here more enjoyable and healthier. To share input on this document, please contact our Community Relations Office at 524-1044.

105 Continental Place
Brentwood, TN 37027
1.800.233.1470
www.QHR.com

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EXECUTIVE SUMMARY

Executive Summary

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

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

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

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

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

Project Objectives

Northwestern Medical Center (NMC) partnered with QHR for the following[4]:

- Complete a Community Health Needs Assessment report, compliant with Treasury – IRS;
- Provide the Hospital with information required to complete the IRS – 990h schedule; and
- Produce the information necessary for the hospital to issue an assessment of community health needs and document its intended response.

Brief Overview of Community Health Needs Assessment

Typically, nonprofit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c) 3 of the Internal Revenue Code; however, the term "Charitable Organization" is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided to the less fortunate without means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit

[2] Part 3 Treasury/IRS – 2011 – 52 Notice … Community Health Needs Assessment Requirements…
[3] As of the date of this report Notice of proposed rulemaking was published 6/26/2012 and available at http://federalregister.gov/a/2012-15537
[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- Emergency room open to all, regardless of ability to pay;
- Surplus funds used to improve patient care, expand facilities, train, etc.;
- Control by independent civic leaders; and
- All available and qualified physicians are privileged.

Specifically, the IRS requires:

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

[5] Section 6652

Financial Opportunity Summary

NMC intends to work toward a Community Benefit allocation of $2,608,348 annually[6] in response to Community Benefit[7] obligations (see chart below).

12 Months Ending June 2012[8]	
Net Revenue	**$87,328,523**
Bad Debt	**$3,609,352**
Total Net Revenue	**$83,719,171**
Community Benefit Goal 3% to 5% of Total Net Revenue	**$2,512,575 to $4,185,959**
Current Charity	**$1,877,098**
990 Documented Community Benefit	**$0**
CHNA Anticipated Expenditures	**$731,250**
Total Provided Community Benefit	**$2,608,348**

[6] Response to Schedule H (Form 990) Part V B 6 f

[7] "Community Benefit" is defined as the term used in the Accountable Care Act and by the IRS 990 instructions. This term may be defined differently by the Hospital when complying with reporting requirements of "Community Benefit" or "Charity" as defined by the State. Amounts shown are for planning and budgetary purposes only. Actual dollar allocations will vary year to year and are documented on the Corporate 990 return.

[8] All values are obtained from the QHR comparative database, except "990 Documented Community Benefit" and "CHNA Anticipated Expenditures" both of which is sourced from the hospital.

APPROACH

Approach

To complete a CHNA, the Hospital must:

- Describe the processes and methods used to conduct the assessment;
  - Sources of data, and dates retrieved;
  - Analytical methods applied;
  - Information gaps impacting ability to assess the needs; and
  - Identify with whom the Hospital collaborated.
- Describe how the hospital gained input from community representatives;
  - When and how the organization consulted with these individuals;
  - Names, titles and organizations of these individuals; and
  - Any special knowledge or expertise in public health possessed by these individuals.
- Describe the process and criteria used in prioritizing health needs;
- Describe existing resources available to meet the community health needs; and
- Identify the programs and resources the hospital facility plans to commit to meeting each identified need and the anticipated impact of those programs and resources on the health need.

QHR takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with local survey data and resolve any data inconsistency or discrepancies from the combined opinions formed from local experts. We rely on secondary source data and most secondary sources use the county as the smallest unit of analysis. Since the service area comprises parts of two counties, we asked local residents to note if they perceived the problems, or needs, identified by secondary sources to exist in their portion of the county.[9]

The data displays used in our analysis are presented in the Appendices. Data sources include:[10]

- www.countyhealthrankings.com – to assess the health needs of Franklin and Grand Isle Counties compared to all Vermont counties;
- www.Communityhealth.hhs.gov – to assess the health needs of Franklin and Grand Isle compared to its national set of "peer counties";
- Truven (formerly known as Thomson) Market Planner – to assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into

[9] Response to Schedule H (Form 990) Part V B 1 i
[10] Response to Schedule H (Form 990) Part V B 1 d

various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the contribution each group makes to the entire area; and, to access population size and socio-economic characteristics;

- www.capa.org – to determine the availability of Palliative Care programs and services in the area;
- http//apps.nccd.gov – to determine the potential importance of stroke and heart attack comorbidities, complications and death rates, and cholesterol checking; and
- http://www.worldlifeexpectancy.com/usa-health-rankings – to determine cause of death.

In addition, we deployed a Community Health Need Assessment survey within the local population for any resident to complete.[11]

- We received community input from 258 area residents; survey responses started Wednesday, February 29, 2012 at 12:23 p.m. and ended with the last response on Saturday, April 7, 2012 at 3:48 p.m.;
- The terms of gaining input stipulated each respondent would remain anonymous;
- The internet based survey was promoted through a paid advertisement in a local newspaper and distributed to local civic and health organizations with a request for participation. Preliminary conclusions were presented to a local group of experts, who were asked to validate prior assessments and to establish priority among various identified health and medical issues[12]; and
- Information analysis augmented by local opinions showed how Franklin and Grand Isle Counties relate among its peers in terms of primary and chronic needs, as well as other issues of uninsured persons, low-income persons and minority groups; respondents commented on if they believe certain population groups (or people with certain situations) need help to improve their condition and if so, who needs to do what[13].

When the analysis was complete, we put the information and summary conclusions before our local group of experts[14] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional statements of need; new needs could, and did, emerge from this exchange.[15] Consultation with local experts occurred again via an internet based survey (explained below) during the period beginning Thursday, May 24, 2012 at 9:25 a.m. and ending Saturday, June 16, 2012 at 9:03 a.m.

[11] Response to Schedule H (Form 990) Part V B 1 h
[12] Part response to Schedule H (Form 990) Part V B 3
[13] Response to Schedule H (Form 990) Part V B 1 f
[14] Part response to Schedule H (Form 990) Part V B 3
[15] Response to Schedule H (Form 990) Part V B 1 e

With the prior steps identifying potential community needs, the local experts participated in a structured communication technique called a Delphi method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts. Experts answer questionnaires in a series of rounds. We contemplated and implemented one round as referenced during the above dates. After each round, we provided an anonymous summary of the experts' forecasts from the previous round, as well as the reasons provided for their judgments. The process encourages experts to revise their earlier answers in light of the replies of other members of their panel. Typically, this process decreases the range of answers and moves the expert opinions toward a consensus "correct" answer. The process stops when we identify the most pressing, highest priority community needs.

In the NMC process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. A rank order of priorities emerged, with some needs receiving virtually no support and other needs receiving identical point allocations.

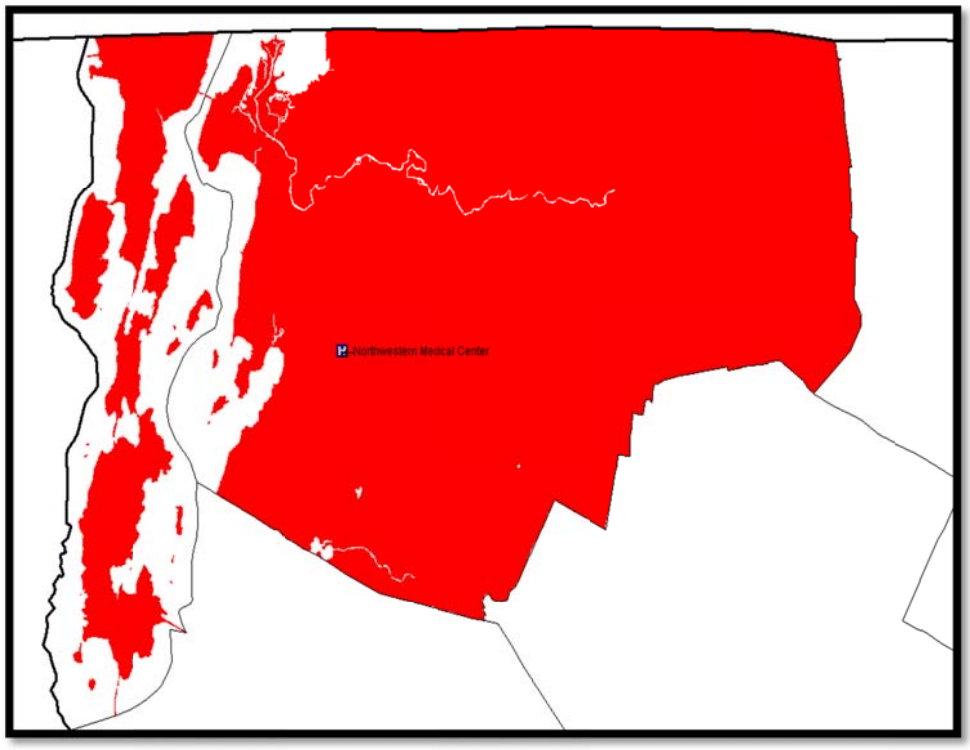
We dichotomized the rank order into two groups: high priority needs and low priority needs. The determination of the break point, high as opposed to low, was a qualitative interpretation by QHR and the NMC executive team where a reasonable break point in rank occurred, indicated by the weight amount of points each potential need received and the number of local experts allocating any points to the need. When presented to the NMC executive team, the dichotomized need rank order identified which needs the hospital considered high responsibility to respond vs. low responsibility to respond. The result provided a matrix of needs and guided the hospital in developing its implementation response[16].

[16] Response to Schedule H (Form 990) Part V Section B 6 g, h and Part V B 1 g

FINDINGS

Findings

Definition of Area Served by the Hospital Facility[17]



Northwestern Medical Center, in conjunction with QHR, defines its service area as Franklin and Grand Isle Counties in Vermont which includes the following ZIP codes:

05440 Alburgh, VT;	05441 Bakersfield, VT;	05444 Cambridge, VT;
05447 East Berkshire, VT;	05448 East Fairfield, VT;	05450 Enosburg Falls, VT;
05454 Fairfax, VT;	05455 Fairfield, VT;	05457 Franklin, VT;
05458 Grand Isle, VT;	05459 Highgate Center, VT:	05463 Isle La Motte, VT;
05468 Milton, VT;	05471 Montgomery Center, VT;	05474 North Hero, VT;
05476 Richford, VT;	05478 Saint Albans, VT;	05483 Sheldon, VT;
05486 South Hero, VT;	05488 Swanson, VT.	

In 2011, the Medical Center received 93.7% of its patients from this area.

[17] Responds to IRS Form 990 (h) Part V B 1 a

Demographic of the Community[18]

The 2012 population for the two county Northwest Medical Center service area is estimated to be 54,056[19], and is expected to grow at a rate (3.8%) about equal to the national rate of growth, projecting a 2017 population of 56,120. This population growth is at a faster rate than for Vermont as a whole (2.3%).

According to the population estimates utilized by Truven, provided by The Neilson Company, the 2012 median age for two county service area is 39.7 years, younger than the Vermont median age (41 years) but older than the national median age (36.8 years). The 2012 Median Household Income for the area is $51,273, which is higher than the Vermont median income of $49,396 and the national median income of $49,599. Median Household Wealth and Median Home Values likewise are above State and national values. Grand Isle's unemployment rate as of July, 2012 was 4.9% and for Franklin County, it was 5.1%[20], which are similar rates to the statewide rate of 5%, but considerably better than the national civilian unemployment rate of 8.6%.

The portion of the population in the two counties over 65 is 12.3%, below the Vermont average of 14.4%. The portion of the population of women of childbearing age is 19.3%, basically the same as the Vermont average of 19.4%. In the two county area and for Vermont as a whole, the female population age 15 to 44 is anticipated to decline at a rate of just over 2%. Additional demographic data is presented in Appendix F.

Findings

Upon completion of the CHNA, QHR identified several issues within the Northwestern Medical Center community:

Conclusions from Public Input to Community Health Needs Assessment

- Respondents overwhelmingly have access to physician, dental and eye professionals and perceive themselves to be in good health. Most survey respondents do not have a mental health advisor. While they state the local economy is worse than it was a year ago, they have not personally experienced financial problems accessing medical services. Approximately ¾ of respondents were employed, middle aged, college educated, married and females with a household income over $50,000 and held health insurance;
- Over 60% of responses indicated three issues as major problems:
    - People making unhealthy food choices – obesity;
    - Not having health insurance; and

[18] Responds to IRS Form 990 (h) Part V B 1 b
[19] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[20] http://research.stlouisfed.org/fred2/series/VTGRAN3URN ;
http://research.stlouisfed.org/fred2/series/VTFRAN1URN

  - Mental health related problems – typically access.
- Over 70% of responses indicated adult substance abuse problems, prescription drug abuse and drug use among youth as major problems;
- About 2/3 of responses perceive a problem with healthcare availability, healthy living and individual/family health problems in the community;
- Healthcare availability (access to primary care and to a lesser extent specialty medicine) not only was the most often cited problem, it also is considered the most important to resolve;
- Free text response to the question of what is the most important health or medical issue reaffirmed the statistical analysis of major concerns being:
  - Access to primary health care;
  - Drug abuse;
  - Insurance – affordability – cost issues;
  - Mental health, and;
  - Obesity.

Summary of Observations from Grand Isle and Franklin Counties Compared to All Other Vermont Counties, in Terms of Community Health Needs

- In general, Grand Isle County health status compares favorably among Vermont Counties. It generally has values at the Vermont average and ranks 4th in HEALTHY OUTCOMES (with 1st being the best) among the 14 ranked counties;
- Franklin County health status generally compares unfavorably among Vermont Counties. It generally has values above the Vermont average and ranks 12th (out of 14) in HEALTHY OUTCOMES;
- Among the various HEALTH FACTORS analyzed, the relative positions of both counties show the same pattern; Grand Isle ranks 5th and Franklin ranks 12th;
- PHYSICAL ENVIRONMENTAL FACTORS generally are positive influences on overall county rankings for both counties. The percentage of fast food restaurants and limited access of low income to healthy food are a common concern. Environmental pollution factors are a low concern to both counties;
- CLINICAL FACTORS are not a serious depressing factor in scoring the rankings. UNINSURED RATES, PREVENTABLE HOSPITAL STAYS, DIABETIC SCREENING RATES and MAMMOGRAPHY show little difference between the counties. Improvement is possible but would have little impact on improving the ranking. PRIMARY CARE PHYSICIAN access is a problem for both counties and improvement would impact rankings;

- HEALTHY BEHAVIORS generally shows the same patterns with Grand Isle at about the Vermont average and Franklin showing excess values. The most important factor, SMOKING, needs to improve in Franklin County; smoking rates are 50% higher than desired goal. The next most important consideration OBESITY is a problem for both counties and notably, Franklin leads Vermont values. DRINKING is at the state average for both counties. SEXUAL DISEASE is below the state average for both counties. TEEN BIRTHS (2002 to 2008 data) is not a Grand Isle concern but Franklin has some of the worst values in the State; and
- SOCIAL AND ECONOMIC FACTORS are generally positive health status factors for both counties. The one notable exception is the high incident of VIOLENT CRIME for Franklin County, where again it sets the upper value for Vermont.

Summary of Observations from Grand Isle and Franklin Counties Peer Comparisons

The federal government administers a process to allocate all counties into "Peer" groups, i.e., groups having similar social, economic and demographic characteristics. Health and wellness observations when Grand Isle and Franklin Counties are compared to their respective national set of Peer Counties and compared to national rates makes some similar and some vastly different observations (Grand Isle and Franklin are not Peer counties and apparently too small a Hispanic population exists to calculate group rates):

UNFAVORABLE OBSERVATIONS when compared to their peers and national averages are as follows:

- INFANT MORTALITY;
- WHITE NON-HISPANIC INFANT MORTALITY;
- NEONATAL INFANT MORTALITY;
- CORONARY HEART DISEASE;
- LUNG CANCER;
- SUICIDE;
- BREAST CANCER, Franklin only – no Grand Isle data;
- COLON CANCER, Franklin only – no Grand Isle data;
- LOW BIRTH WEIGHT (<2500g) Grand Isle ONLY, this indicator is FAVORABLE for Franklin County;
- VERY LOW BIRTH WEIGHT Grand Isle ONLY, Franklin County is UNFAVORABLE among Peers but below national average;
- BIRTHS TO WOMEN 40-54 Grand Isle ONLY, Franklin County is UNFAVORABLE among Peers but below national average;

- POST NEONATAL INFANT MORTALITY Grand Isle ONLY, Franklin County values are FAVORABLE to peers but below US Median values; and
- MOTOR VEHICLE INJURY Grand Isle ONLY, Franklin County values are FAVORABLE to peers and to National average.

SOMEWHAT A CONCERN observations as rates are unfavorable compared to peer counties (but better than national average):

- BIRTHS TO UNMARRIED WOMEN;
- VERY LOW BIRTH WEIGHT (less than 1500 g) Franklin County only, noted above as concern for Grand Isle;
- BIRTHS TO WOMEN 40 to 54 Franklin County only, noted above as concern for Grand Isle;
- PREMATURE BIRTHS Grand Isle ONLY, Franklin County not a concern; and
- BIRTHS TO WOMEN UNDER 18 (2005 data only) Grand Isle ONLY, Franklin County not a concern.

SOMEWHAT A CONCERN observations as rates are unfavorable compared to national rates:

- POST NEONATAL INFANT MORTALITY Franklin County ONLY; Grand Isle presents as a concern as noted above; and
- STROKE Grand Isle ONLY; Franklin County presents as NOT A CONCERN.

There is only one potential condition which is not a health need because performance is BETTER than Peers and National rates in both counties – UNINTENTIONAL INJURY. Other BETTER Franklin Co metrics include:

- LOW BIRTH WEIGHT (<2500 grams);
- PREMATURE BIRTHS (<37 weeks);
- BIRTHS TO WOMEN UNDER 18 (2005 data only);
- MOTOR VEHICLE INJURY; and
- STROKE.

Conclusions from the Demographic Analysis Comparing the Service Area to National Averages

Adverse uses and rates compared to national norms brought forward the following issues impacting 8% to 24% of the population:

- CHRONIC ASTHMA 12% below average, impacts 8.5% of population;
- CHRONIC OSTEOPOROSIS 6% below average, impacts 9.3% of population;

- NOT RECEIVING A CANCER SCREEN TEST IN THE LAST 2 YEARS 9% below average, impacts 11.6% of population;
- SPORT INJURY 6% below average, impacts 12% of population;
- NOT OBTAINING A ROUTINE CARDIAC STRESS TEST 9% below average, impacts 17% of population;
- HEALTH CARE COST PROBLEM 5% above average, impacts 18% to 19% of population;
- CHRONIC HIGH CHOLESTEROL 8% below average, impacts 20% of population; and
- (LACK OF) HEALTHY EATING HABITS 10% below average, impacts 24% of population.

25% or more of the population:

- MORBID OBESE 5% above average, impacts 27% of population;
- (NOT OBTAINING) PROSTATE SCREENING TEST IN LAST 2 YEARS 6% below average, impacts 30% of population;
- PEDIATRICIAN USAGE 12% higher than national average, impacts 33% of population; and
- VISIT TO PRIMARY CARE PHYSICIAN 9% above average, impacts 73% of population.

Key Conclusions from Consideration of the Other Statistical Data Examinations

Additional examinations of Grand Isle and Franklin County data found:

Leading causes of deaths in Vermont are:

- #1 CANCER (Grand Isle has highest VT rate and is significantly above national average);
- #2 HEART DISEASE (Franklin has highest VT rate but is in line with national average);
- #3 CHRONIC LUNG DISEASE (Grand Isle has highest VT rate and is significantly above national average);
- #4 ACCIDENTS (both Counties are about at VT average); and
- #5 STROKE (Grand Isle has highest VT rate while Franklin has the lowest VT rate, which is significantly lower than national average).

Other Significant Death Rate Observations listed in sequence of declining rate of deaths:

- ALZHEIMER – Grand Isle has lowest VT rate, Franklin third to last ranked VT county;
- DIABETES – Franklin top VT county, Grand Isle about at VT average;
- SUICIDE – Franklin top VT county, Grand Isle ranked 5th;
- FLU & PNEUMONIA DEATHS – Grand Isle second to last, Franklin ranked #5 in VT;
- HYPERTENSION DEATHS – Grand Isle top VT County; and

- HOMICIDE – Grand Isle ranked #1 death rate and Franklin #2.

MALE AND FEMALE LIFE EXPECTANCY – values for the two counties are the same with Female expectancy being 81.5 years and Male expectancy being 77.4 years, each about four years behind the top tier counties in the nation.

PALLIATIVE CARE programs exist in Franklin County.

Parts of Franklin are DESIGNATED MEDICALLY UNDERSERVED but no designation exists for Grand Isle County.

HEART DISEASE DEATHS rates (based on data older than used in #1 above) for both Counties are in the second lowest national quartile.

STROKE DEATHS (based on older data than used in #1 above) in Franklin County are in the lowest national quartile while Grand Isle is in the second to lowest national quartile.

HYPERTENSION (based on older data than used in #2 above) has a high incidence; both counties are in the highest national quartile.

DIABETES (based on older data than used in #2 above) prevalence is among the lower values in the nation.

EXISTING HEALTH CARE FACILITIES AND RESOURCES

Existing Health Care Facilities and Resources Available to Respond to the Community Health Needs

We used the priority ranking of area health needs to organize the search for locally available resources.[21] The following identifies locally available resources corresponding to each priority need.

In general, NMC is the major hospital in the service area. NMC is a 51 bed acute care medical facility located in St Albans, VT and is 31.7 miles from Grand Isle, VT (38 minutes). The next closest facilities are outside the service area and include:

- Fletcher Allen Health Care Medical Center Campus – 433 bed acute care medical facility in Burlington, VT; 25.4 miles from St Albans, VT (30 minutes) and 23.5 miles from Grand Isle, VT (34 minutes);
- Champlain Valley Physicians Hospital Medical Center – 391 bed acute care medical facility in Plattsburgh, NY; 56.7 miles from St Albans, VT (1 hour 13 minutes) and 52.8 miles from Grand Isle, VT (1 hour 11 minutes); and
- The Canadian border lies 15 miles north of St Albans, VT with the closest hospitals located in the Montreal area, generally 69 miles (1 hour 31 minutes).

An Overview of Available Community Resources

> Northern Vermont is served by a wide variety of agencies, organizations, initiatives and resources focused on issues relating to community health. The following is simply a sampling to provide an initial insight into the depth of support available to those with concerns. Many community resources are difficult to categorize in this manner, as they span issues (e.g., Franklin Grand Isle United Way or the Franklin Grand Isle Community Partnership) and some issues are inter-related (e.g., obesity, heart disease, diabetes and cholesterol). For up-to-date personalized help finding the care, support and assistance you need, please speak to your primary care provider or call the three digit number 211 or visit www.vermont211.org.

In response to rank order of need, the following local resources could be available.

Definitions of High Priority Need Listed in Highest to Lowest Rank Order of Need

1. MENTAL HEALTH & SUBSTANCE ABUSE: Mental Health was one of three top concerns by +60% of residents, expressed as access problem; Substance Abuse was a problem expressed by +70% of residents; prescription drug abuse and youth drug use are major problems;

> ***Problem Statement: There is a shortage of available, affordable mental health resources. There is a need for a comprehensive, integrated approach to the care of individuals suffering from specialty substance abuse, often associated with Chronic***

[21] Response to IRS Form 990 h Part V B 1 c

Pain or abuse of narcotics and prescription medication.

Local resources include the following:

- NMC will work collaboratively with Northwestern Counseling & Support Services to support their efforts regarding expanding access to mental health care in our community, including efforts to integrate into the Vermont Blueprint for Health;
- NMC is establishing an Interventional Pain Management service. NMC will work collaboratively with The Howard Center and other providers, agencies and organizations in the community to help create a comprehensive, integrated approach to chronic pain management and narcotic addiction. This effort will be aligned with the patient-centered medical home effort being fostered through the implementation of the Blueprint for Health;
- Howard Center;
- Northwestern Counseling & Support Services;
- Maple Leaf Farms;
- Northwestern Medical Center: Interventional Pain Service;
- Community Forum on Chronic Pain & Narcotic Addiction;
- Turning Point;
- Center Point;
- Alcoholics Anonymous;
- Narcotics Anonymous;
- Vermont Department of Health.

2. ACCESS/AVAILABILITY TO HEALTHCARE & PHYSICIANS: 2/3 of residents cite a problem; primary care access and specialty medicine access are the most important issues to resolve; visits to primary care from the two counties are 9% above the U.S. average; Pediatrician use is 12% above the U.S. average; parts of Franklin County are designated MEDICALLY UNDERSERVED; community residents did not report difficulty in having a physician;

Problem Statement: Access / Availability to primary and specialty care needs to increase to ensure an adequate supply of practitioners to meet identified needs in the community.

Local resources include the following:

- NMC will continue implementing its Medical Staff Development Plan which outlines the necessary recruitments of practitioners to meet the community's need for primary care and specialists. This plan will be updated during NMC's next round of strategic planning efforts, expected to be complete in May of 2013. Included in this will be NMC's continued support

of the implementation of the Vermont Blueprint for Health, ongoing collaboration with NOTCH (Northern Tiers Centers for Health) and private practice physicians, and pursuit of appropriate medical clinics for specialists;

- Northwestern Medical Center: Physician Recruitment & Referral;
- Northwestern Walk-In Clinic;
- Northern Tiers Centers for Health (NOTCH);
- Franklin County Home Health Agency;
- Ladies First Program;
- Healthcare Ombudsman Program;

Lorne Babb, MD	Family Medicine	Enosburg Falls	(802) 933-6664
Michael Barnum, MD	Orthopaedic Surgery	St. Albans	(802) 524-8915
Max Bayard, MD	Family Medicine	St. Albans	(802) 524-8805
Robert Beattie, MD	Orthopaedic Surgery	St. Albans	(802) 524-8915
Laura Bellstrom, MD	Pediatrics	St. Albans	(802) 524-6410
Gregory Brophey, MD	Ophthalmology	St. Albans	(802) 524-4274
Peter Burke, MD	Pathology	St. Albans	(802) 524-1074
Chip Chiappinelli, MD	Pediatrics	St. Albans	(802) 527-8189
Keith Collins, MD	Hospitalist	St. Albans	(802) 524-8494
Jonathan Cooperman, MD	Emergency Medicine	St. Albans	(802) 524-1037
Michael Corrigan, MD	Family Medicine	Swanton	(802) 868-3175
Louis Dandurand, MD	Emergency Medicine	St. Albans	(802) 524-1037
Sarah DeSilvey, APRN	Family Medicine	Georgia	(802) 524-9595
John DiMichele, MD	Pediatrics	St. Albans	(802) 527-8189
Thomas Dowhan, MD	Ophthalmology	St. Albans	(802) 527-7787
Denise Durant, MD	Orthopaedic Surgery	St. Albans	(802) 524-8915
Gamal Eltabbakh, MD	GYN Oncology	South Burlington	(802) 859-9500
Cengiz Esenler, MD	Urology	St. Albans	(802) 524-0719
John Fitzgerald, MD	Cardiology	St. Albans	(802) 524-8909

Elisabeth Fontaine, MD	Obstetrics & Gynecology	St. Albans	(802) 524-5523
Jodi Forwand, FACEP MD	Emergency Medicine	St. Albans	(802) 524-1037
Jun Fu, MD	Internal Medicine	St. Albans	(802) 524-8805
Christopher Fukuda, MD	Urology	St. Albans	(802) 524-7551
Uwe Goehlert, MD	Emergency Medicine	St. Albans	(802) 524-1037
Luis Gonzalez, MD	Radiology	St. Albans	(802) 524-1058
David Groening, DPM	Podiatry	St. Albans	(802) 527-1155
Richard Grunert, MD	Urology	St. Albans	(802) 524-7551
Deanne Haag, MD	Pediatrics	St. Albans	(802) 527-8189
Edward Haak, DO	Emergency Medicine	St. Albans	(802) 524-5911 Ext. 4363
Thomas Harrison, MD	Anesthesiology	St. Albans	(802) 524-1073
Jeremy Hatch, MD	Orthopaedic Surgery	St. Albans	(802) 524-8915
Fred Holmes, MD	Pediatrics	St. Albans	(802) 527-8189
Amanda Hurliman, MD	Obstetrics & Gynecology	St. Albans	(802) 524-5523
Paul Julien, MD	ENT/Otolaryngology	Newport	(802) 334-9009
Michael Kennedy, MD	General Surgery	St. Albans	(802) 524-2168
Richard Kershen, MD	Urology	St. Albans	(802) 847-2884
Rajvinder Donny Khela, MD	Hospitalist	St. Albans	(802) 524-8494
Marc Kutler, MD	Emergency Medicine	St. Albans	(802) 524-1037
Steven Landfish, DO	Sports Medicine	St. Albans	(802) 524-8937
Juli Larson, MD	Ophthalmology	South Burlington	(802) 862-1808
Erick Lavallee, MD	Family Medicine	Alburg	802) 796-4414
Robert Lesny, DDS	Oral & Maxillofacial Surgery	St. Albans	(802) 524-0490

Olga Lopatina, MD	Radiology	St. Albans	(802) 524-1058
Stewart Manchester, MD	Family Medicine	St. Albans	(802) 527-0753
Roya Mansoorani, MD	Pediatrics	St. Albans	(802) 527-8189
Teig Marco, MD	Internal Medicine	Fairfax	(802) 849-2844
Stephen Mason, MD	Anesthesiology	St. Albans	(802) 524-1073
John Minadeo, FACEP MD	Emergency Medicine	St. Albans	(802) 524-1037
Joseph Nasca, MD	Pediatrics	Georgia	(802) 527-2237
William Newman, MD	Allergy & Immunology	St. Albans	(802) 524-2550
Terri Nielsen, MD	Family Medicine	St. Albans	(802) 527-0753
Juan Carlos Nuñez, MD	Internal Medicine	St. Albans	(802) 524-8805
Casey Patunoff, MD	Psychiatry	St. Albans	(802) 524-6554
Stephen Payne, MD	General Surgery	St. Albans	(802) 524-2168
Pamela Pedersen, MD	Internal Medicine	St. Albans	(802) 524-4554
Elizabeth Perez, MD	Urology	St. Albans	(802) 524-8974
William Purdy, MD	Oral & Maxillofacial Surgery	St. Albans	(802) 524-0490
Donna Queyquep, MD	Pediatrics	Milton	(802) 893-0330
Sadi Raza, MD	Hospitalist	St. Albans	(802) 524-8494
Harvey Reich, MD	Hospitalist	St. Albans	(802) 524-8494
Tamara Rimash, MD	ENT/Otolaryngology	St. Albans	(802) 524-5292
William Roberts, MD	Anesthesiology	St. Albans	(802) 527-7804
Amy Roberts, MD	Internal Medicine	St. Albans	(802) 527-1064

Quentin Rose, MD	Radiology	St. Albans	(802) 524-1058
Toby Sadkin, MD	Family Medicine	St. Albans	(802) 527-0753
Susan Saferstein, AAFP MD	Family Medicine	Georgia	(802) 524-9595
Joseph Salomone, MD	General Surgery	St. Albans	(802) 524-2779
Sarah Serafini, MD	Emergency Medicine	St. Albans	(802) 524-1037
David Shea, Director MD Ph.D	Hospitalist	St. Albans	(413) 537-7292
Ned Shulman, MD	Hospitalist	St. Albans	(802) 524-8494
Steven Sobel, MD	Psychiatry	St. Albans	(802) 524-6554
Molly Somaini, PA-C	Family Medicine	St. Albans	(802) 524-8805
David Spence, PA	Family Medicine	Georgia	(802) 524-9595
Jaspinder Sra, MD	Hospitalist	St. Albans	(802) 524-8494
Anne Standish, FNP	Family Medicine	Georgia	(802) 524-9595
Miriam Sturgis, MD	Family Medicine	Georgia	(802) 524-9595
Lowrey Sullivan, MD	Obstetrics & Gynecology	St. Albans	(802) 524-5523
Austin Sumner, MD MPH	Occupational Medicine	Georgia	(802) 524-1223
Thomas Suppan, MD	Pathology	St. Albans	(802) 524-1074
Carol Thayer, MD	Family Medicine	Georgia	(802) 524-9595
Nathaniel Thompson, MD	Hospitalist	St. Albans	(802) 524-8494
Leonard Tremblay, MD	Obstetrics & Gynecology	St. Albans	(802) 524-5523
Mara Vijups, MD	Family Medicine	St. Albans	(802) 524-6333

Audrey von Lepel, MD	Internal Medicine	Fairfax	(802) 849-2844
Katja Von Sitas, PA	Obstetrics & Gynecology	St. Albans	(802) 524-3215
Adrian Webb, MD	Psychiatry	St. Albans	(802) 524-6554
Mary Woodhouse, MD	General Surgery	St. Albans	(802) 524-8974
Taylor Yates, Jr., FAAP MD	Pediatrics	St. Albans	(802) 524-6746
Mary Ann Yeatts-Peterson, MD	Obstetrics & Gynecology	St. Albans	(802) 527-7717
Eiad Youssef, MD	Hospitalist	St. Albans	(802) 524-8494
Robert Zelazo, MD	Internal Medicine	Swanton	(802) 868-2454
Frank Zsoldos, FACP MD	Internal Medicine	St. Albans	(802) 524-2106
Heidi Zvolensky, MD	Pediatrics	St Albans	(802) 527-8189
Cold Hollow Family Practice	Family Practice	Enosburg	
Enosburg Health Center		Enosburg	
Mousetrap Pediatrics	Pediatrics	Enosburg	
Fairfax Associates in Medicine			
Georgia Health Center			
Center for Health		Richford	
Swanton Health Center	Family Medicine	Swanton	

3. OBESITY is a top resident concern; HEALTHY EATING HABITS 10% below U.S. average; MORBID OBESE rates 5% above U.S. average; number of FAST FOOD restaurants is high; LOW INCOME ACCESS TO HEALTHY FOOD a minor concern.

Problem Statement: Additional obesity reduction efforts, including an emphasis on health eating are needed.

Local resources include the following:

- NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community. This will include: investigation of a collaborative opportunity in a larger-scale community-based approach to obesity; continued participation in the Fit & Healthy Community initiatives; expansion of the Better U pilot program into the community; and work with employers to replicate NMC's successful Healthy U program in other worksites. NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding obesity;
- Northwestern Medical Center: Registered Dietitians & Better U;
- Vermont Department of Health;
- Primary Care Providers & Pediatricians;
- Center For Health & Wellness;
- Municipal Recreation Departments;
- Fit & Healthy (Swanton & Enosburg);
- Collins Perley Sports Complex & Private Facilities;
- Mississquoi Valley Rail Trail; and
- Walk & Bike St. Albans.

4. SMOKING: Grand Isle rate is below the VT average, Franklin rate is above the VT average.

Problem Statement: The number of local residents who smoke needs to decline.

Local resources include the following:

- NMC will continue to take a leading role in the Franklin Grand Isle Tobacco Coalition's efforts regarding reduction in the use of tobacco. NMC will also play an active role in tobacco cessation efforts in the community and will help incorporate these efforts into the implementation of community care team of the Blueprint for Health;
- Franklin Grand Isle Tobacco Coalition;
- Vermont Department of Health;
- Primary Care Providers;
- Fit & Healthy (Swanton & Enosburg); and
- Northwestern Medical Center: Smoking Cessation.

5. CANCER is the #1 VT cause of death, Grand Isle rate is the highest in VT and greatly above U.S. average; Cancer SCREENING TEST usage is 9% below average; PROSTATE SCREENING testing rate is 6% below average; deaths from BREAST & COLON CANCER is a Franklin concern, no Grand Isle data exists; LUNG CANCER as a cause of death is a concern for both counties;

Problem Statement: Early detection of cancer and coordination of treatment should be increased.

Local resources include the following:

- NMC will build upon its accredited cancer program to improve awareness of cancer related issues, promote early detection and expand oncology case management. Special emphasis will be placed on improving the early detection of colon cancer and streamlining the treatment of breast cancer. We will continue to work collaboratively with the Vermont Center for Cancer Medicine and Fletcher Allen Health Care on the treatment of cancer patients. NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding cancer;
- Vermont Center for Cancer Medicine;
- Northwestern Medical Center: Cancer Program;
- American Cancer Society;
- Center for Health & Wellness;
- Vermont Department of Health; and
- Jim Bashaw Fund.

6. HEALTH INSURANCE/UNINSURED: Second of top three major concerns by over 60% of residents, COST PROBLEMS present 5% above the U.S. average;

Problem Statement: Healthcare costs are a potential barrier to access to care in the community.

Local resources include the following:

- NMC will continue to take an active role in the implementation of healthcare reform activities focused on bending the cost curve, including: the implementation of the Blueprint for Health to better manage chronic conditions; the expansion of the NMC Emergency Department Pilot to reduce avoidable ED visits; participation in the "One Care" Accountable Care Organization with Fletcher Allen & Dartmouth; etc. NMC will also continue our charity care program and maintain our internal organizational focus on cost containment. NMC will work collaboratively with the Green Mountain Care Board as the State works to restructure the healthcare system to provide enhanced access to lower cost high quality care to all Vermonters;

- Green Mountain Care Board;
- Vermont Department of Health;
- Northwestern Medical Center: Charity Care Program; and
- Northern Tiers Centers for Health (NOTCH): Sliding Fee Scale.

7. SUICIDE Franklin County has the highest VT rate and the death rate in Grand Isle County is above the VT average;

Problem Statement: An enhanced strategy is needed to implement proven Suicide Prevention techniques.

Local resources include the following:

- As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to suicide prevention and look for appropriate opportunities to assist. NMC's collaboration in the work regarding narcotic addiction could contribute to the effort to reduce suicide in our community;
- Northwestern Counseling & Support Services;
- Vermont Department of Health;
- Voices Against Violence;
- Private Practice Psychologists & Counselors;
- Law Enforcement Professionals;
- Teen Centers; and
- Area Churches.

8. DOMESTIC AND SEXUAL ABUSE: Many physicians and even mental health workers are not trained to either identify domestic violence or treat patients adequately.

Problem Statement: Expansion of community response is needed in relation to the education, prevention, diagnosis and treatment of domestic and sexual abuse.

Local resources include the following:

- NMC will continue to support and encourage the community efforts relating to domestic and sexual abuse led by Voices Against Violence. We will continue our active role in the detection and treatment of abuse victims through the Sexual Assault Nurse Examiners service in our Emergency Department;
- Voices Against Violence;
- Northwest Unit of Special Investigations;
- Northwestern Medical Center: Sexual Assault Nurse Examiners;

- Prevent Child Abuse Vermont;
- Vermont Department of Children & Families; and
- Safe At Home Program.

9. CORONARY HEART DISEASE is the second leading VT cause of death; Franklin County has the highest rate in VT, its coronary death rate is worse than its peer counties and somewhat worse than U.S. average, older data has heart disease death rates in second lowest U.S. quartile; CARDIAC STRESS TESTING is 9% below U.S. average.

> ***Problem Statement: The number of heart related deaths needs to decline. Diagnostic and medical treatment resources need to increase. Prevention efforts should be pursued on a broader scale.***

Local resources include the following:

- NMC will continue to grow Northwestern Cardiology, our new successful medical cardiology collaboration with Fletcher Allen. We will continue to expand our diagnostic resources as necessary to support community need relating to this initiative. NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding heart disease. NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community to include: investigation of a collaborative opportunity in a larger-scale community-based approach to obesity which will impact heart disease longer term; continued participation in the Fit & Healthy Community initiatives; expansion of the Better U pilot program into the community; and work with employers to replicate NMC's successful Healthy U program in other worksites;
- Northwestern Cardiology;
- Primary Care Providers;
- American Heart Association;
- Northwestern Medical Center: Better U & Cardiac Rehab;
- Center for Health & Wellness;
- Vermont Department of Health;
- Franklin Grand Isle Tobacco Coalition; and
- Fit & Health Communities (Swanton & Enosburg).

10. CHRONIC LUNG DISEASE & CHRONIC ASTHMA is the third leading VT cause of death; Grand Isle County has the highest death rate in VT and this rate is greatly above U.S. average.

> ***Problem Statement: The number of pulmonary related deaths needs to decline. Diagnostic and medical treatment resources need to increase. Prevention efforts should be pursued on a broader scale. Enhancement of services relating to chronic***

Asthma should be included in these efforts.

Local resources include the following:

- NMC will continue to pursue the establishment of a pulmonary service similar in nature to our successful establishment of the medical cardiology service. NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding lung disease and asthma. NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community, including continued leadership in the Franklin Grand Isle Tobacco Coalition;
- Primary Care Providers;
- American Lung Association;
- Vermont Department of Health;
- Northwestern Medical Center: Respiratory Therapy;
- Franklin Grand Isle Tobacco Coalition;
- Safe Homes Parent Network of Franklin County;
- Chronic Conditions Information Network, P.O. Box 3, Cavendish VT (802) 226-7807; and
- Asthma Research Center, American Lung Association at the Medicine Department of the University of Vermont School of Medicine, Principle Investigator – C.G. Irvin.

11. HIGH BLOOD PRESSURE related deaths in Grand Isle County are the highest in VT; both counties have incident rates placing them in the highest U.S. quartile.

Problem Statement: More residents need blood pressure awareness including condition management education and treatment.

Local resources include the following:

- NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding high blood pressure. NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community to include: investigation of a collaborative opportunity in a larger-scale community-based approach to obesity which will impact high blood pressure; continued participation in the Fit & Healthy Community initiatives; expansion of the Better U pilot program into the community; and work with employers to replicate NMC's successful Healthy U program in other worksites;
- Primary Care Providers;
- American Heart Association;
- Vermont Department of Health; and
- Center for Health & Wellness.

Definitions of Low Priority Needs Listed in Highest to Lowest Rank Order of Need

12. STROKE is the fifth leading cause of death in VT; Grand Isle County has the highest death rate in VT, while Franklin County has the lowest VT death rate;

Problem Statement: The number of local residents having strokes should decline and Franklin success should be evaluated for adoption in Grand Isle.

Local resources include the following:

- NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding stroke. NMC will continue our direct involvement through the clinical stroke protocol. NMC's collaborative health promotion and wellness initiatives regarding obesity, heart disease, high blood pressure and high cholesterol will positively impact stroke risk in the community;
- Primary Care Providers;
- Northwestern Cardiology;
- American Heart Association;
- Vermont Department of Health;
- Northwestern Medical Center: Stroke Protocol Initiative.

13. DIABETES prevalence rates are among the lower rates observed in the US;

Problem Statement: Diabetic education and treatment resources should be expanded to continue to reduce the impact of this disease.

Local resources include the following:

- NMC will continue its diabetes education and counseling service, expanding access as needed to continue to meet community need. NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding diabetes. NMC's collaborative health promotion and wellness initiatives regarding obesity, heart disease, high blood pressure and high cholesterol will positively impact diabetes risk in the community;
- Primary Care Providers & Pediatricians;
- Specialists: Podiatrists, Ophthalmologists, etc.;
- Northwestern Medical Center: Diabetes Counseling;
- Northwestern Medical Center: Diabetes & You;
- Northwestern Medical Center: Diabetes Fund;
- Vermont Department of Health; and
- Center for Health & Wellness.

14. HOMICIDE: Grand Isle County has the highest death rate from homicides in VT although it has the lowest violent crime rate; Franklin County has the second highest homicide rate in the State and a violent crime rate 50% above the Vermont average.

Problem Statement: Violent crime and Homicide rates must be reduced.

Local resources include the following:

- As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to suicide prevention and look for appropriate opportunities to assist. NMC's collaboration in the work regarding narcotic addiction could contribute to the effort to reduce violent crime and homicide in our community;
- Law Enforcement Professionals;
- Voices Against Violence; and
- Northwest State Correctional Facility.

15. JOBS: Develop job opportunities which pay a living wage and are considered worthwhile occupations; the unemployment rate in Grand Isle exceeds the Vermont average by about 0.3% while Franklin County unemployment is below the Vermont average by about 0.8%.

Problem Statement: Reduce the unemployment rate to not exceed the State average.

Local resources include the following:

- As this priority is not within NMC's direct scope of expertise, we will monitor community-based work relating to job development and look for appropriate opportunities to assist. NMC will continue to actively participate in, support and encourage the work of the Franklin County Industrial Development Corporation, the Franklin County Regional Chamber of Commerce and the Franklin Grand Isle Workforce Investment Board. NMC's Scholarship Work Experience Program will facilitate access to the professional training necessary for local students to obtain healthcare careers;
- Franklin County Industrial Development;
- Franklin Grand Isle Workforce Investment Board;
- Champlain Valley Office of Equal Opportunity;
- VocRehab Vermont;
- Area High Schools & Technical Centers;
- Vermont Adult Learning;
- Vermont Associates for Training & Development;
- Champlain Valley Area Health Education Center; and
- Northwestern Medical Center: Health Professions Scholarships.

16. PALLIATIVE CARE programs exist in Franklin County.

Problem Statement: Palliative care services should expand as appropriate into both Counties.

Local resources include the following:

- NMC will develop a more formal approach to palliative care within the hospital setting, drawing upon expertise from the Medical Staff and community partners;
- Franklin County Home Health Agency;
- Northwestern Medical Center: Palliative Care Initiative; and
- Primary Care Providers.

17. BABY DEATHS – INFANT MORTALITY & NEONATAL INFANT MORTALITY worse than peers and U.S. average; LOW BIRTH WEIGHT & PREMATURE BABIES & POSTNEONATAL INFANT MORTALITY a Grand Isle concern, favorable Franklin rates; VERY LOW BIRTH WEIGHT a Grand Isle concern, somewhat a Franklin concern; WHITE NON HISPANIC INFANT MORTALITY worse than peers and U.S. average.

Problem Statement: Efforts are needed to reduce infant mortality.

Local resources include the following:

- NMC's Family Birth Center and the Northwestern Obstetrics & Gynecology practice will collaborate to implement a "Centering Pregnancy" program, an innovative evidence-based approach to prenatal care which has been shown to improve clinical outcomes. NMC will continue to work collaboratively with the Vermont Department of Health and other providers on other issues relating to healthy childbirth, including special services for opioid dependent mothers, breastfeeding in the workplace, etc.;
- Pediatricians;
- Northwestern Obstetrics & Gynecology;
- Vermont Department of Health; and
- Safe Kids Vermont.

18. BIRTHS – TO WOMEN AGE 40 TO 54 a Grand Isle concern, somewhat a Franklin concern; TO UNMARRIED WOMEN somewhat a concern in both counties; TEEN BIRTHS most recent data suggests a Franklin concern, but further analysis shows teen births concentrated in the 18-19 range whereas the 13-17 range is typically the greater cause for concern.

Problem Statement: Target critical populations should have increased availability to prenatal care educational programs.

Local resources include the following:

- NMC's Family Birth Center and the Northwestern Obstetrics & Gynecology practice will collaborate to implement a "Centering Pregnancy" program, an innovative evidence-based approach to prenatal care which has been shown to improve clinical outcomes. NMC will continue to work collaboratively with the Vermont Department of Health and other providers on other issues relating to healthy childbirth, including special services for opioid dependent mothers, breastfeeding in the workplace, etc.;
- Northwestern Obstetrics & Gynecology;
- Northwestern Medical Center: Family Birth Center;
- Vermont Department of Health; and
- CareNet Pregnancy Center.

19. PHYSICAL ENVIRONMENTAL FACTORS do not appear a concern as it has a positive influence on health status.

Problem Statement: A determination is needed to identify and implement actions to continue to improve the local physical environment.

Local resources include the following:

- As this priority is not within NMC's direct scope of expertise, we will monitor community-based work and look for appropriate opportunities to assist. There may be opportunities within the Fit & Healthy Communities Initiatives for NMC to play a supportive role in developing resources to promote increased health status, as NMC did with the establishment of the walking path in Swanton.
- Northwest Regional Planning Commission;
- Friends of Northern Lake Champlain;
- Habitat for Humanity;
- Samaritan House;
- Municipal Parks Departments & Hardack Association;
- Missisquoi Valley Rail Trail; and
- CIDER & Green Mountain Transit Authority.

20. ACCIDENTS while the fourth leading cause of VT deaths, do not present as a problem; MOTOR VEHICLE INJURY rates are favorable in Franklin; SPORT INJURY is 6% below national average; UNINTENTIONAL INJURY rates are better than peer and U.S. values

Problem Statement: A determination is needed to identify and implement actions to reduce the number of accidental injuries.

Local resources include the following:

- As this priority is not within NMC's direct scope of expertise, we will monitor community-based work and look for appropriate opportunities to assist;
- Law Enforcement Professionals;
- Vermont Department of Health;
- Franklin County Home Health Agency;
- Community Emergency Response Team; and
- Northwestern Medical Center: Emergency Department.

21. CHRONIC HIGH CHOLESTEROL rate is 8% below the U.S. average;

Problem Statement: More residents need cholesterol awareness including condition management education and treatment.

Local resources include the following:

- NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding high cholesterol. NMC will continue its collaborative partnership in health promotion and wellness initiatives in the community to include: investigation of a collaborative opportunity in a larger-scale community-based approach to obesity which will impact high cholesterol; continued participation in the Fit & Healthy Community initiatives; expansion of the Better U pilot program into the community and work with employers to replicate NMC's successful Healthy U program in other worksites;
- Primary Care Providers;
- American Heart Association; and
- Center for Health & Wellness.

22. CHRONIC OSTEOPOROSIS rate is 6% below the U.S. average.

Problem Statement: Continued efforts relating to osteoporosis awareness including condition management education and treatment are needed to further reduce the impact of the condition.

Local resources include the following:

- NMC will collaborate with efforts within the Blueprint for Health to increase primary care focus regarding osteoporosis. NMC will continue our direct involvement through our bone density screening service. NMC's collaborative health promotion and wellness initiatives regarding senior exercise will positively impact osteoporosis risk in the community;
- Primary Care Providers;
- Northwestern Obstetrics & Gynecology;

- Vermont Department of Health;
- Center for Health & Wellness
- Northwestern Medical Center: Bone Density Screening
- Northwestern Medical Center: Strong Women Program

23. SEXUALLY TRANSMITTED DISEASE is not a concern; Chlamydia in Grand Isle occurs at a rate of 168 per 100,000 and Franklin County has an occurrence rate of 121, both of which are below the Vermont statewide average

Problem Statement: More residents need awareness of sexually transmitted diseases including condition management education and treatment.

Local resources include the following:

- As this priority is not within NMC's direct scope of expertise, we will monitor community-based work and look for appropriate opportunities to assist;
- Primary Care Provider;
- Northwestern Obstetrics & Gynecology;
- Vermont Department of Health;
- Planned Parenthood; and
- Area High School Health Programs.

24. PREMATURE DEATHS: Grand Isle favorable but Franklin unfavorable; LIFE EXPECTANCY for females is 81.5 years, for males 77.4 years, both about 4 years behind top U.S. values solutions; however, may lie with other needs;

Problem Statement: A determination is needed to identify and implement actions to reduce the number of residents dying prior to age 75.

Local resources include the following:

- As this priority is not within NMC's direct scope of expertise, we will monitor community-based work and look for appropriate opportunities to assist;
- Primary Care Providers;
- Law Enforcement Professionals;
- Vermont Department of Health; and
- Center for Health & Wellness.

Overall Community Need Statement and Priority Ranking Score:

High Priority Issues where Hospital has High Implementation Responsibility

2. Access/Availability to Healthcare & Physicians;
3. Obesity;
4. Smoking;
5. Cancer;
9. Chronic Heart Disease;
10. Chronic Lung Disease Chronic Asthma; and
11. High Blood Pressure.

Low Priority Issues where Hospital has High Implementation Responsibility

12. Stroke
13. Diabetes
16. Palliative Care
18. Births
21. Chronic High Cholesterol

High Priority Issues where Hospital has Low Implementation Responsibility

1. Mental Health & Substance Abuse
6. Health Insurance/Uninsured
7. Suicide
8. Domestic & Sexual Abuse

Low Priority Issues where Hospital has Low Implementation Responsibility

14. Homicide
15. Jobs
17. Baby Deaths
19. Physical Environmental Factors
20. Accidents
22. Chronic Osteoporosis
23. Sexually Transmitted Disease
24. Premature Death/Life Expectancy

MANAGEMENT ACTION PLAN

Management Action Plan

The following Management Action Plan (MAP) provides Hospital management with a standalone tool to operationalize its response to the Community Health Needs identified.[22]

[22] Response to Schedule H (Form 990) Part V B 6 a and b

NMC Community Need Response to Needs Identified as HIGH PRIORITY and where NMC Holds HIGH RESPONSIBILITY					
Reference Number	**Issue to Address**	**Fundamental Desired Change Sought**	**Hospital Role or Action**	**Hospital Assigned Resources**	**Other Resources to Apply or Seek**
Priority	(problem statement)	(end result and leading indicator(s) used to measure change)	([H] Has sole / primary responsibility to enact change; [L] Take leadership role to enact change; [C] Coordinate actions primarily taken by others; [A] Allocate resources to address need; [E] Educational effort; [M] Monitor issue for change; [O] Other role as specified)	(assigned to whom; budget; other resources from Hospital)	(what collaboration or other actions are required by others; what resource contributions / commitments made by others)
2. Access / Availability to Healthcare& Physicians	***Problem Statement: Access / Availability to primary and specialty care needs to increase to ensure an adequate supply of practitioners to meet identified needs in the community.***	Increase Access	L,C,A,E	$374,750	NOTCH,Primary Care, Area Providers, FAHC
3. Obesity	***Problem Statement: Additional obesity reduction efforts, including an emphasis on health eating are needed.***	Reduce Obesity, percentage of adult population having body mass index greater than 30	L,C,A,E	$35,545	Public Health, Community Collaborative, Primary Care, Public Schools
4. Smoking	***Problem Statement: The number of local residents who smoke needs to decline.***	Reduce the percent of the population using tabacco products	C,A,E	$7,720	Public Health, Community Collaborative, Primary Care , OB/GYN
5. Cancer	***Problem Statement: Early detection of cancer and coordination of treatment should be increased.***	Reduce the number of deaths from cancer	L,C,A,E	$26,870	FAHC,Oncologists, Vermont Center for Cancer Medicine, Primary Care, Specialists, American Cancer Society, Vermonters Taking Action Against Cancer
9. Coronary Heart Disease	***Problem Statement: The number of heart related deaths needs to decline. Diagnostic and medical treatment resources need to increase. Prevention efforts should be pursued on a broader scale.***	Reduce the number of deaths from heart disease	L,C,A,E	$86,820	Heart Association, FAHC Cardiologists, Public Health, Home Health Collaboration, Primary Care, Go Red for Women, Better You
10.Chronic Lung Disease & Chronic Asthma	***Problem Statement: The number of pulmonary related deaths needs to decline. Diagnostic and medical treatment resources need to increase. Prevention efforts should be pursued on a broader scale. Enhancement of services relating to chronic Asthma should be included in these efforts.***	Reduce the number of deaths from lung disease	L,C,E,A	$500	Lung Association, Pulmonologist, Public Health, Home Health Collaboration, Primary Care
11.High Blood Pressure	***Problem Statement: More residents need blood pressure awareness including condition management education and treatment.***	Reduce the portion of the population having undiagnosed and not maintained high blood pressure	A,E	$9,940	Public Health, Primary Care

NMC Community Need Response to Needs Identified as LOW PRIORITY and where NMC Holds HIGH RESPONSIBILITY					
Reference Number	**Issue to Address**	**Fundamental Desired Change Sought**	**Hospital Role or Action**	**Hospital Assigned Resources**	**Other Resources to Apply or Seek**
Priority	(problem statement)	(end result and leading indicator(s) used to measure change)	([H] Has sole / primary responsibility to enact change; [L] Take leadership role to enact change; [C] Coordinate actions primarily taken by others; [A] Allocate resources to address need; [E] Educational effort; [M] Monitor issue for change; [O] Other role as specified)	(assigned to whom; budget; other resources from Hospital)	(what collaboration or other actions are required by others; what resource contributions / commitments made by others)
12.Stroke	***Problem Statement: The number of local residents having strokes should decline and Franklin success should be evaluated for adoption in Grand Isle.***	Lower the number of deaths from stroke	L,C,E	$4,970	FAHC, Primary Care, Specialists
13.Diabetes	***Problem Statement: Diabetic education and treatment resources should be expanded to continue to reduce the impact of this disease.***	Lower the number of deaths from diabetes	E,A,C,L	$12,770	Community Collaborative, Home Health, Primary Care, Podiaty, Specialists,Public Health
16.Palliative Care	***Problem Statement: Palliative care services should expand as appropriate into both Counties.***	Increase the availability of palliative care services	O - Participating, E	$9,200	Hospic, Home Health
18.Births	***Problem Statement: Target critical populations should have increased availability to prenatal care educational programs;***	Increase the number of pregnant women utilizing prenatal care	E,L,C,A	$3,300	Public Health, Community Collaborative, Prdiatricians, OB/GYN, Primary Care, FAHC, Home Health
21.Chronic High Cholesterol	***Problem Statement: More residents need cholesterol awareness including condition management education and treatment.***	Increase the portion of the population who know and monitor their cholesterol level	O - Participating, E	$4,970	Public Health, Primary Care

NMC Community Need Response to Needs Identified as HIGH PRIORITY and where NMC Holds LOW RESPONSIBILITY					
Reference Number	**Issue to Address**	**Fundamental Desired Change Sought**	**Hospital Role or Action**	**Hospital Assigned Resources**	**Other Resources to Apply or Seek**
Priority	(problem statement)	(end result and leading indicator(s) used to measure change)	([H] Has sole / primary responsibility to enact change; [L] Take leadership role to enact change; [C] Coordinate actions primarily taken by others; [A] Allocate resources to address need; [E] Educational effort; [M] Monitor issue for change; [O] Other role as specified)	(assigned to whom; budget; other resources from Hospital)	(what collaboration or other actions are required by others; what resource contributions / commitments made by others)
1. Mental Health & Substance Abuse	***Problem Statement: There is a shortage of available, affordable mental health resources. There is a need for a comprehensive, integrated approach to the care of individuals suffering from specialty substance abuse, often times associated with Chronic Pain or abuse of narcotics and prescription medication.***	Establish additional resources for mental health and substance abuse treatment	C,A,E	$117,875	NCSS, Howard Center, Law enforcement, Community Forum, Public Health, Primary Care, State of Vermont, Corrections, Vermont Referal Hospitals
6. Health Insurance / Uninsured	***Problem Statement: Healthcare costs are a potential barrier to access to care in the community.***	Remove financial barriers limiting access to medical care	O - Participating, E, M	$0	Green Mountain Care Board, Public Health, Primary Care, DVHA
7. Suicide	***Problem Statement: An enhanced strategy is needed to implement proven Suicide Prevention techniques.***	Reduce the number of deaths from suicide	O - Participating, M	$0	Law Enforcements, NCSS
8. Domestic & Sexual Abuse	***Problem Statement: Expansion of community response is needed in relation to the education, prevention, diagnostics, and treatment of domestic and sexual abuse.***	Reduce the incident of domestic and sexual abuse	O- Participating, M	$1,750	SANE, Voices Against Voilence,NCSS, DCF, Law Enforcement

NMC Community Need Response to Needs Identified as LOW PRIORITY and where NMC Holds LOW RESPONSIBILITY					
Reference Number	**Issue to Address**	**Fundamental Desired Change Sought**	**Hospital Role or Action**	**Hospital Assigned Resources**	**Other Resources to Apply or Seek**
Priority	(problem statement)	(end result and leading indicator(s) used to measure change)	([H] Has sole / primary responsibility to enact change; [L] Take leadership role to enact change; [C] Coordinate actions primarily taken by others; [A] Allocate resources to address need; [E] Educational effort; [M] Monitor issue for change; [O] Other role as specified)	(assigned to whom; budget; other resources from Hospital)	(what collaboration or other actions are required by others; what resource contributions / commitments made by others)
14.Homicide	***Problem Statement: Violent crime and Homicide rates must be reduced.***	Reduction in violent crime	M	$0	
15.Jobs	***Problem Statement: Reduce the unemployment rate to not exceed the State average.***	Reduction in the unemployment rate	A, M	$26,200	
17.Baby Deaths	***Problem Statement: Efforts are needed to reduce infant mortality.***	Reduction in infant mortality	M	$0	
19.Physical Environmental Factors	***Problem Statement: A determination is needed to identify and implement actions to continue to improve the local physical environment.***	Improve local living conditions	A, M	$1,100	
20.Accidents	***Problem Statement: A determination is needed to identify and implement actions to reduce the number of accidental injuries.***	Reduce deaths caused by accidents	M	$0	
22.Chronic Osteoporosis	***Problem Statement: Continued efforts relating to osteoporosis awareness including condition management education and treatment are needed to further reduce the impact of the condition.***	Enhance management of Chronic Osteoporosis	A, M	$6,970	
23.Sexually Transmitted Disease	***Problem Statement: More residents need awareness of sexually transmitted diseases including condition management education and treatment.***	Reduce the incident of sexually transmitted disease	M	$0	
24.Premature Death/Life Expectancy	***Problem Statement: A determination is needed to identify and implement actions to reduce the number of residents dying prior to age 75.***	Determine appropriate actions to prevent early death	M	$0	

By definition, the needs identified as LOW Priority and for which NMC holds LOW RESPONSIBILITY for implementation are needs the hospital will monitor but generally will not otherwise address unless specified in the above chart. Reasons for this response:

- Actions required are beyond the mission of NMC;
- NMC can be more effective applying its resources to higher priority needs;
- The hospital does not possess the expertise necessary for substantive positive improvement;
- Actions contemplated for implementation fall more appropriately to the responsibility of others;
- Other than providing encouragement, implementation efforts for some needs require appropriate actions by individuals modifying their personal habits rather than a response by an organization or the Health System; and
- The best use of NMC resources is to focus on resolving or improving higher priority needs rather than attempting to respond to everything with small, perhaps ineffective, efforts.[23]

The intended resource allocation by priority:

- High Priority Community Health Needs where NMC holds high responsibility for implementation – $542,145;
- High Priority Community Health Needs where NMC holds low responsibility for implementation – $119,625;
- Low Priority Community Health Needs where NMC holds high responsibility for implementation – $35,210;
- Low Priority Community Health Needs where NMC holds low responsibility for implementation – $34,270; and
- Total budget for providing services that address the needs identified in the Needs Assessment = $731,250.[24]

[23] Reference Schedule H (Form 990) Part V Section B 7
[24] Reference Schedule H (Form 990) Part V Section B 6. f

APPENDICES

Appendix A – Community Response

258 Community Responses to Community Health Need Survey Questions

Respondents overwhelmingly have access to physician, dental and eye professionals and perceive themselves to be in good health. Most survey respondents do not have a mental health advisor. While the local economy is worse than it was a year ago, they have not personally experienced financial problems in accessing medical services. Approximately ¾ of respondents were employed, middle aged, college educated, married and females with a household income over $50,000 and held health insurance.

Over 60% of responses indicated three issues as major problems

- People making unhealthy food choices – obesity
- Not having health insurance
- Mental health related problems – typically access

Over 70% of responses indicated adult substance abuse problems, prescription drug abuse and drug use among youth as major problems.

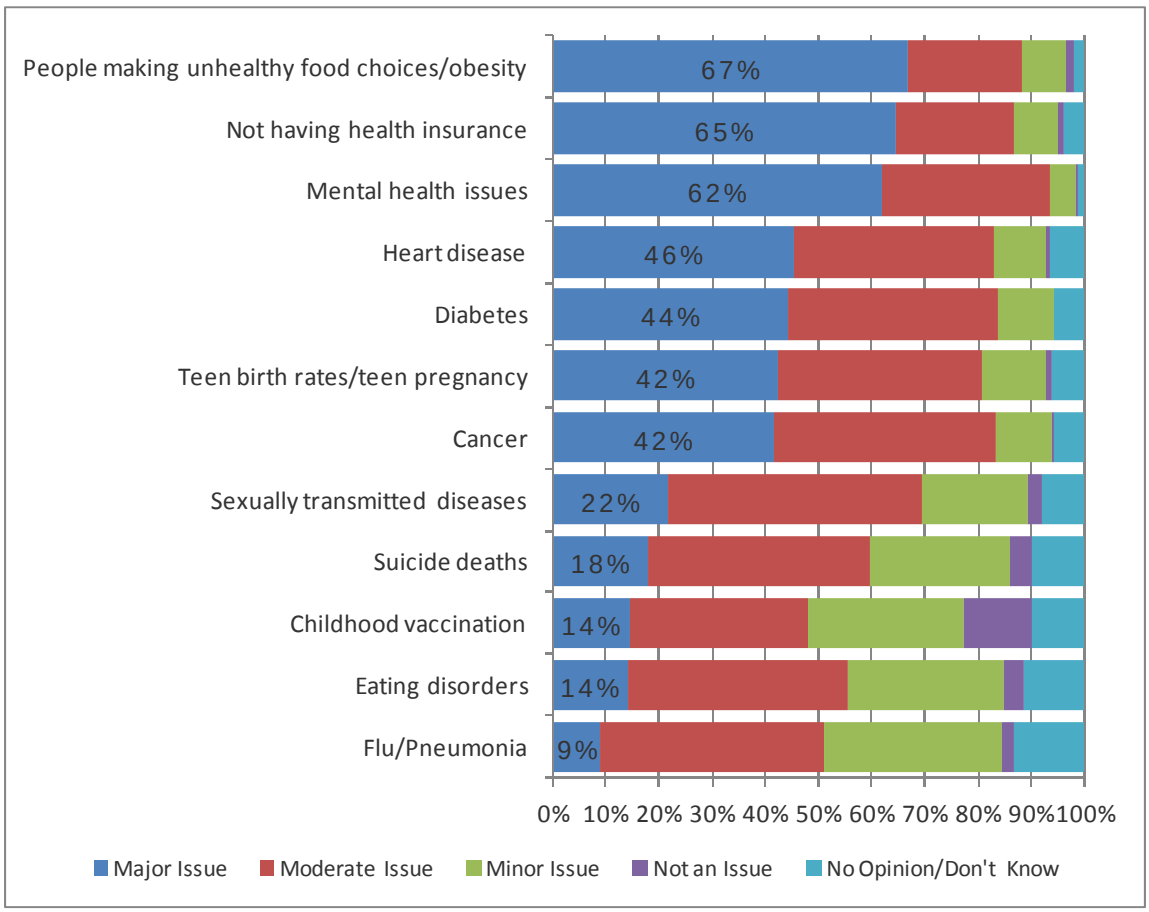
About 2/3 of responses perceive a problem with healthcare availability, healthy living and individual/family health problems in the community. Healthcare availability (access to primary care and to a lesser extent specialty medicine) not only was the most often cited problem, it also is considered the most important to resolve.

Free text response to the question of what is the most important health or medical issue reaffirmed the statistical analysis of major concerns being Access to primary health care; drug abuse; insurance – affordability – cost issues; mental health and obesity.

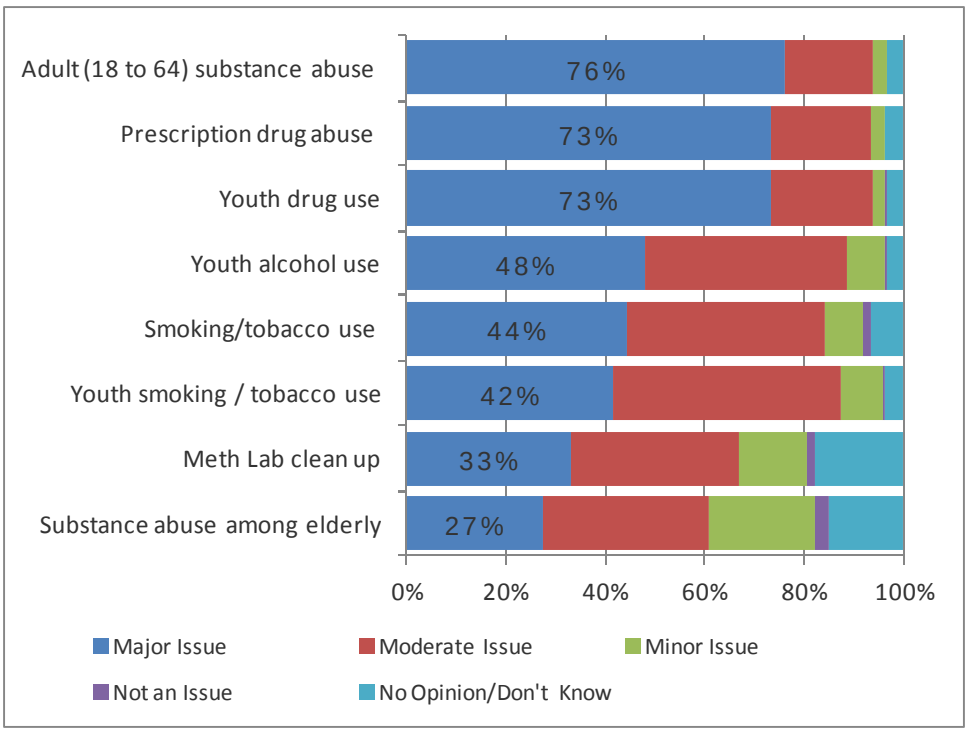
What is your opinion about the following health and mental health issues in your community?

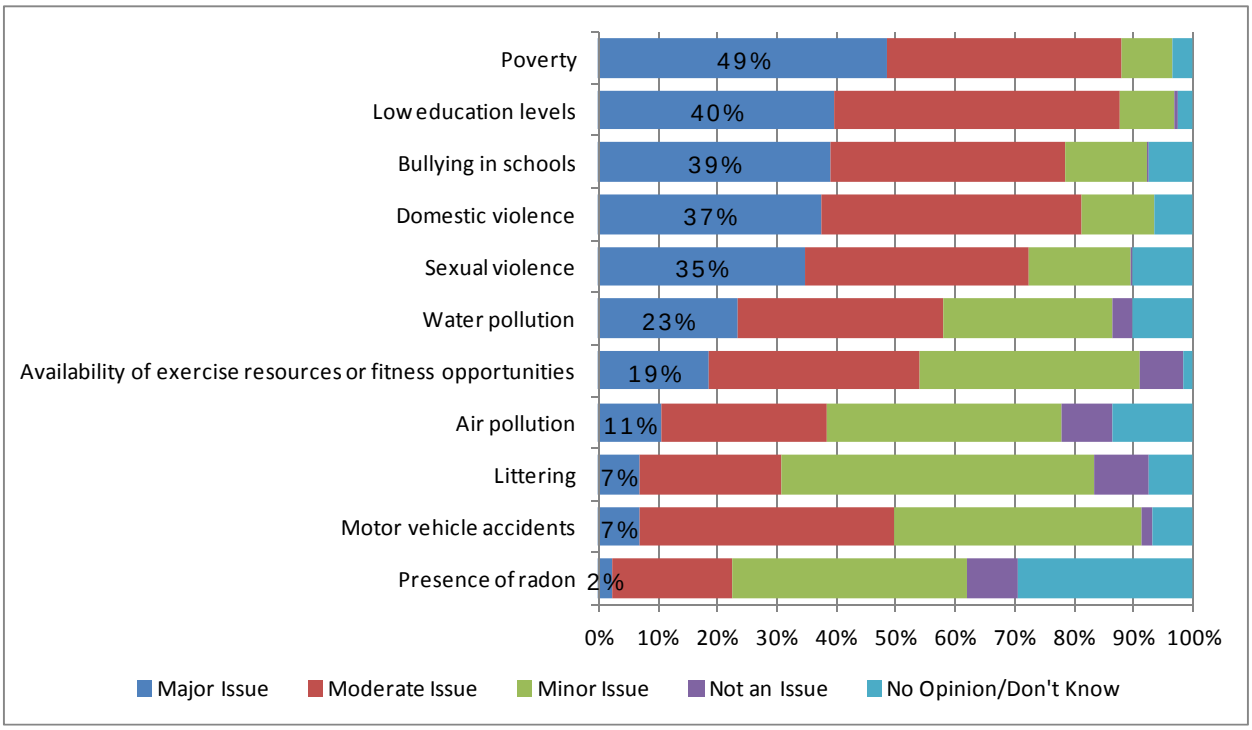
Interpretation – We asked survey participants to offer free text response to several questions and interpreted their responses by developing "Word Clouds." Word Clouds are analytical tools which give greater visual prominence to words appearing more frequently in the source text. This information visualization establishes a portrait of the aggregate responses, presenting the more frequently used terms with greater text size and distinction in the visual depiction. Common article word (i.e. "a," "the," etc.), non-contextual verbs (i.e. "is," "are," etc.) and similar words used when writing sentences are suppressed by this application.

In the above visualization, survey participants responded to the question "What is the most important health or medical issue"? Free text response to the question of what is the most important health or medical issue reaffirmed the statistical analysis of major concerns being: access to primary health care, drug abuse, insurance – affordability – cost issues, mental health and obesity.



After the open question, we posed two multiple choice questions. Listed were potential health needs with the question, "What is your opinion about the following medical and mental health issues in your community?"



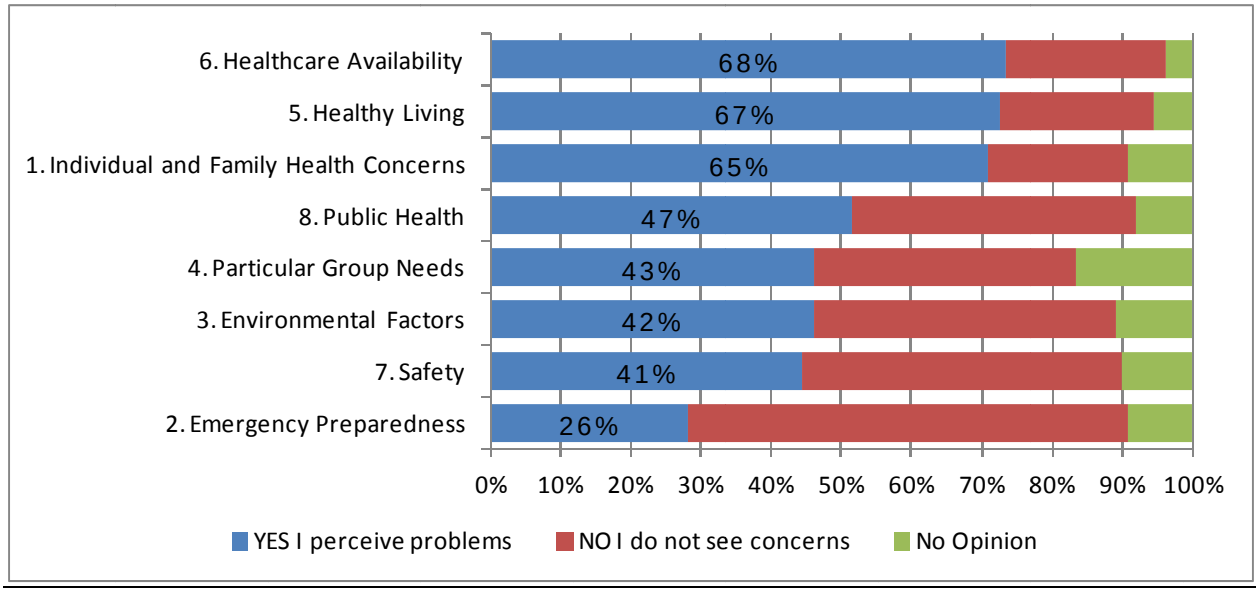


Three needs were identified by respondents as a "Major Issue." In descending order, the major needs were:

- Adult substance abuse;

- Prescription drug abuse, and;
- Youth drug abuse

Additional comments made to explain their voting are shown above. The verbal comments agree with the statistical voting to identify drug abuse as a prevailing concern.



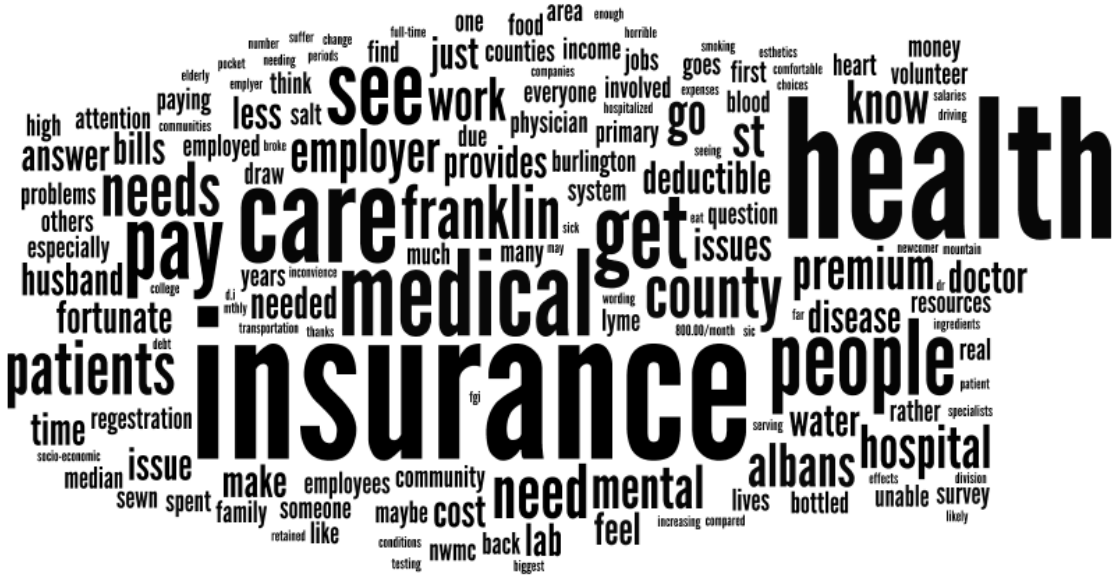
People were asked if they in the last two years had perceived a specific problem needing to be addressed. As shown above, three issues gathered more than half of participant responses stating

there is a specific problem. 68% cited healthcare availability, 67% cited health living concerns and 65% cited personal or family health concerns.

Free text comments augmented the statistical opinion as shown above; health care has many issues and needs. Concerns about availability or access to primary care providers seem to be a more common response.

Question: In the last two years have you or anyone in your household left the county in search of medical care?

Answer: 52% Yes. Destinations seem to be Chittenden, Burlington and Franklin for primary care, surgery, cancer and dermatology.



Question: Are there any health needs you want to emphasize? Answer: Insurance issues are the main point to emphasize which was interpreted as reinforcing the concerns about limitations to ability to access medical care.

Over 75% of survey participants had a regular source of eye care, a dental provider and a primary care physician. Only 17% had a mental health counselor. 51% of participants either themselves or a family member left the county for medical care. Destinations seem to be Chittenden, Burlington and Franklin for primary care, surgery, cancer and dermatology.

Major characteristics of survey participant's note

- 76% did not have a problem paying for medical care in the last year;
- 97% had older children in their household and 89% had younger children (age 0 to 4);

- Except for the under 18 age group, all age ranges participated in the survey. 47% were age 35 to 54;
- 79% of survey participants were female;
- 98% of survey participants were white, non-Hispanic;
- Except for no survey participant holding less than a high school education, 80% held a college degree or more advanced education;
- 71% of participants were married;
- All household income groups were represented but the largest response, 43%, had earnings between $50,000 to $99,000 and 88% were employed in some capacity; and
- Less than 2% did not have health insurance and 51% held insurance costing them less than 12% of their household monthly income.

Conclusions from Public Input to Community Health Need Assessment

Respondents overwhelmingly have access to physician, dental and eye professionals and perceive themselves to be in good health. Most survey respondents do not have a mental health advisor. While the local economy is worse than it was a year ago, they have not personally experienced financial problems in accessing medical services. Approximately ¾ of respondents were employed, middle aged, college educated, married and females with a household income over $50,000 and held health insurance.
Over 60% of responses indicated three issues as major problems:

- People making unhealthy food choices – obesity;
- Not having health insurance; and
- Mental health related problems – typically access.

Over 70% of responses indicated adult substance abuse problems, prescription drug abuse and drug use among youth as major problems. About 2/3 of responses perceive a problem with healthcare availability, healthy living and individual/family health problems in the community.

Healthcare availability (access to primary care and to a lesser extent specialty medicine) not only was the most often cited problem, it also is considered the most important to resolve.

Free text response to the question of what is the most important health or medical issue reaffirmed the statistical analysis of major concerns being:

- Access to primary health care;
- Drug abuse;
- Insurance – affordability – cost issues;
- Mental health, and;

- Obesity.

Appendix B – Franklin and Grand Isle Counties Compared to National Peer Counties[25]

Demographics: Franklin County, VT

Population size[1]	47,949
Population density (people per square mile)[2]	75
Individuals living below poverty level[3]	9.9%

Age distribution[1]		**Race/Ethnicity**[1]	
Under Age 19	25.6%	White	96.3%
Age 19-64	63.0%	Black	0.5%
Age 65-84	10.0%	American Indian	1.1%
Age 85+	1.4%	Asian/Pacific Islander	0.4%
		Hispanic origin (non add)	1.0%

Peer Counties

Peer counties (counties and county-like geographic areas) in stratum number 29 were stratified on the basis of the following factors: frontier status, population size, poverty, age. Below are peer county ranges representing the 10th and 90th percentile of values. This trimmed range of peer county value is used consistently throughout the report.

Population size[1]	27,949 - 58,506
Population density (people per square mile)[2]	39 - 149
Individuals living below poverty level[3]	10.4 - 15.2%

Age distribution[1]		**Race/Ethnicity**[1]	
Under Age 19	22.9 - 32.0%	White	79.7 - 97.8%
Age 19-64	58.9 - 63.5%	Black	0.5 - 18.1%
Age 65-84	7.7 - 12.9%	American Indian	0.2 - 1.2%
Age 85+	0.9 - 2.1%	Asian/Pacific Islander	0.3 - 2.1%
		Hispanic origin (non add)	0.9 - 19.6%

nda No data available.

[1] The Census Bureau. Current Population Estimates, 2008.
[2] HRSA. Area Resource File, 2008.
[3] The Census Bureau. Small Area Income Poverty Estimates, 2008.

[25] http://communityhealth.hhs.gov
Partial response to IRS Schedule H (form 990) Part V B 1 b.

Demographics: Grand Isle County, VT

Population size[1]	7,729
Population density (people per square mile)[2]	94
Individuals living below poverty level[3]	8.4%

Age distribution[1]		Race/Ethnicity[1]	
Under Age 19	21.0%	White	97.2%
Age 19-64	65.0%	Black	0.2%
Age 65-84	13.0%	American Indian	0.7%
Age 85+	1.0%	Asian/Pacific Islander	0.6%
		Hispanic origin (non add)	0.8%

Peer Counties

Peer counties (counties and county-like geographic areas) in stratum number 37 were stratified on the basis of the following factors: frontier status, population size, poverty, age. Below are peer county ranges representing the 10th and 90th percentile of values. This trimmed range of peer county value is used consistently throughout the report.

Population size[1]	5,463 - 25,813
Population density (people per square mile)[2]	10 - 2,060
Individuals living below poverty level[3]	4.4 - 11.6%

Age distribution[1]		Race/Ethnicity[1]	
Under Age 19	19.4 - 24.5%	White	73.3 - 97.2%
Age 19-64	61.2 - 72.7%	Black	0.5 - 16.1%
Age 65-84	7.7 - 15.8%	American Indian	0.1 - 1.0%
Age 85+	0.5 - 2.9%	Asian/Pacific Islander	0.3 - 7.3%
		Hispanic origin (non add)	1.0 - 13.9%

nda No data available.

1The Census Bureau. Current Population Estimates, 2008.
2HRSA. Area Resource File, 2008.
3The Census Bureau. Small Area Income Poverty Estimates, 2008.

Franklin County lies in Peer Group # 29 and Grand Isle County's Peer Group is #37[26]

CHSI 2008-09 Peer County Strata Listing:
Number of Counties and Range of Population Size, Population Density, and Poverty

Strata ID Number	Number of Counties	Population Size		Population Density		Poverty (%)	
		min.	max.	min.	max.	min.	max.
24	35	55,928	110,624	21	2,160	11.7	17.5
25	21	30,848	49,276	49	166	6.0	11.0
26	40	26,602	76,410	20	2,137	6.9	11.3
27	25	24,463	49,671	21	3,783	5.1	10.6
28	39	24,885	60,813	16	375	8.7	14.8
29	37	26,571	60,658	21	370	9.0	13.4
30	57	24,515	54,359	11	379	8.9	15.0
31	22	26,010	49,111	14	107	9.4	13.4
32	37	27,757	56,196	7	3,941	12.2	19.4
33	41	24,540	69,932	12	212	10.9	18.6
34	22	27,995	47,971	7	72	11.1	18.4
35	27	24,695	64,182	13	1,072	13.1	20.9
36	23	24,273	51,663	11	67	15.0	32.4
37	30	111	26,598	8	5,418	3.0	11.3

[26]http://communityhealth.hhs.gov/Companion_Document/CHSI-Data_Sources_Definitions_And_Notes.pdf
Partial response to IRS Schedule H (form 990) Part V B 1. d.

Franklin County Peer County List[27]

Peer County List

A distinctive aspect of this report is the ability to compare a county with its peers, those counties similar in population composition and selected demographics. Strata, or peer group size averages 36 and ranges from 15 to 62 counties. There are a total of 88 strata. Listed below are the 36 peer counties in stratum number 29. Due to the population size of counties within this stratum, data on vital statistics (e.g. births and deaths) and nationally notifiable diseases were aggregated across the most recent 5 year time period (2001-2005) in order to ensure stable estimates.

Note: These links open in a new window.

Alabama
- Autauga County

Arkansas
- Lonoke County

California
- San Benito County

Georgia
- Barrow County
- Camden County
- Effingham County
- Gordon County
- Murray County

Indiana
- Miami County
- Washington County

Kansas
- Finney County
- Ford County
- Lyon County

Kentucky
- Meade County
- Nelson County

Louisiana
- St. Charles Parish

Michigan
- Branch County
- Gratiot County
- Hillsdale County
- Newaygo County

Missouri
- Lincoln County
- Newton County

New York
- Cortland County
- Lewis County
- Orleans County
- Wyoming County

North Carolina
- Lee County

Ohio
- Brown County
- Carroll County
- Holmes County

Pennsylvania
- Wyoming County

Tennessee
- Dickson County

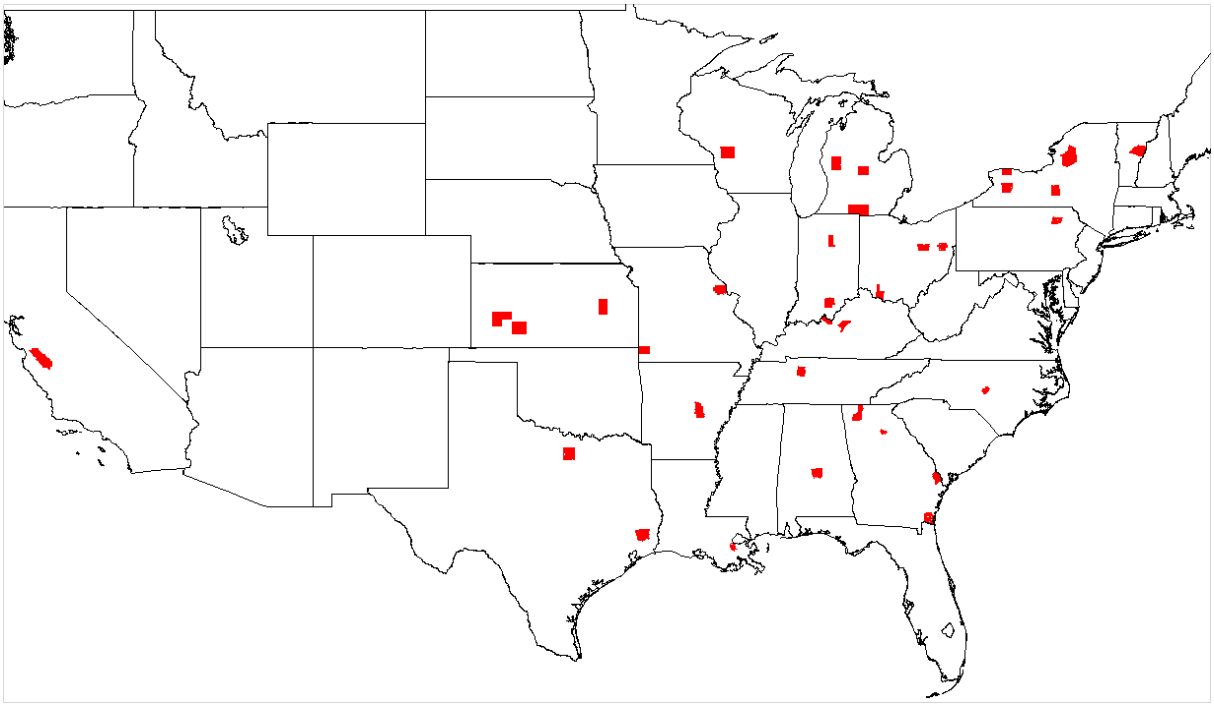
Texas
- Hardin County
- Wise County

Vermont
- Orange County

Wisconsin
- Monroe County

[27] http://communityhealth.hhs.gov/Demographics.aspx?GeogCD=50011&PeerStrat=29&state=Vermont&county=Franklin

Franklin County Peer Group Map



Grand Isle County Peer County List[28]

Peer County List

A distinctive aspect of this report is the ability to compare a county with its peers, those counties similar in population composition and selected demographics. Strata, or peer group size averages 36 and ranges from 15 to 62 counties. There are a total of 88 strata. Listed below are the 29 peer counties in stratum number 37. Due to the population size of counties within this stratum, data on vital statistics (e.g. births and deaths) and nationally notifiable diseases were aggregated across the most recent 10 year time period (1996-2005) in order to ensure stable estimates.

Note: These links open in a new window.

Alaska
- Ketchikan Gateway Borough

Colorado
- Clear Creek County
- Gilpin County
- Pitkin County
- Routt County
- Summit County

Hawaii
- Kalawao County

Idaho
- Blaine County

Indiana
- Brown County
- Ohio County

Kentucky
- Anderson County
- Woodford County

Massachusetts
- Nantucket County

Nebraska
- Wayne County

Nevada
- Storey County

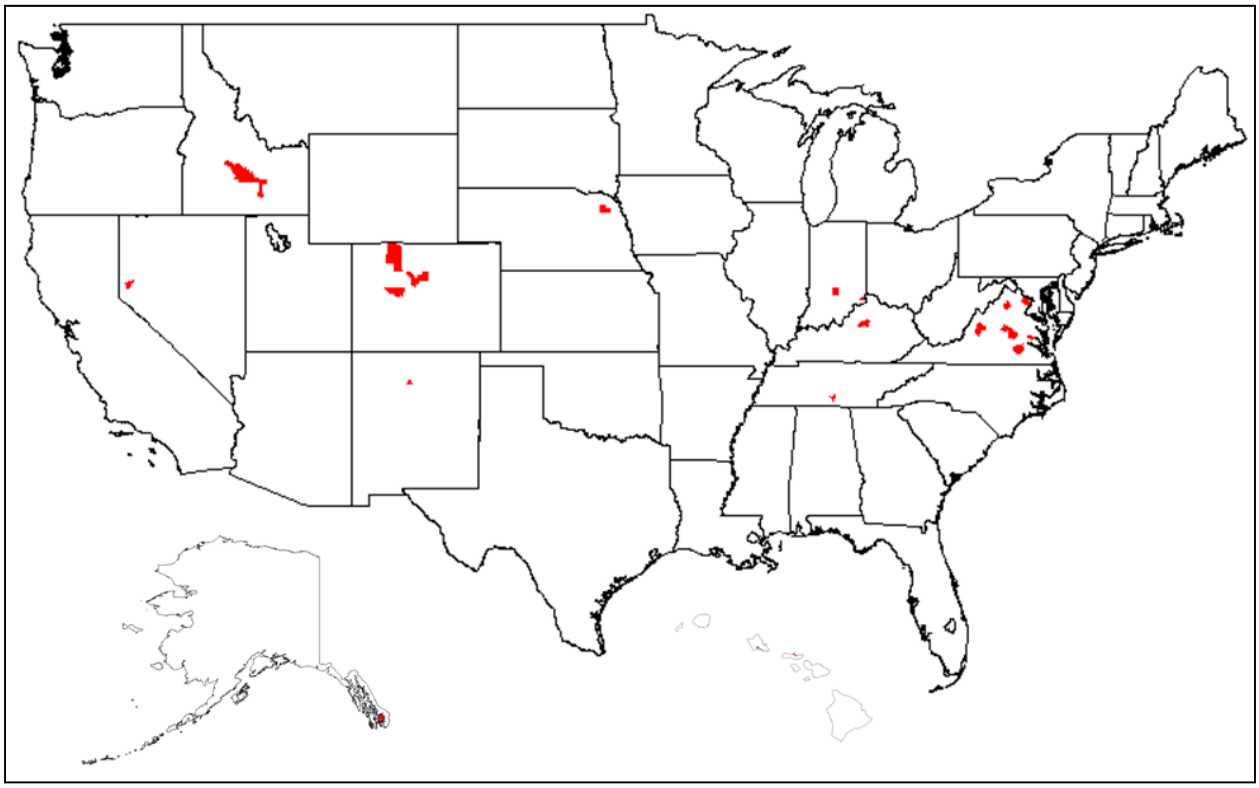
New Mexico
- Los Alamos County

Tennessee
- Moore County

Virginia
- Colonial Heights City
- Dinwiddie County
- Fairfax City
- Falls Church City
- Fluvanna County
- Goochland County
- New Kent County
- Poquoson City
- Powhatan County
- Rappahannock County
- Rockbridge County
- Salem City

[28]http://communityhealth.hhs.gov/Demographics.aspx?GeogCD=50013&PeerStrat=37&state=Vermont&county=Grand%20Isle

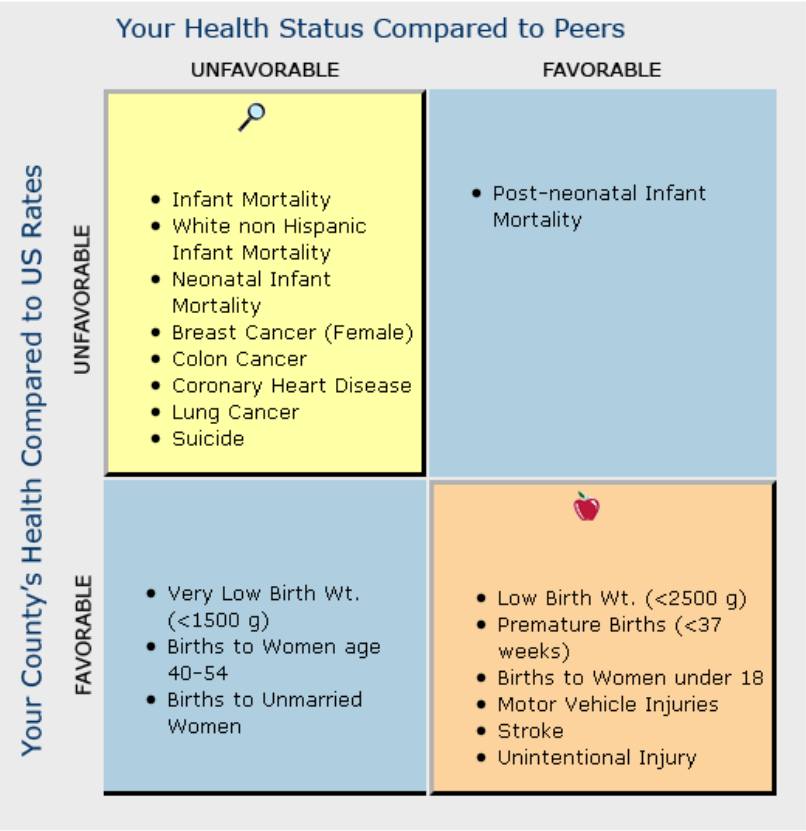
Grand Isle County Peer County Map



Franklin County Performance Compared to Peer Counties and National Averages[29]

Indicates a status favorable to peer county median value

Indicates that a closer look and perhaps reduction to the percent or rate may be needed. Blank indicates no comparison.



The Relative Health Importance table creates four categories of relative concern by simply comparing a county to its peers and to the U.S.

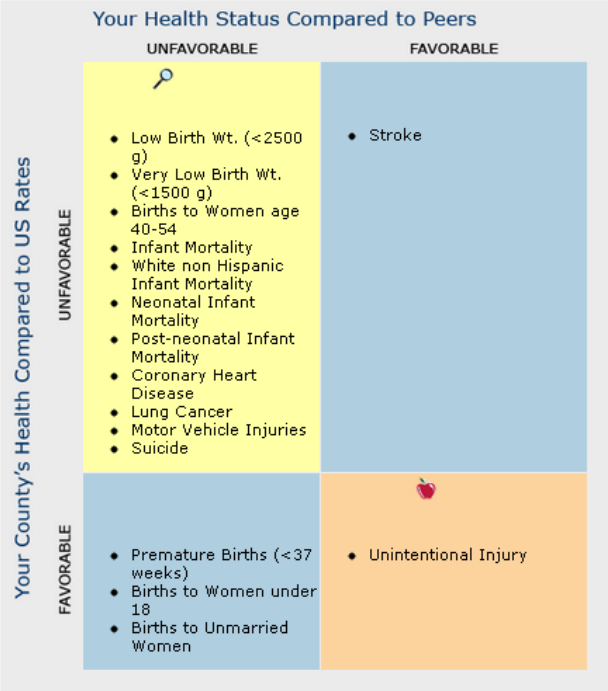
A county's indicators in the Unfavorable/Unfavorable Quadrant ( ) are higher than the U.S. and its peers and may warrant more attention. Conversely, indicators in the Favorable/Favorable Quadrant ( ) of the table compare favorably to both peers and the U.S. The other boxes represent intermediate levels of health where a county's rate is higher than either its peers or the U.S., but not both.

[29] Partial response to IRS Schedule H (form 990) Part V B 1 f

Grand Isle County Performance Compared to Peer Counties and National Averages

Relative Health Importance: Grand Isle County, VT

Indicates a status favorable to peer county median value
Indicates that a closer look and perhaps reduction to the percent or rate may be needed. Blank indicates no comparison.



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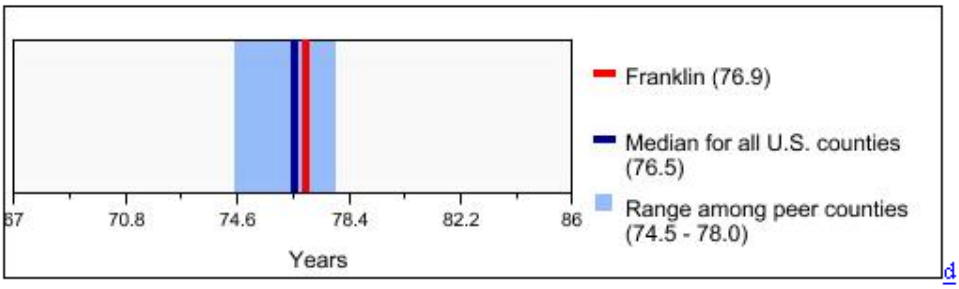
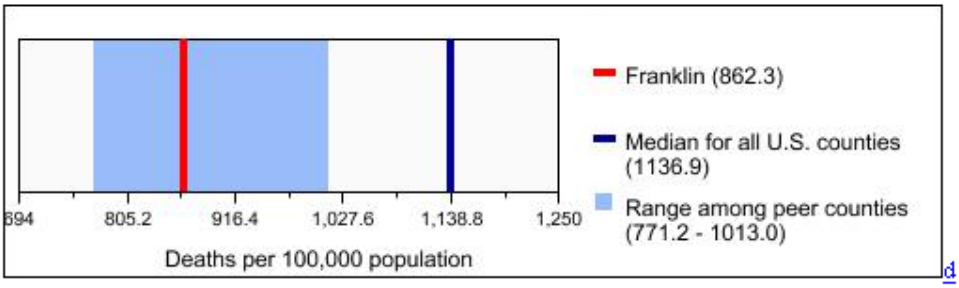
A county's indicators in the Unfavorable/Unfavorable Quadrant ( ) are higher than the U.S. and its peers and may warrant more attention. Conversely, indicators in the Favorable/Favorable Quadrant ( ) of the table compare favorably to both peers and the U.S. The other boxes represent intermediate levels of health where a county's rate is higher than either its peers or the U.S., but not both.

Franklin County Summary Measures of Health

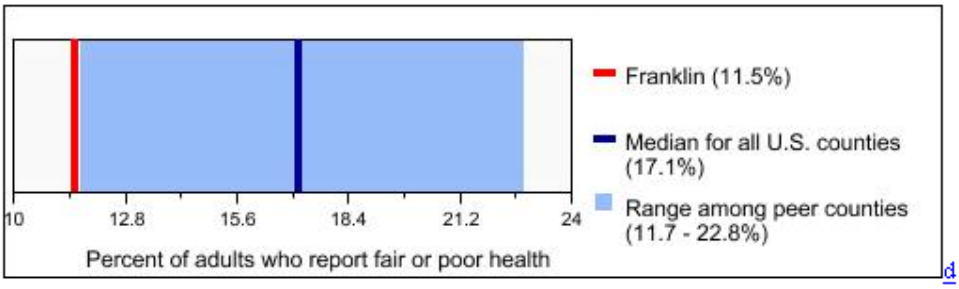
AVERAGE LIFE EXPECTANCY[1]



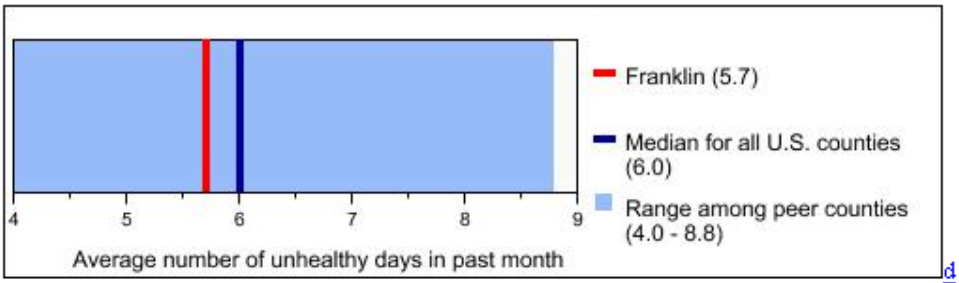
ALL CAUSES OF DEATH[2]



SELF-RATED HEALTH STATUS[3]

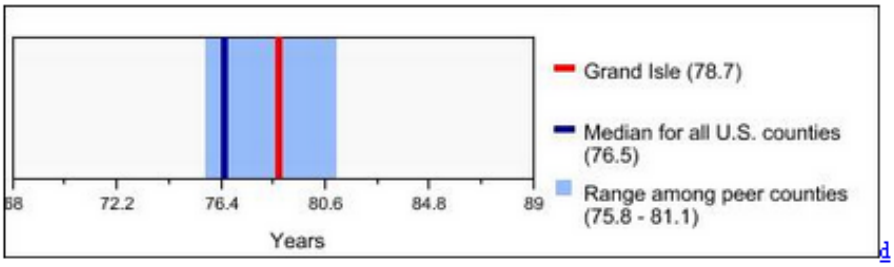


AVERAGE NUMBER OF UNHEALTHY DAYS IN PAST MONTH[3]

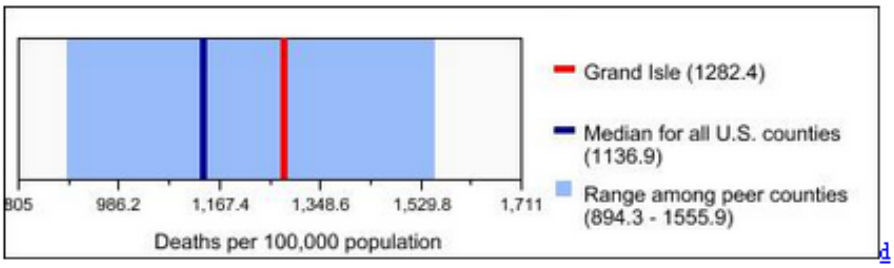


Grand Isle County Summary Measures of Health

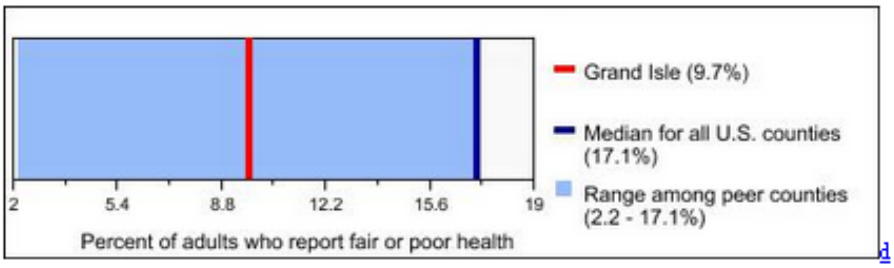
AVERAGE LIFE EXPECTANCY[1]



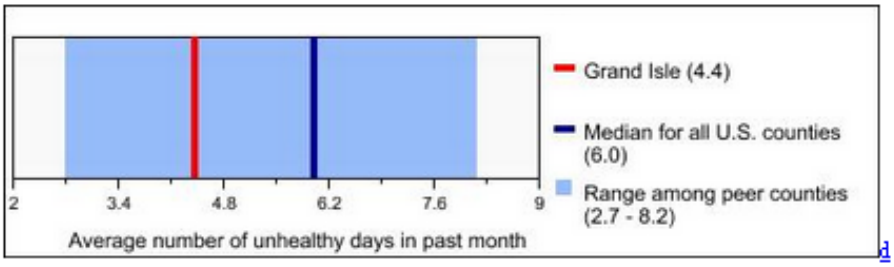
ALL CAUSES OF DEATH[2]



SELF-RATED HEALTH STATUS[3]



AVERAGE NUMBER OF UNHEALTHY DAYS IN PAST MONTH[3]



Franklin County Measures of Birth and Death

Indicates a status favorable to peer county median value

Indicates that a closer look and perhaps reduction to the percent or rate may be needed. Blank indicates no comparison.

County Percent	Status	Peer County Range	Birth Measures	U.S. Percent 2005	Healthy People 2010 Target
6.6		6.1 - 8.3	Low Birth Wt. (<2500 g)	8.2	5.0
1.3		0.9 - 1.6	Very Low Birth Wt. (<1500 g)	1.5	0.9
9.1		9.1 - 14.0	Premature Births (<37 weeks)	12.7	7.6
1.8		1.8 - 5.5	Births to Women under 18	3.4	No objective
2.0		1.2 - 2.8	Births to Women age 40-54	2.7	No objective
33.5		26.9 - 41.8	Births to Unmarried Women	36.9	No objective
cdna		cdna	No Care in First Trimester[2]	cdna	10.0

County Rate	Status	Peer County Range	Infant Mortality[3]	U.S. Rate 2005	Healthy People 2010 Target
8.7		3.7 - 9.2	Infant Mortality	6.9	4.5
8.5		3.6 - 9.4	White non Hispanic Infant Mortality	5.8	4.5
nrf		0.0 - 58.8	Black non Hispanic Infant Mortality	13.6	4.5
nrf		0.0 - 13.7	Hispanic Infant Mortality	5.6	4.5
6.0		2.2 - 6.0	Neonatal Infant Mortality	4.5	2.9
2.7		0.7 - 4.1	Post-neonatal Infant Mortality	2.3	1.2

County Rate	Status	Peer County Range	Death Measures[4]	U.S. Rate 2005	Healthy People 2010 Target
26.7		14.1 - 31.1	Breast Cancer (Female)	24.1	21.3
26.6		14.7 - 26.3	Colon Cancer	17.5	13.7
219.5		131.9 - 219.5	Coronary Heart Disease	154.0	162.0
nrf		0.3 - 6.0	Homicide	6.1	2.8
61.5		40.3 - 74.6	Lung Cancer	52.6	43.3
13.3		13.3 - 32.3	Motor Vehicle Injuries	14.6	8.0
41.1		46.0 - 66.4	Stroke	47.0	50.0
15.4		6.0 - 15.7	Suicide	10.9	4.8
22.1		16.6 - 32.9	Unintentional Injury	39.1	17.1

Grand Isle Measures of Birth and Death

Indicates a status favorable to peer county median value

Indicates that a closer look and perhaps reduction to the percent or rate may be needed. Blank indicates no comparison.

County Percent	Status	Peer County Range	Birth Measures	U.S. Percent 2005	Healthy People 2010 Target
8.4		5.5 - 9.7	Low Birth Wt. (<2500 g)	8.2	5.0
1.9		0.9 - 1.8	Very Low Birth Wt. (<1500 g)	1.5	0.9
11.6		8.9 - 13.2	Premature Births (<37 weeks)	12.7	7.6
2.2		1.0 - 4.2	Births to Women under 18	3.4	No objective
3.3		1.5 - 5.9	Births to Women age 40-54	2.7	No objective
26.7		15.3 - 35.6	Births to Unmarried Women	36.9	No objective
cdna		cdna	No Care in First Trimester[2]	cdna	10.0

County Rate	Status	Peer County Range	Infant Mortality[3]	U.S. Rate 2005	Healthy People 2010 Target
8.7		3.4 - 8.2	Infant Mortality	6.9	4.5
8.4		2.4 - 7.2	White non Hispanic Infant Mortality	5.8	4.5
nrf		0.0 - 23.3	Black non Hispanic Infant Mortality	13.6	4.5
nrf		0.0 - 39.7	Hispanic Infant Mortality	5.6	4.5
5.1		1.2 - 5.9	Neonatal Infant Mortality	4.5	2.9
3.6		0.0 - 4.2	Post-neonatal Infant Mortality	2.3	1.2

County Rate	Status	Peer County Range	Death Measures[4]	U.S. Rate 2005	Healthy People 2010 Target
nrf		14.3 - 58.9	Breast Cancer (Female)	24.1	21.3
nrf		16.2 - 42.8	Colon Cancer	17.5	13.7
333.2		119.5 - 335.0	Coronary Heart Disease	154.0	162.0
nrf		0.0 - 10.5	Homicide	6.1	2.8
89.5		46.0 - 117.0	Lung Cancer	52.6	43.3
30.8		12.7 - 45.9	Motor Vehicle Injuries	14.6	8.0
68.4		43.4 - 119.1	Stroke	47.0	50.0
23.0		8.7 - 35.7	Suicide	10.9	4.8
28.5		21.2 - 60.2	Unintentional Injury	39.1	17.1

Franklin County Environmental Health Factors

Environmental Health: Franklin County, VT

INFECTIOUS DISEASES [1]

Status	Cases	Reported	Expected
🔍	E.coli	8	2
🍎	Salmonella	29	38
🍎	Shigella	0	12

TOXIC CHEMICALS RELEASED ANNUALLY[2]: 5,477 pounds

NATIONAL AIR QUALITY STANDARDS MET?[3]

Carbon Monoxide	Nitrogen Dioxide	Sulfur Dioxide	Ozone	Particulate Matter	Lead
Yes	Yes	Yes	Yes	Yes	Yes

🍎 *Indicates a status favorable to peers.*
🔍 *Indicates a status less than favorable.*
nda *No data available.*

Grand Isle Environmental Health Factors

Environmental Health: Grand Isle County, VT

INFECTIOUS DISEASES [1]

Status	Cases	Reported	Expected
🍎	E.coli	0	1
🔍	Salmonella	10	9
🍎	Shigella	0	2

TOXIC CHEMICALS RELEASED ANNUALLY[2]: nda

NATIONAL AIR QUALITY STANDARDS MET?[3]

Carbon Monoxide	Nitrogen Dioxide	Sulfur Dioxide	Ozone	Particulate Matter	Lead
Yes	Yes	Yes	Yes	Yes	Yes

🍎 *Indicates a status favorable to peers.*
🔍 *Indicates a status less than favorable.*
nda *No data available.*

Franklin County Preventative Service Use

Preventive Services Use: Franklin County, VT

INFECTIOUS DISEASE CASES[1]

These diseases respond to public health control efforts. The expected number is based on the occurrence of cases among peer counties.

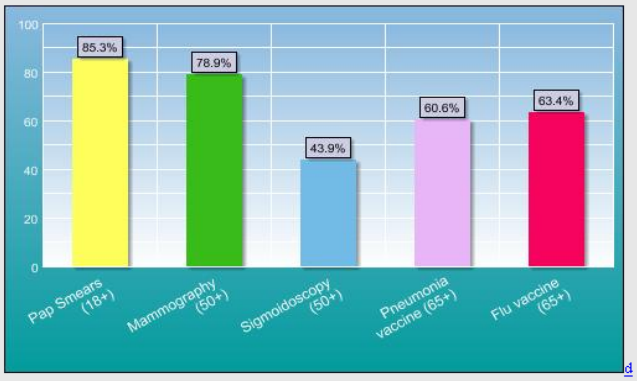
Status		Reported Cases	Expected Cases
	AIDS	rna	rna
	Tuberculosis	rna	rna
🍎	Haemophilus influenzae B	1	0
🍎	Hepatitis A	3	2
🍎	Hepatitis B	0	2
🍎	Measles	0	0
🔍	Pertussis	12	14
🍎	Congenital Rubella Syndrome	0	0
🍎	Syphilis	0	0

🍎 *Indicates a status favorable to peers.*
🔍 *Indicates a status less than favorable.*
nda *No data available.*
rna *The release of data for all counties has not been authorized.*

CHILD PREVENTIVE SERVICES USE

Indicators such as immunizations, dental caries, and the prevalence of lead screening are not collected at the national level and must be obtained locally.

ADULT PREVENTIVE SERVICES USE (%)[2]



Franklin County, VT

nrf No report, survey sample size fewer than 50.

Note: Confidence intervals are available as tooltips for the Adult Preventive Services Use (%). To view the confidence intervals, hover your mouse over any bar on the graph.

[1] CDC. National Notifiable Diseases Surveillance System, 2003-2007.
[2] CDC. Behavioral Risk Factor Surveillance System, 2000-2006.

Grand Isle Preventative Service Use

Preventive Services Use: Grand Isle County, VT

INFECTIOUS DISEASE CASES[1]

These diseases respond to public health control efforts. The expected number is based on the occurrence of cases among peer counties.

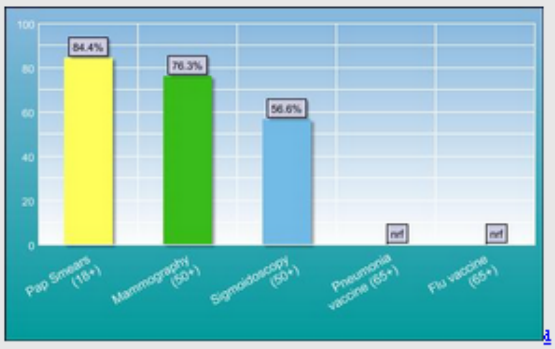
Status		Reported Cases	Expected Cases
	AIDS	rna	rna
	Tuberculosis	rna	rna
🔎	Haemophilus influenzae B	1	0
🍎	Hepatitis A	1	1
🍎	Hepatitis B	0	1
🍎	Measles	0	0
🔎	Pertussis	15	6
🍎	Congenital Rubella Syndrome	0	0
🍎	Syphilis	0	0

🍎 *Indicates a status favorable to peers.*
🔎 *Indicates a status less than favorable.*
nda No data available.
rna The release of data for all counties has not been authorized.

CHILD PREVENTIVE SERVICES USE

Indicators such as immunizations, dental caries, and the prevalence of lead screening are not collected at the national level and must be obtained locally.

ADULT PREVENTIVE SERVICES USE (%)[2]



Grand Isle County, VT

nrl No report, survey sample size fewer than 50.

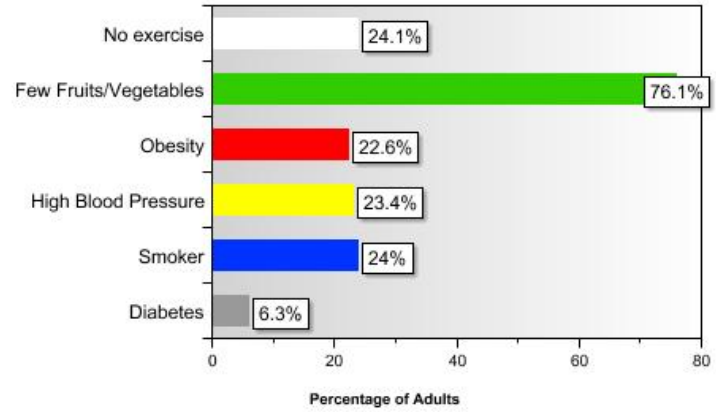
Note: Confidence intervals are available as tooltips for the Adult Preventive Services Use (%). To view the confidence intervals, hover your mouse over any bar on the graph.

[1] CDC. National Notifiable Diseases Surveillance System, 1998-2007.
[2] CDC. Behavioral Risk Factor Surveillance System, 2000-2006.

Franklin County Risk factors for Premature Death

Risk Factors for Premature Death:[1] Franklin County, VT

Communities may wish to obtain information about these measures, collected and monitored at local level.



d

nrf No report, survey sample size fewer than 50.

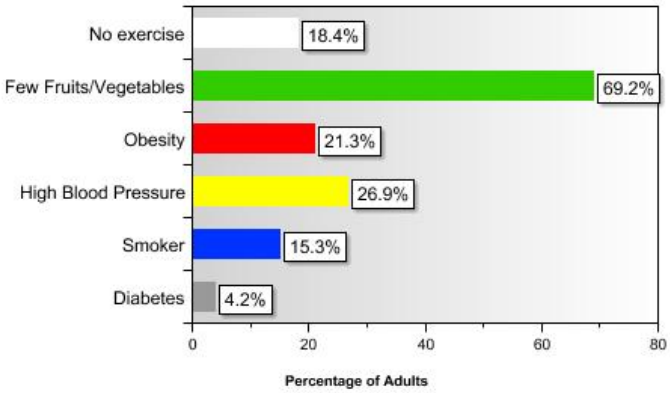
Note: Confidence intervals are available as tooltips for Risk Factors for Premature Death. To view the confidence intervals, hover your mouse over any of the bars on the graph.

[1] CDC. Behavioral Risk Factor Surveillance System, 2000-2006.

Grand Isle Risk Factors for Premature Death

Risk Factors for Premature Death:[1] Grand Isle County, VT

Communities may wish to obtain information about these measures, collected and monitored at local level.



d

nrf No report, survey sample size fewer than 50.

Note: Confidence intervals are available as tooltips for Risk Factors for Premature Death. To view the confidence intervals, hover your mouse over any of the bars on the graph.

[1] CDC. Behavioral Risk Factor Surveillance System, 2000-2006.

Observation of Franklin and Grand Isle Counties Compared to National Set of "Peer" Counties

The federal government administers a process to allocate all counties into "Peer" groups, i.e., groups having similar social, economic and demographic characteristics. Health and wellness observations when Grand Isle & Franklin Counties are compared to their respective national set of Peer Counties and compared to national rates makes some similar and some vastly different observations (Grand Isle and Franklin are not Peer counties and apparently too small a Hispanic population exists to calculate group rates):

UNFAVORABLE OBSERVATIONS when compared to their peers and national averages are as follows

1. INFANT MORTALITY;
2. WHITE NON-HISPANIC INFANT MORTALITY;
3. NEONATAL INFANT MORTALITY;
4. CORONARY HEART DISEASE;
5. LUNG CANCER;
6. SUICIDE;
7. BREAST CANCER Franklin only – no Grand Isle data;
8. COLON CANCER Franklin only – no Grand Isle data;
9. LOW BIRTH WEIGHT (<2500g) Grand Isle ONLY, this indicator is FAVORABLE for Franklin County;
10. VERY LOW BIRTH WEIGHT Grand Isle ONLY, Franklin County is UNFAVORABLE among Peers but below national average;
11. BIRTHS TO WOMEN 40-54 Grand Isle ONLY, Franklin County is UNFAVORABLE among Peers but below national average;
12. POST NEONATAL INFANT MORTALITY Grand Isle ONLY, Franklin County values are FAVORABLE to peers but below US Median values; and
13. MOTOR VEHICLE INJURY Grand Isle ONLY, Franklin County values are FAVORABLE to peers and to National average.

SOMEWHAT A CONCERN observations as rates are unfavorable compared to peer counties (but better than national average):

- BIRTHS TO UNMARRIED WOMEN;
- VERY LOW BIRTH WEIGHT (less than 1500 g) Franklin County only, noted above as concern for Grand Isle;

- BIRTHS TO WOMEN 40 to 54 Franklin County only, noted above as concern for Grand Isle;
- PREMATURE BIRTHS Grand Isle ONLY, Franklin County not a concern; and
- BIRTHS TO WOMEN UNDER 18 (2005 data only) Grand Isle ONLY, Franklin County not a concern.

SOMEWHAT A CONCERN observations as rates are unfavorable compared to national rates:

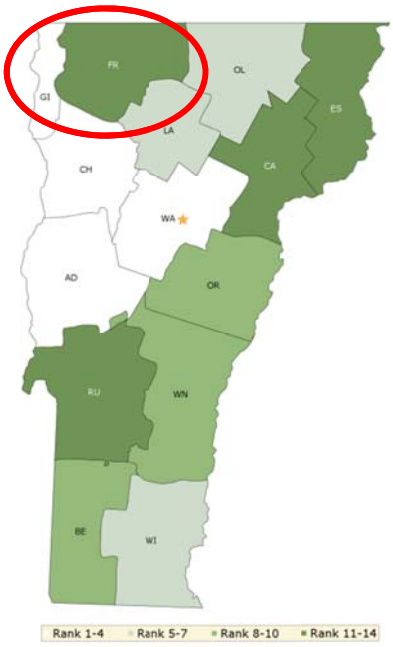
- POST NEONATAL INFANT MORTALITY Franklin County ONLY, Grand Isle presents as a concern as noted above; and
- STROKE Grand Isle ONLY, Franklin County presents as NOT A CONCERN.

Potential conditions which are not a health need because performance is BETTER than Peers; National rates in both counties only include UNINTENTIONAL INJURY. Other BETTER Franklin Co metrics include:

- LOW BIRTH WEIGHT (<2500 grams);
- PREMATURE BIRTHS (<37 weeks);
- BIRTHS TO WOMEN UNDER 18 (2005 data only);
- MOTOR VEHICLE INJURY; and
- STROKE.

Appendix C – Franklin and Grand Isle Counties Compared to All Other Vermont Counties[30]

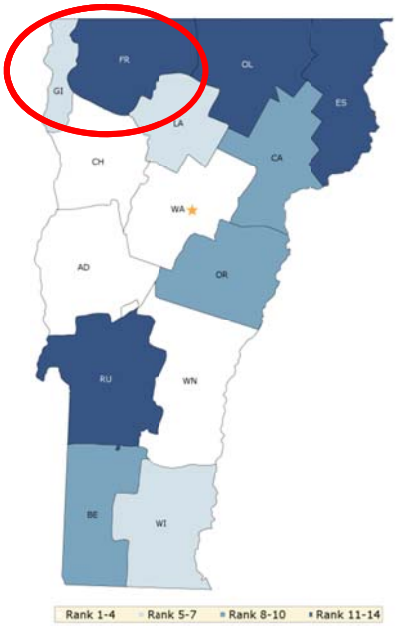
Health Outcomes



[redacted]

[30] www.communityhealthrankings.org
Partial response to IRS Schedule H (form 990) Part V B 1. d.

Health Factors



[redacted]

Observations from Franklin and Grand Isle Counties compared to all other Vermont counties, in terms of Community Health Needs

In general, Grand Isle County health status compares favorably among Vermont Counties. It generally has values at the Vermont average and ranks 4th in HEALTHY OUTCOMES (with 1st being the best) among the 14 ranked counties.

Franklin County health status generally compares unfavorably among Vermont Counties. It has values above the Vermont average and ranks 12th (out of 14) in HEALTHY OUTCOMES.

Among the various HEALTH FACTORS analyzed, the relative positions of both counties show the same pattern; Grand Isle ranks 5th and Franklin ranks 12th.

PHYSICAL ENVIRONMENTAL FACTORS generally are positive influences on overall county rankings for both counties. The percentage of fast food restaurants and limited access of low income to healthy food are a common concern. Environmental pollution factors are a low concern to both counties.

CLINICAL FACTORS are not a serious depressing factor in scoring the rankings. UNINSURED RATES, PREVENTABLE HOSPITAL STAYS, DIABETIC SCREENING RATES and MAMMOGRAPHY show little difference between the counties. Improvement is possible but would have little impact on improving the ranking. PRIMARY CARE PHYSICIAN access is a problem for both counties and improvement would impact rankings.

HEALTHY BEHAVIORS generally shows the same patterns with Grand Isle at about the Vermont average and Franklin showing excess values. The most important factor, SMOKING, needs to improve in Franklin County; smoking rates are 50% higher than desired goal. The next most important consideration, OBESITY, is a problem for both counties and notably, Franklin leads Vermont values. DRINKING is at the state average for both counties. SEXUAL DISEASE is below the state average for both counties. TEEN BIRTHS (2002 to 2008 data) is not a Grand Isle concern but Franklin has some of the worst values in the State.

SOCIAL AND ECONOMIC FACTORS are generally positive health status factors for both counties. The one notable exception is the high incident of VIOLENT CRIME for Franklin County, where again it sets the upper value for Vermont.

Appendix D – Leading Causes of Death[31]

VERMONT CAUSES OF DEATH BY AGE AND GENDER

Rank Vermont causes of death by age, gender and population all in one chart. Use buttons in center to select gender. Use green links to sort by age range. Note how cause of death column rankings change. Scroll to bottom of page to see population by age range selected. Latest CDC data for total deaths is used.

Click on any cause to highlight, click again to remove highlight

VERMONT

9/26/2012

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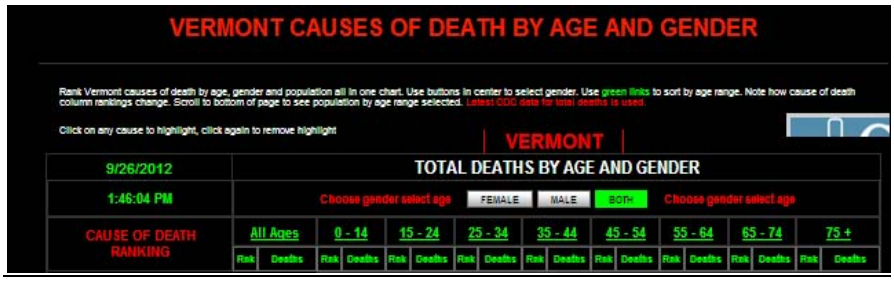
TOTAL DEATHS BY AGE AND GENDER

Choose gender select age | FEMALE | MALE | BOTH | Choose gender select age

CAUSE OF DEATH RANKING	All Ages		0 - 14		15 - 24		25 - 34		35 - 44		45 - 54		55 - 64		65 - 74		75 +	
	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths
CORONARY HEART DISEASE	1	778	1	0	2	0	4	0	2	10	1	45	1	86	1	121	1	516
LUNG CANCERS	2	368	2	0	3	0	5	0	3	0	2	38	2	73	2	100	5	157
LUNG DISEASE	3	346	3	0	4	0	6	0	6	0	7	0	3	43	3	98	2	205
STROKE	4	192	4	0	5	0	7	0	7	0	8	0	12	0	9	12	4	180
ALZHEIMERS	5	182	5	0	6	0	8	0	8	0	9	0	13	0	15	0	3	182
DIABETES MELLITUS	6	126	6	0	7	0	9	0	9	0	10	0	6	11	4	29	7	86
FALLS	7	100	7	0	8	0	10	0	10	0	11	0	14	0	16	0	6	100
HYPERTENSION	8	93	8	0	9	0	11	0	11	0	12	0	7	10	12	0	8	83
BREAST CANCER	9	62	9	0	10	0	12	0	12	0	5	13	9	0	8	18	13	31
COLON-RECTUM CANCERS	10	55	10	0	11	0	13	0	13	0	13	0	15	0	17	0	9	55
ENDOCRINE DISORDERS	11	54	11	0	12	0	14	0	14	0	14	0	16	0	10	11	11	43
SUICIDE	12	48	12	0	13	0	1	10	1	13	8	0	5	13	8	12	24	0
PARKINSON DISEASE	13	45	13	0	14	0	15	0	15	0	15	0	17	0	18	0	10	45
PANCREAS CANCER	14	41	14	0	15	0	16	0	16	0	16	0	8	10	5	20	21	11
PROSTATE CANCER	15	41	15	0	16	0	17	0	17	0	17	0	18	0	19	0	12	41
LYMPHOMAS	16	38	16	0	17	0	18	0	18	0	18	0	19	0	11	10	14	28
LIVER DISEASE	17	27	17	0	18	0	19	0	19	0	19	0	4	14	7	13	23	0
INFLUENZA & PNEUMONIA	18	24	18	0	19	0	20	0	20	0	20	0	20	0	20	0	15	24
ROAD TRAFFIC ACCIDENTS	19	22	19	0	1	10	3	0	4	0	5	12	11	0	14	0	26	0
POISONINGS	20	22	20	0	20	0	2	10	5	0	4	12	10	0	13	0	25	0
KIDNEY DISEASE	21	21	21	0	21	0	21	0	21	0	21	0	21	0	21	0	16	21
OTHER NEOPLASMS	22	20	22	0	22	0	22	0	22	0	22	0	22	0	22	0	17	20
BLADDER CANCER	23	13	23	0	23	0	23	0	23	0	23	0	23	0	23	0	18	13
INFLAMMATORY/HEART	24	12	24	0	24	0	24	0	24	0	24	0	24	0	24	0	19	12
OTHER INJURIES	25	12	25	0	25	0	25	0	25	0	25	0	25	0	25	0	20	12
LIVER CANCER	26	11	26	0	26	0	26	0	26	0	26	0	26	0	26	0	22	11
TUBERCULOSIS	27	0	27	0	27	0	27	0	27	0	27	0	27	0	27	0	27	0
SYPHILIS	28	0	28	0	28	0	28	0	28	0	28	0	28	0	28	0	28	0
CHLAMYDIA	29	0	29	0	29	0	29	0	29	0	29	0	29	0	29	0	29	0
HIV/AIDS	30	0	30	0	30	0	30	0	30	0	30	0	30	0	30	0	30	0

[31] Leading Causes of death obtained from http://www.worldlifeexpectancy.com/vermont-cause-of-death-by-age-and-gender



VERMONT CAUSES OF DEATH BY AGE AND GENDER

Rank Vermont causes of death by age, gender and population all in one chart. Use buttons in center to select gender. Use green links to sort by age range. Note how cause of death column rankings change. Scroll to bottom of page to see population by age range selected. Latest CDC data for total deaths is used.

Click on any cause to highlight, click again to remove highlight

VERMONT

9/26/2012

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TOTAL DEATHS BY AGE AND GENDER

Choose gender select age | FEMALE | MALE | BOTH | Choose gender select age

CAUSE OF DEATH RANKING	All Ages		0 - 14		15 - 24		25 - 34		35 - 44		45 - 54		55 - 64		65 - 74		75 +	
	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths	Rnk	Deaths
DIARRHOEAL DISEASES	31	0	31	0	31	0	31	0	31	0	31	0	31	0	31	0	31	0
PERTUSSIS	32	0	32	0	32	0	32	0	32	0	32	0	32	0	32	0	32	0
DIPHTHERIA	33	0	33	0	33	0	33	0	33	0	33	0	33	0	33	0	33	0
MEASLES	34	0	34	0	34	0	34	0	34	0	34	0	34	0	34	0	34	0
TETANUS	35	0	35	0	35	0	35	0	35	0	35	0	35	0	35	0	35	0
MENINGITIS	36	0	36	0	36	0	36	0	36	0	36	0	36	0	36	0	36	0
HEPATITIS B	37	0	37	0	37	0	37	0	37	0	37	0	37	0	37	0	37	0
HEPATITIS C	38	0	38	0	38	0	38	0	38	0	38	0	38	0	38	0	38	0
MALARIA	39	0	39	0	39	0	39	0	39	0	39	0	39	0	39	0	39	0
TRYPANOSOMIASIS	40	0	40	0	40	0	40	0	40	0	40	0	40	0	40	0	40	0
CHAGAS DISEASE	41	0	41	0	41	0	41	0	41	0	41	0	41	0	41	0	41	0
SCHISTOSOMIASIS	42	0	42	0	42	0	42	0	42	0	42	0	42	0	42	0	42	0
LEISHMANIASIS	43	0	43	0	43	0	43	0	43	0	43	0	43	0	43	0	43	0
LEPROSY	44	0	44	0	44	0	44	0	44	0	44	0	44	0	44	0	44	0
DENGUE	45	0	45	0	45	0	45	0	45	0	45	0	45	0	45	0	45	0
ENCEPHALITIS	46	0	46	0	46	0	46	0	46	0	46	0	46	0	46	0	46	0
ASCARIASIS	47	0	47	0	47	0	47	0	47	0	47	0	47	0	47	0	47	0
TRICHURIASIS	48	0	48	0	48	0	48	0	48	0	48	0	48	0	48	0	48	0
HOOKWORM DISEASE	49	0	49	0	49	0	49	0	49	0	49	0	49	0	49	0	49	0
UPPER RESPIRATORY	50	0	50	0	50	0	50	0	50	0	50	0	50	0	50	0	50	0

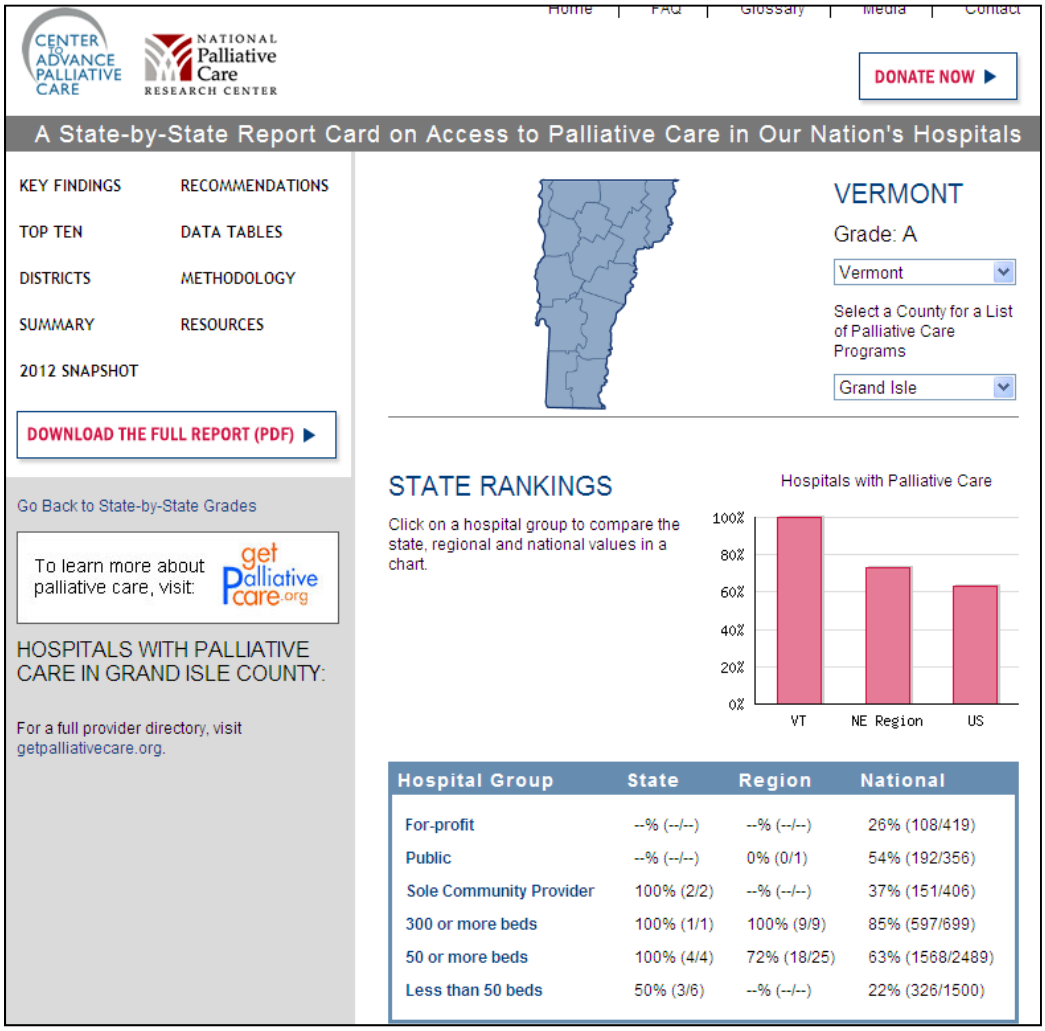
UNITED STATES		All Ages	0 - 14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 +
FEMALE	POPULATION	315,736	49,546	45,841	34,159	40,386	51,746	43,643	25,123	25,492
MALE	POPULATION	306,024	52,055	47,902	34,926	39,113	50,267	42,465	23,144	16,152
BOTH	POPULATION	621,760	101,601	93,743	69,085	79,499	102,013	86,108	48,267	41,644

County	Cause	Rate	Significance
Franklin	Heart	239.1	Not Significantly high or low; #1 VT Co
Grand Isle	Heart	208.4	Not Significantly high or low; #2 VT Co
Franklin	Cancer	190.9	Not Significantly high or low; #3 VT Co
Grand Isle	Cancer	234.2	Significantly high; #1 VT Co
Franklin	Stroke	25.5	Significantly low; last VT Co
Grand Isle	Stroke	55.1	Not Significantly high or low; #1 VT Co

County	Cause	Rate	Significance
Franklin	Chronic Lung	53.4	Significantly high#5 VT Co
Grand Isle	Chronic Lung	82.8	Significantly high: #1 VT Co
Franklin	Accidents	45.4	Not Significantly high or low
Grand Isle	Accidents	44.6	Not Significantly high or low
Franklin	Diabetes	30.2	Significantly high; #2 VT Co
Grand Isle	Diabetes	24.1	Not Significantly high or low
Franklin	Alzheimer's	17.7	Significantly low; 3rd to last VT Co
Grand Isle	Alzheimer's	6	Significantly low; Lowest VT Co
Franklin	Influenza	14.4	Significantly low; #5 VT Co
Grand Isle	Influenza	7	Significantly low; Second lowest VT Co
Franklin	Kidney	10.4	Significantly low; #2 VT Co
Grand Isle	Kidney	9.7	Significantly low; #4 VT Co
Franklin	Blood Poisoning	4.5	Significantly low; #6 VT Co
Grand Isle	Blood Poisoning	7.8	Significantly low; #2 VT Co
Franklin	Suicide	18.4	Significantly high; #1 VT Co
Grand Isle	Suicide	15.4	Significantly high; #5 VT Co
Franklin	Liver	7.4	Significantly low
Grand Isle	Liver	3.7	Significantly low; 2nd lowest VT Co
Franklin	Hypertension	6.6	Significantly low; #3 VT Co
Grand Isle	Hypertension	7.8	Not Significantly high or low; #1 VT Co
Franklin	Parkinson's	7.3	Not Significantly high or low
Grand Isle	Parkinson's	4.8	Not Significantly high or low; 3rd lowest Co
Franklin	Homicide	3.8	Not Significantly high or low; #2 VT Co
Grand Isle	Homicide	4.4	Not Significantly high or low; #1 VT Co

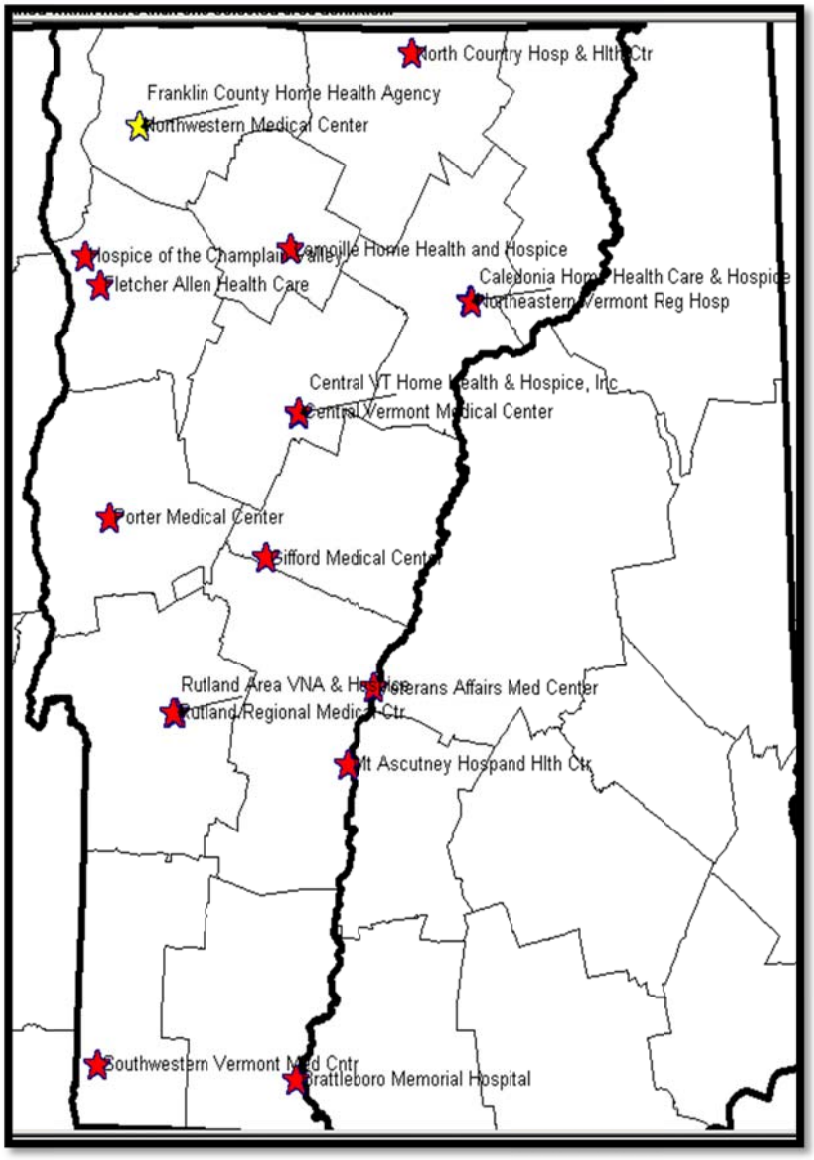
Appendix E – Franklin and Grand Isle Counties Selected Additional Health Status Factors

Palliative Care Programs (programs to relieve pain, symptoms and stress of serious illness) are available at Northwest Medical Center in Franklin County[32]



[32] www.getpalliativecare.org

Area Hospice Locations[33]



[33] http://iweb.nhpco.org/iweb/Membership/MemberDirectorySearch.aspx?pageid=3257&showTitle=1

Access to Care[34]

Access to Care: Franklin County, VT

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

Uninsured individuals (age under 65)[1]	**4,776**
Medicare beneficiaries[2]	
Elderly (Age 65+)	**4,910**
Disabled	**1,261**
Medicaid beneficiaries[2]	**14,194**
Primary care physicians per 100,000 pop[2]	**58.4**
Dentists per 100,000 pop[2]	**39.6**
Community/Migrant Health Centers[3]	**Yes**
Health Professional Shortage Area[3]	**No**

nda No data available.

[1] The Census Bureau. Small Area Health Insurance Estimates Program, 2006.
[2] HRSA. Area Resource File, 2008.
[3] HRSA. Geospatial Data Warehouse, 2009.

Access to Care: Grand Isle County, VT

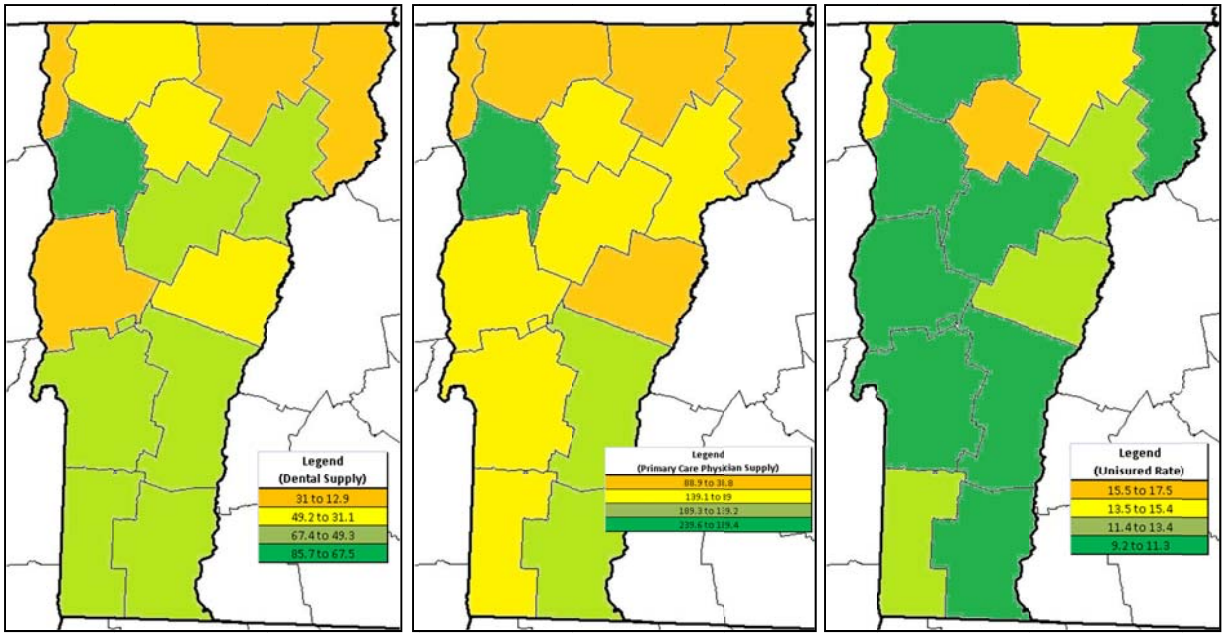
In addition to use of services, access to care may be characterized by medical care coverage and service availability

Uninsured individuals (age under 65)[1]	**1,075**
Medicare beneficiaries[2]	
Elderly (Age 65+)	**1,045**
Disabled	**190**
Medicaid beneficiaries[2]	**1,771**
Primary care physicians per 100,000 pop[2]	**38.8**
Dentists per 100,000 pop[2]	**12.9**
Community/Migrant Health Centers[3]	**Yes**
Health Professional Shortage Area[3]	**No**

nda No data available.

[1] The Census Bureau. Small Area Health Insurance Estimates Program, 2006.
[2] HRSA. Area Resource File, 2008.
[3] HRSA. Geospatial Data Warehouse, 2009.

[34]http://communityhealth.hhs.gov/AccessToCare.aspx?GeogCD=50011&PeerStrat=29&state=Vermont&county=Franklin



Unemployment[35]

USA	9.3%	8.2%
Vermont	5.7%	4.7%
Grand Isle	6.9%	6.0%
Franklin County	5.9%	4.6%

[35] Bls.gov

Franklin County Health Status[36]

Franklin County	ZIP Code	ZIP City Name	Score	Rank	+/- Below US Mean
	05468	Milton	74.2	2-Very Good	29.1%
	05454	Fairfax	68.4	2-Very Good	19.0%
	05483	Sheldon	62.3	3-Good	8.3%
	05455	Fairfield	62.2	3-Good	8.2%
	05444	Cambridge	61.9	3-Good	7.7%
	05488	Swanton	58.5	3-Good	1.8%
	05478	Saint Albans	56.2	3-Good	-2.3%
	05457	Franklin	55.5	3-Good	-3.4%
	05471	Montgomery	52.9	3-Good	-8.1%
	05450	Enosburg Falls	49.7	4-Fair	-13.5%
	05459	Highgate	49.0	4-Fair	-14.9%
	05476	Richford	31.4	5-Poor	-45.4%
		Total	57.1		-0.6%

US Health Status Score Mean = 57.5	
Excellent	77-100
Very Good	66-76
Good	51-65
Fair	38-50
Poor	0-37

Grand Isle County	ZIP Code	ZIP City Name	Score	Rank	+/- Below US Mean
	05486	South Hero	78.2	1-Excellent	36.1%
	05458	Grand Isle	71.1	2-Very Good	23.6%
	05474	North Hero	69.0	2-Very Good	20.0%
	05463	Isle la Motte	59.1	3-Good	2.8%
	05440	Alburgh	53.1	3-Good	-7.7%
			67.0		16.5%

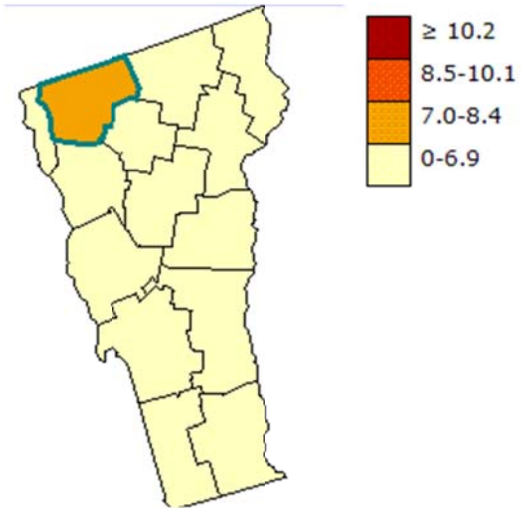
[36] Truven (formerly Thomson Reuters) – Market Expert

Business Patterns[37]

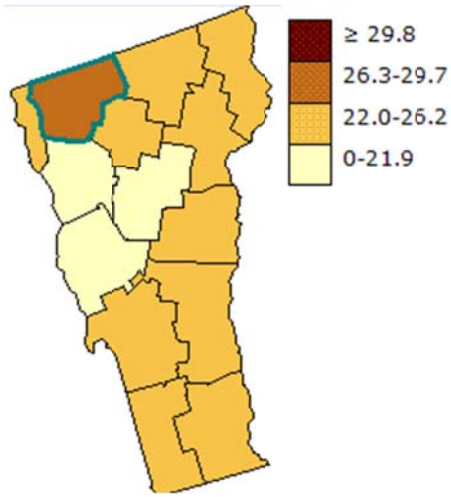
Pattern Indicators	Franklin	Grand Isle
Number of physician offices	35	1
Number of physician offices per 1,000 population	0.77	0.145
Number of dentist offices per 1,000 population	0.33	0.145
Number of dentist offices	15	1
Number of drug stores	7	1
Number of drug stores per 1,000 population	0.15	0.145

[37] Dataplace.org

2008 Age-Adjusted Estimates of the Percentage of Adults with Diagnosed Diabetes in Vermont[38]

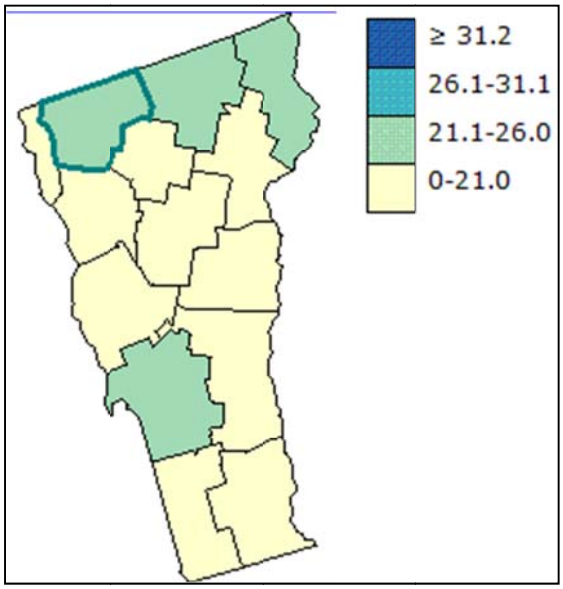


2008 Age-Adjusted Estimates of the Percentage of Adults Who Are Obese in Vermont[38]

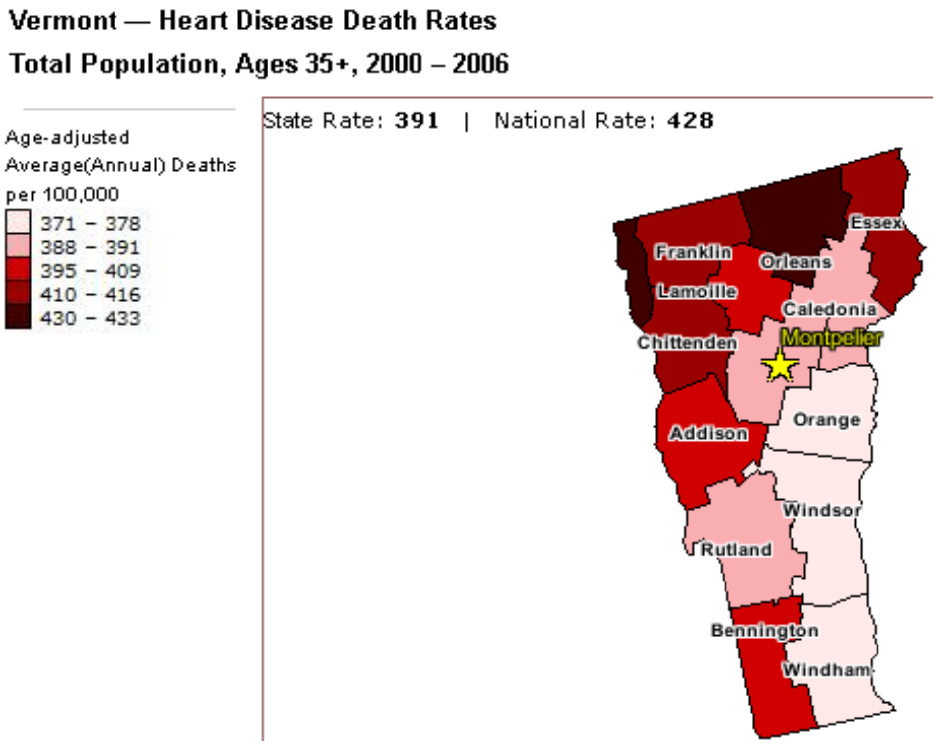


[38] http://apps.nccd.cdc.gov/giscvh2/Results.aspx

2008 Age-Adjusted Estimates of the Percentage of Adults Who Are Physically Inactive in Vermont[38]



Heart Diseases Rates[38]



Comorbidities - Franklin	
All Heart Disease	Normal Incidence
Coronary Heart Disease	Low Incidence
Acute Myocardial Infraction	Very Low Incidence
Cardiac Dysrhythmia	High Incidence
Heart Failure	Normal Incidence
Other Heart Diseases	Normal Incidence

Comorbidities - Grand Isle	
All Heart Disease	Very High Incidence
Coronary Heart Disease	Very High Incidence
Acute Myocardial Infraction	Very High Incidence
Cardiac Dysrhythmia	Very High Incidence
Heart Failure	Very High Incidence
Other Heart Diseases	Very High Incidence

Heart Disease and Stroke Rates by Race/Ethnicity[39]

Franklin, Vermont

Print | Close Window

Heart Disease Death Rates, Total Population, Ages 35+, 2000 – 2006

Race/Ethnicity	Rate*
Total Population	**414**
American Indian and Alaska Natives	Insufficient Data
Asian and Pacific Islanders	Insufficient Data
Blacks	Insufficient Data
Hispanics	Insufficient Data
Whites	418

* Rate per 100,000 age-adjusted and spatially smoothed

Grand Isle, Vermont

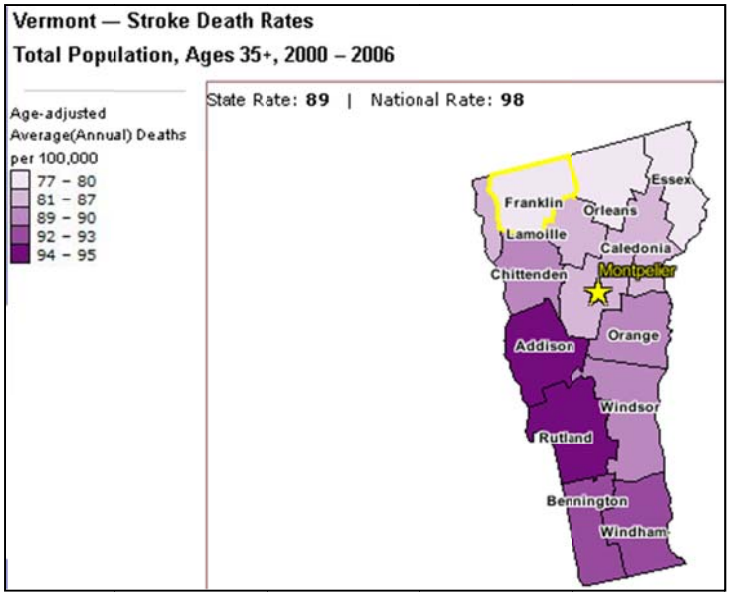
Print | Close Window

Heart Disease Death Rates, Total Population, Ages 35+, 2000 – 2006

Race/Ethnicity	Rate*
Total Population	**430**
American Indian and Alaska Natives	Insufficient Data
Asian and Pacific Islanders	Insufficient Data
Blacks	Insufficient Data
Hispanics	Insufficient Data
Whites	434

* Rate per 100,000 age-adjusted and spatially smoothed

[39] IRS Schedule H (form 990) Part V B 1 f



Comorbidities - Grand Isle	
Diabetes	High Incidence
Atrial Fibrillation	Very Low Incidence
Hypertension	High Incidence

Comorbidities - Grand Isle	
Diabetes	Very High Incidence
Atrial Fibrillation	Very Low Incidence
Hypertension	Very High Incidence

Franklin, Vermont

Print | Close Window

Stroke Death Rates, Total Population, Ages 35+, 2000 – 2006

Race/Ethnicity	Rate*
Total Population	**78**
American Indian and Alaska Natives	Insufficient Data
Asian and Pacific Islanders	Insufficient Data
Blacks	Insufficient Data
Hispanics	Insufficient Data
Whites	78

* Rate per 100,000 age-adjusted and spatially smoothed

Grand Isle, Vermont

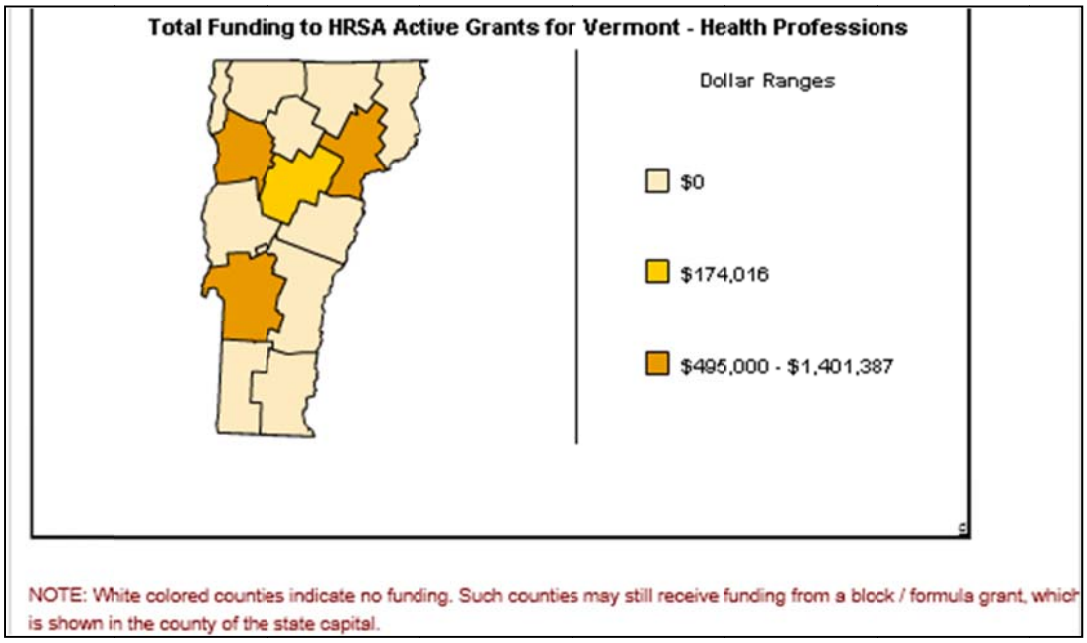
Print | Close Window

Stroke Death Rates, Total Population, Ages 35+, 2000 – 2006

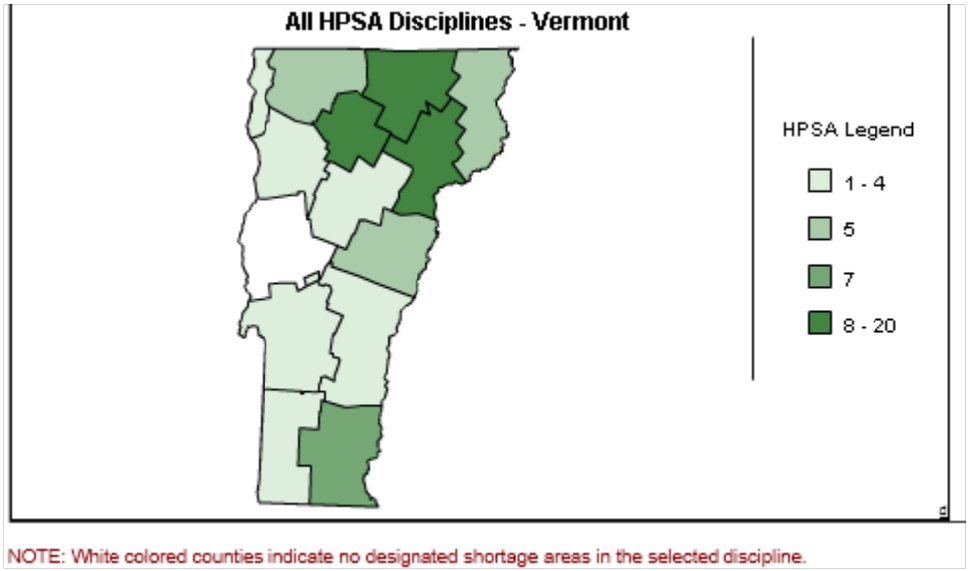
Race/Ethnicity	Rate*
Total Population	**81**
American Indian and Alaska Natives	Insufficient Data
Asian and Pacific Islanders	Insufficient Data
Blacks	Insufficient Data
Hispanics	Insufficient Data
Whites	81

* Rate per 100,000 age-adjusted and spatially smoothed

Health Profession Grants[40]



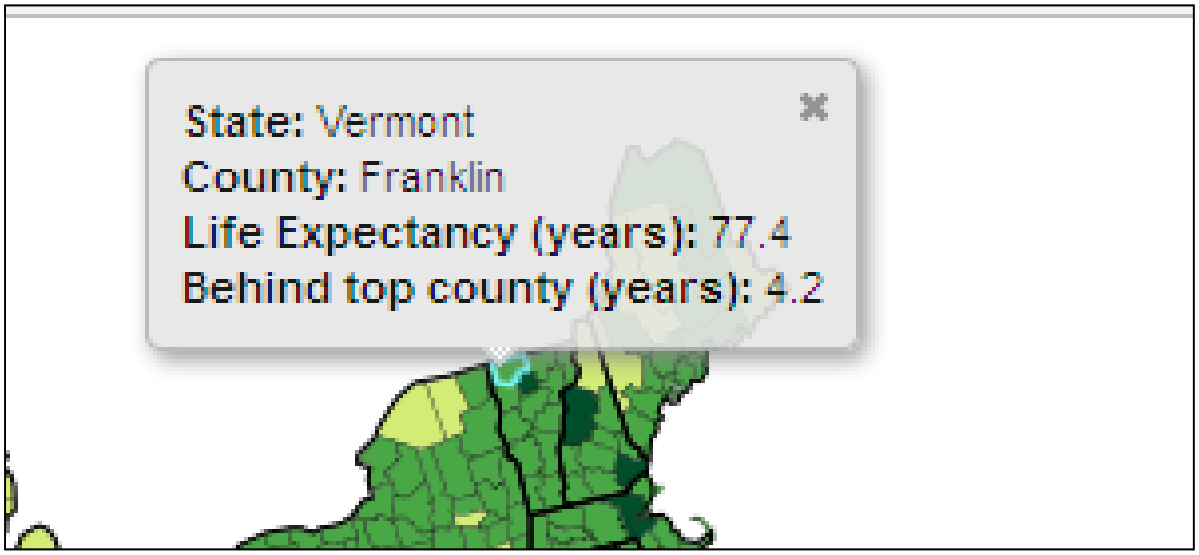
Health Profession Shortage

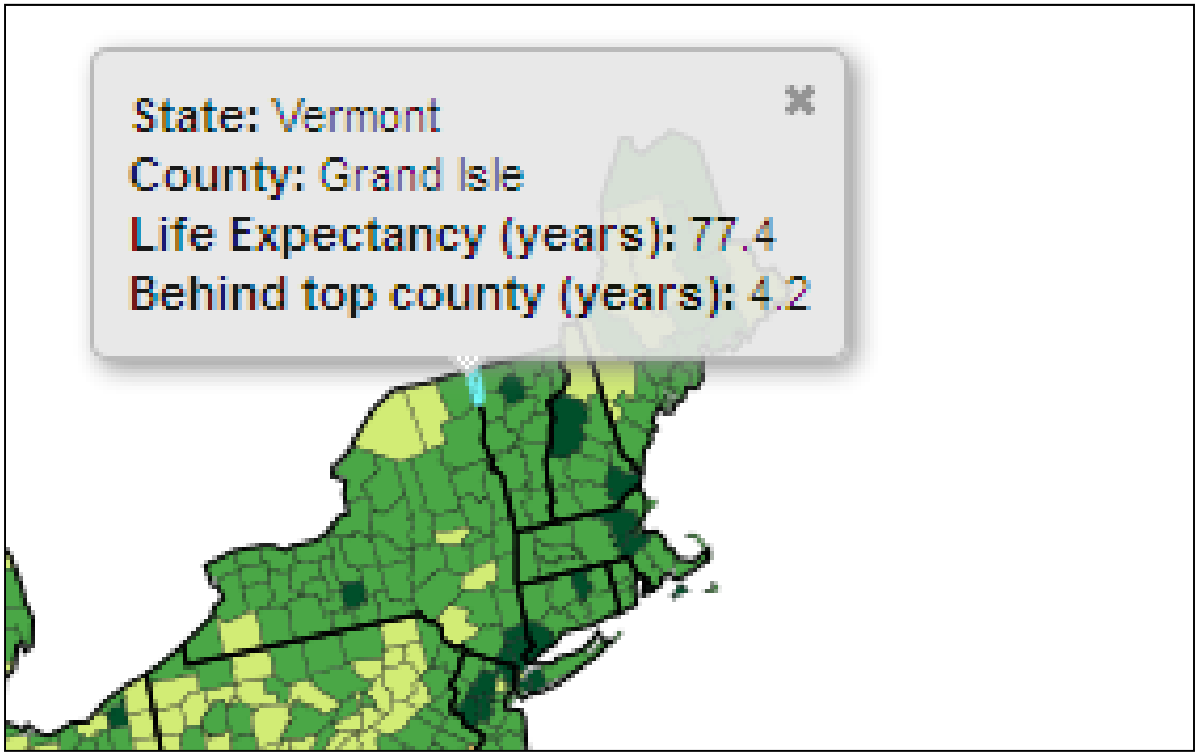


[40] http://datawarehouse.hrsa.gov

Life Expectancy[41]

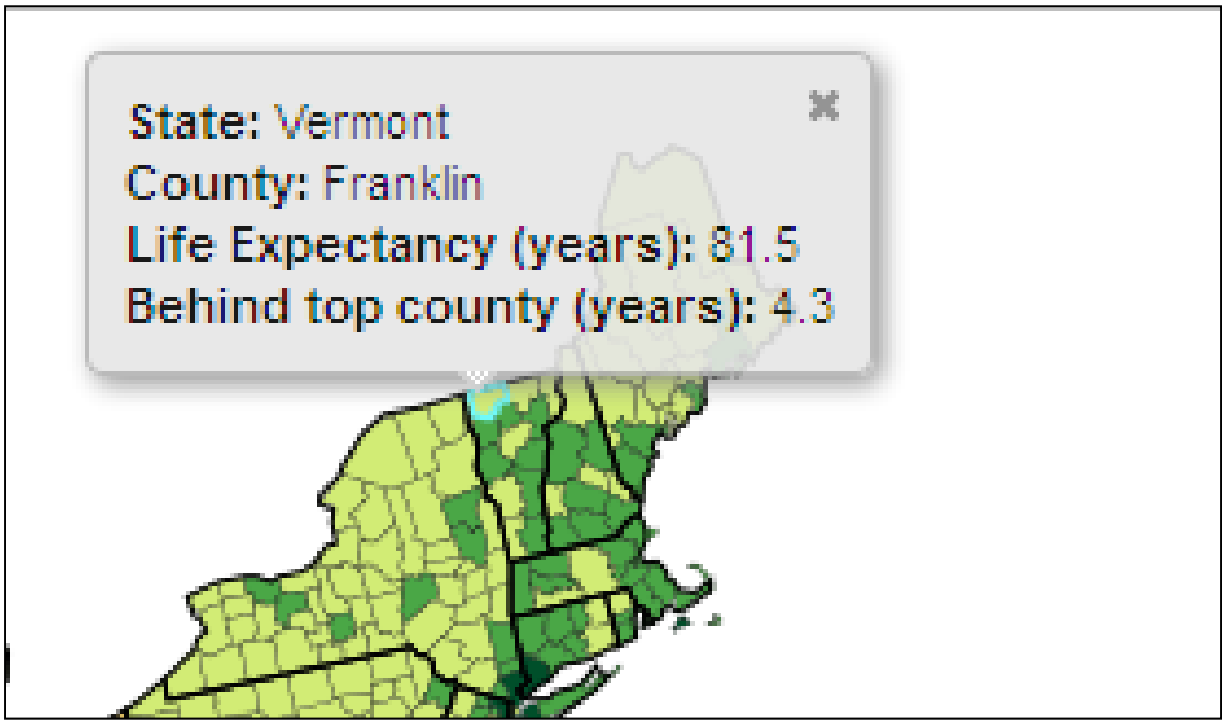
Male

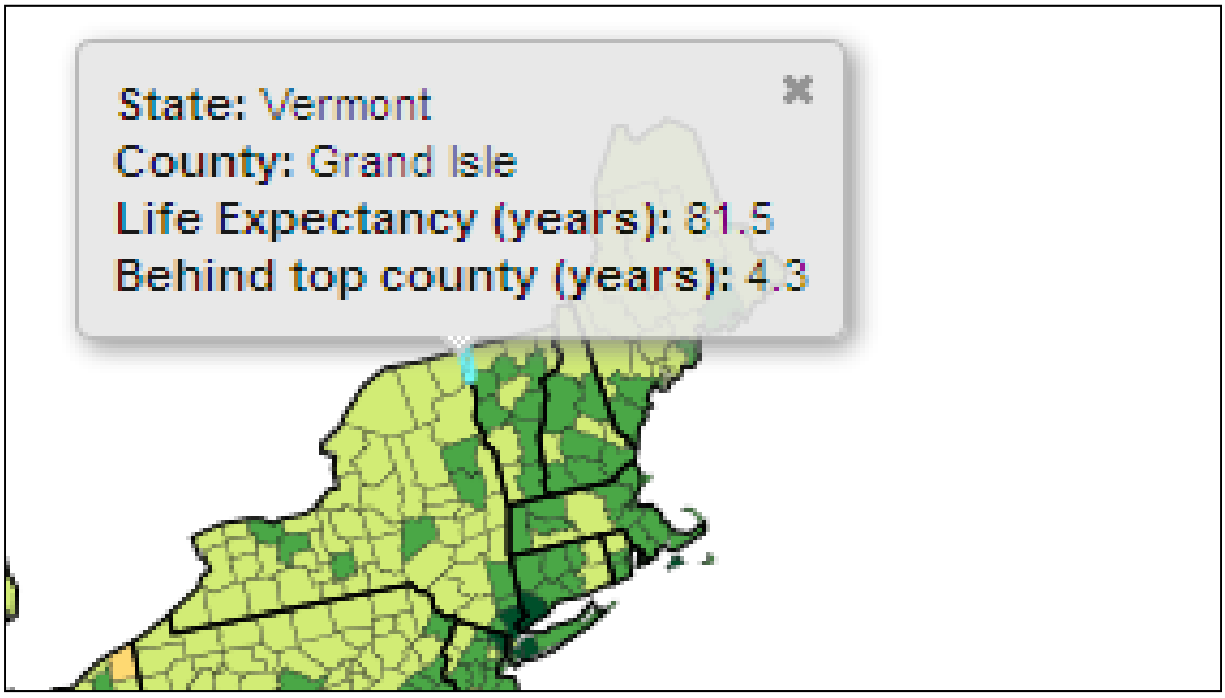




[41] http://www.healthmetricsandevaluation.org/tools/data-visualization/life-expectancy-county-and-sex-us-country-comparison-global-1989-1999-2009#/overview/explore

Female


State: Vermont
County: Franklin
Life Expectancy (years): 81.5
Behind top county (years): 4.3


State: Vermont
County: Grand Isle
Life Expectancy (years): 81.5
Behind top county (years): 4.3

Find Shortage Areas: HPSA by State & County

- Shortage Designation Home
- **Find Shortage Areas**
- HPSA & MUA/P by Address
- HPSA Eligible for the Medicare Physician Bonus Payment
- MUA/P by State & County

Criteria:

State: Vermont
County: Franklin County
ID: All
Date of Last Update: All Dates
HPSA Score (lower limit): 0
Discipline: Primary Medical Care
Metro: All
Status: Designated
Type: All

Results: 1 records found.
(Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee. They are not listed separately.)

HPSA Name	ID	Type	FTE	# Short	Score
011 - Franklin County					
Richford Health Center, Inc.	1509995020	Comprehensive Health Center	1	0	4

Data as of: 9/27/2012

NEW SEARCH | MODIFY SEARCH CRITERIA

Find Shortage Areas: HPSA by State & County

- Shortage Designation Home
- **Find Shortage Areas**
- HPSA & MUA/P by Address
- HPSA Eligible for the Medicare Physician Bonus Payment
- MUA/P by State & County

Criteria:

State: Vermont
County: Grand Isle County
ID: All
Date of Last Update: All Dates
HPSA Score (lower limit): 0
Discipline: Primary Medical Care
Metro: All
Status: Designated
Type: All

Results: 0 records found.
(Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee. They are not listed separately.)

HPSA Name	ID	Type	FTE	# Short	Score
013 - Grand Isle County	No HPSAs in this county.				

Data as of: 9/27/2012

NEW SEARCH | MODIFY SEARCH CRITERIA

Find Shortage Areas: MUA/P by State and County

- Shortage Designation Home
- **Find Shortage Areas**
- HPSA & MUA/P by Address
- HPSA by State & County
- HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:

State: Vermont
County: Franklin County
ID #: All

Results: 8 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Franklin County					
Franklin/Grand Isle Service Area	07084	MUA	61.20	1994/08/05	
MCD (23875) Enosburg town					
MCD (27100) Franklin town					
MCD (33025) Highgate town					
MCD (45850) Montgomery town					
MCD (59125) Richford town					
MCD (64600) Sheldon town					
MCD (71725) Swanton town					

NEW SEARCH | MODIFY SEARCH CRITERIA

Observations from Other Statistical Data Examinations

Additional observations of Grand Isle and Franklin Counties found:

1. Leading causes of deaths in Vermont are

   #1 Cancer (Grand Isle has highest VT rate and it is significantly above national average);

   #2 Heart Disease (Franklin has highest VT rate but is in line with national average);

   #3 Chronic Lung Disease (Grand Isle has highest VT rate and it is significantly above national average);

   #4 Accidents (both Counties are at about VT average); and

   #5 Stroke (Grand Isle has highest VT rate while Franklin has the lowest VT rate, which is significantly lower than national average).

2. Other Significant Death Rate Observations (listed in sequence of declining rate of deaths):

   - Alzheimer – Grand Isle has lowest VT rate, Franklin third to last ranked VT County;
   - Diabetes – Franklin top VT county, Grand Isle about at VT average;
   - Suicide – Franklin top VT county, Grand Isle ranked 5th;
   - Flu & Pneumonia deaths – Grand Isle second to last, Franklin ranked #5 in VT;
   - Hypertension deaths – Grand Isle top VT County; and
   - Homicide – Grand Isle ranked #1 death rate and Franklin #2.

3. Male and Female life expectancy values for the two counties are the same with Female expectancy being 81.5 years and Male expectancy being 77.4 year, each about 4 years behind the top tier counties in the nation.

4. PALLIATIVE CARE programs exist in Franklin County.

5. Parts of Franklin are DESIGNATED MEDICALLY UNDERSERVED but no designation exists for Grand Isle County.

6. HEART DISEASE DEATHS (based on data older than used in #1 above) rates for both Counties are in the second lowest national quartile.

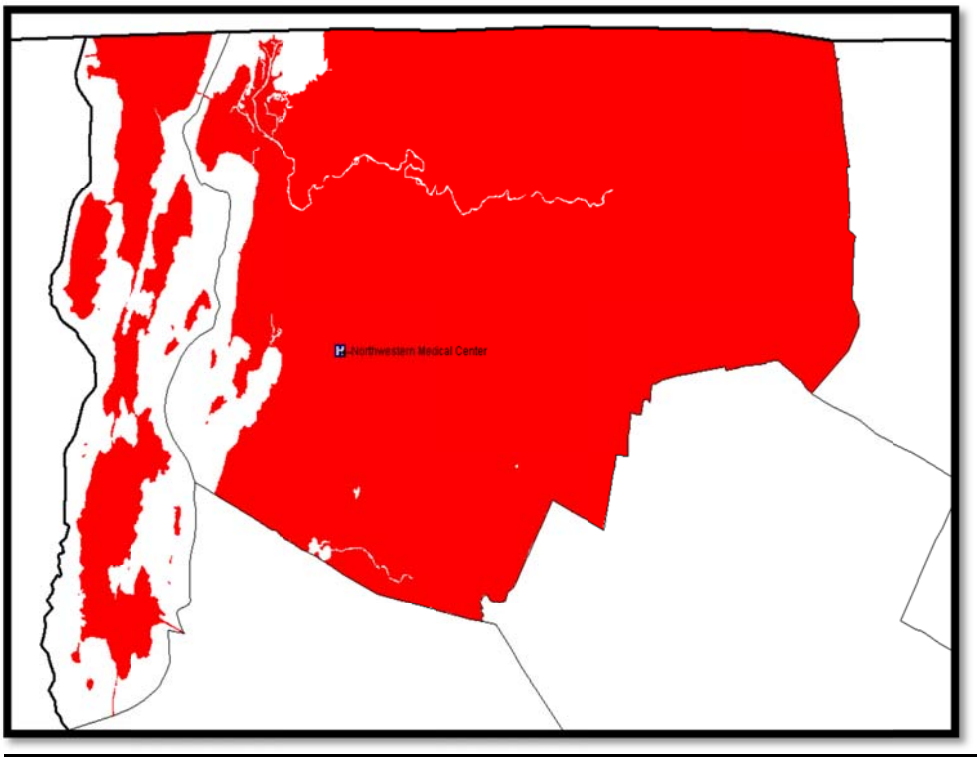
7. STROKE DEATHS (based on older data than used in #1 above) in Franklin County are in the lowest national quartile while Grand Isle is in the second to lowest national quartile.

8. HYPERTENSION (based on older data than used in #2 above) has a high incidence; both counties are in the highest national quartile

9. DIABETES (based on older data than used in #2 above) prevalence is among the lower values in the nation.

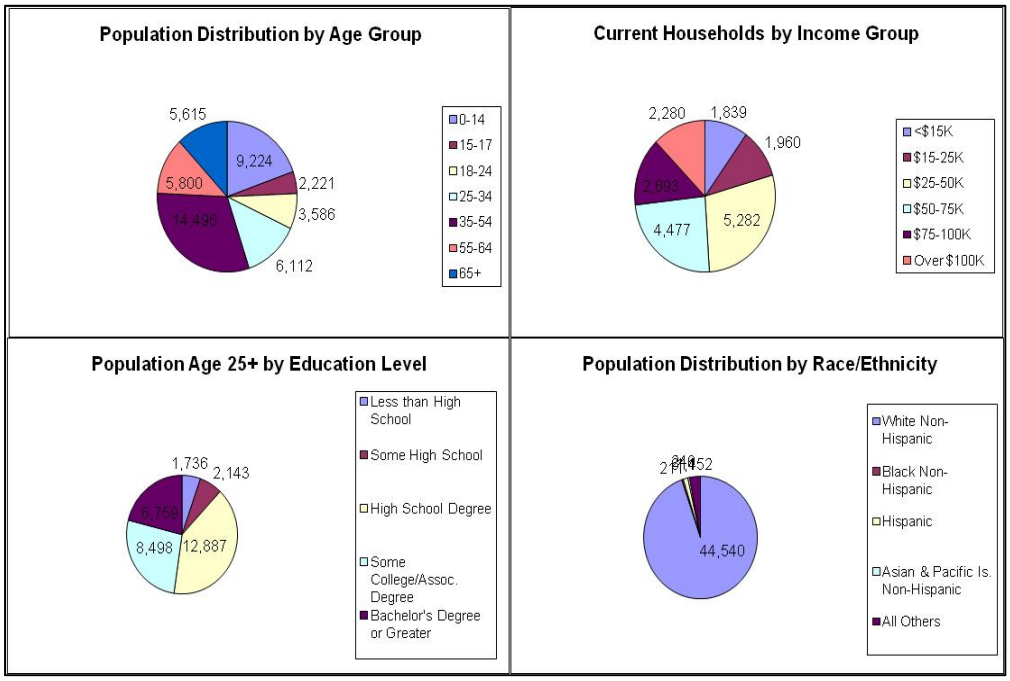
Appendix F – Franklin and Grand Isle County Service Area Population Characteristics[42]

Definition of Area Served by the Hospital Facility[43]

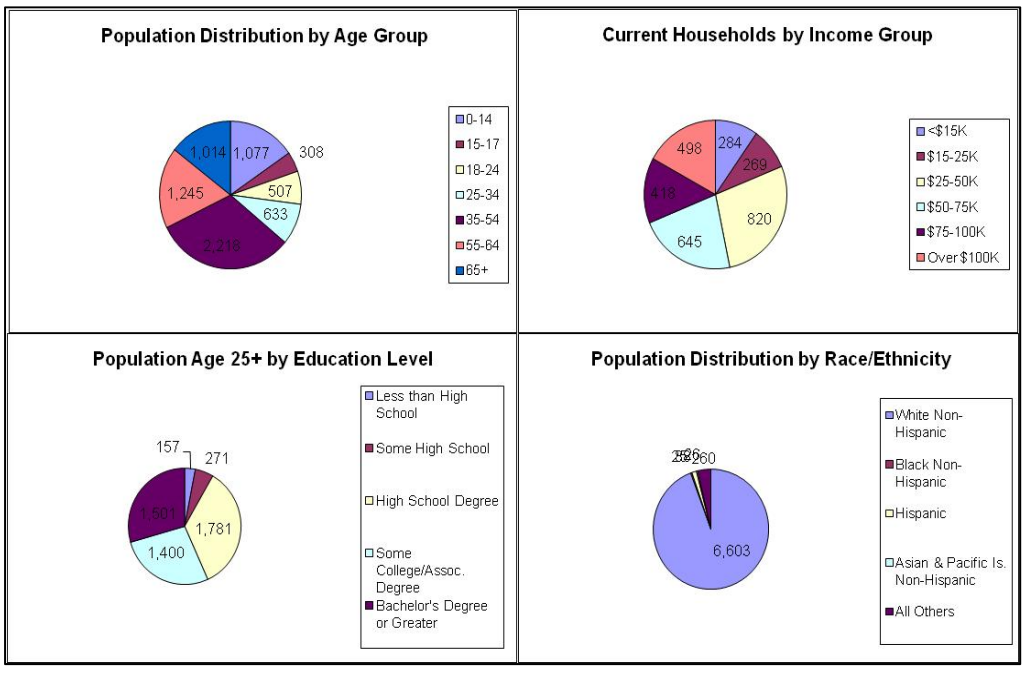


[42] All population values obtained from Truven (formerly Thomson) Market Planner
[43] Responds to IRS Form 990 (h) Part V B 1 a

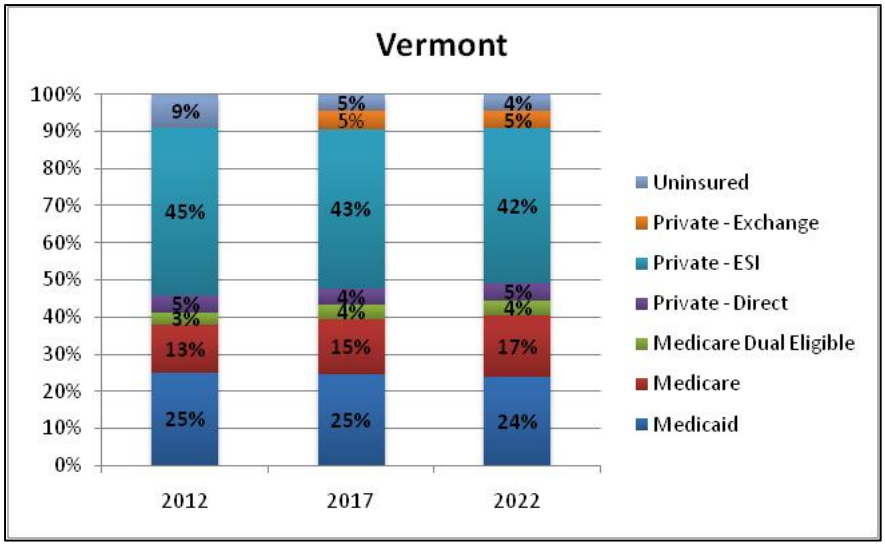
Franklin County Graphs[44]

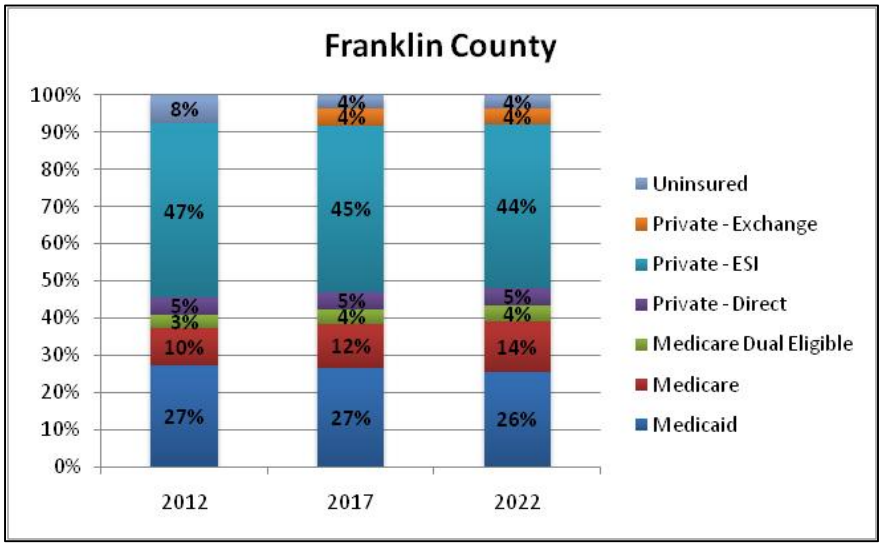


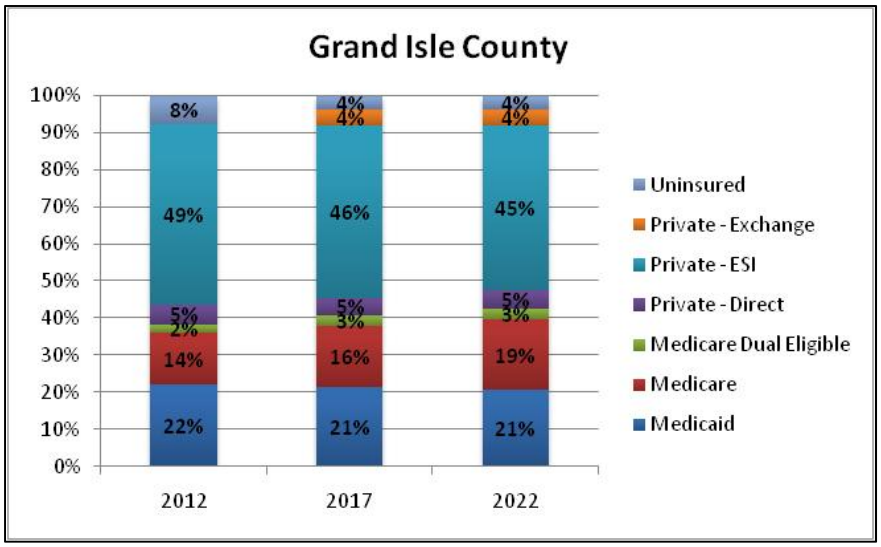
Grand Isle Graphs[42]



[44] Truven Market Expert


Vermont
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
9%
45%
5%
3%
13%
25%
5%
5%
43%
4%
4%
15%
25%
4%
5%
4%
5%
42%
5%
4%
17%
24%
2012
2017
2022
Uninsured
Private - Exchange
Private - ESI
Private - Direct
Medicare Dual Eligible
Medicare
Medicaid


Franklin County
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
8%
47%
5%
3%
10%
27%
4%
4%
45%
5%
4%
12%
27%
4%
4%
4%
44%
5%
4%
14%
26%
2012
2017
2022
Uninsured
Private - Exchange
Private - ESI
Private - Direct
Medicare Dual Eligible
Medicare
Medicaid


Grand Isle County
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
8%
49%
5%
2%
14%
22%
4%
4%
46%
5%
3%
16%
21%
4%
4%
45%
5%
3%
19%
21%
2012
2017
2022
Uninsured
Private - Exchange
Private - ESI
Private - Direct
Medicare Dual Eligible
Medicare
Medicaid

Service Area Population Health Status Analysis According to the Aggregate Composition of Demographic Characteristic Segments[45]

Franklin and Grand Isle Counties

Health Service Topic	Demand as % of National	% of Population Effected
Weight / Lifestyle		
BMI: Morbid/Obese	105.5%	27.3%
Vigorous Excersize	102.4%	52.1%
Chronic Diabetes	95.8%	9.9%
Healthcare Cost Changes: Lifestyle	103.6%	20.0%
Healthy Eating Habits	90.0%	24.6%
Very Unhealthy Eating Habits	103.6%	3.4%
Emergency Service		
Emergency Room Use	102.8%	34.2%
Urgent Care Use	99.5%	23.1%
Pulmonary		
Chronic Asthma	88.5%	8.5%
Tobacco Use: Cigarettes	102.6%	26.7%
Chronic Allergies	100.6%	24.7%
Cancer		
Mammography in Past Yr	99.3%	80.7%
Cancer Screen: Colorectal 2 yr	98.0%	25.9%
Cancer Screen: Pap/Cerv Tst 2 yr	101.3%	68.2%
Routine Screen: Prostate 2 yr	93.9%	30.6%
Cancer Screen: Skin Test 2 yr	91.3%	11.6%
Orthopedic		
Chronic Lower Back Pain	99.7%	25.3%
Chronic Osteoporosis	93.7%	9.3%
Sports Injury	93.1%	11.9%

Health Service Topic	Demand as % of National	% of Population Effected
Heart		
Routine Screen: Cardiac Stress 2yr	91.3%	17.3%
Chronic High Cholesterol	92.1%	20.3%
Chronic High Blood Pressure	97.4%	25.4%
Chronic Heart Disease	95.3%	7.5%
Obstetrical / Pediatric		
Birth	101.9%	4.5%
Pediatric Asthma	92.7%	6.4%
Pediatric Care	112.6%	32.8%
OB/Gyn 1+ Visit	99.7%	42.9%
Routine Services		
FP/GP: 1+ Visit	109.2%	73.2%
Annual Physical	97.8%	65.1%
Other		
Ambulatory Surgery last 12 Months	106.9%	20.6%
Chronic Migraine	103.9%	11.7%
Miscellaneous		
Healthcare Cost Changes: Insurance	105.2%	18.0%
Health Info Svcs: 3+ Use	99.8%	40.4%
Charitable Contrib: Hosp/Hosp Sys	102.5%	24.4%
Charitable Contrib: Other Health Org	103.5%	40.3%
Healthcare Cost Changes: Utilization	105.3%	19.6%
HSA/FSA: Employer Offers	104.4%	32.7%
Emerging Topic		
Seek Info to Judge Quality of Provider/Fac	90.1%	39.6%

Significantly Different from Average Health Service Topic	Demand as % of National	% of Population Effected
FP/GP: 1+ Visit	109.2%	73.2%
Pediatric Care	112.6%	32.8%
Routine Screen: Prostate 2 yr	93.9%	30.6%
BMI: Morbid/Obese	105.5%	27.3%
Healthy Eating Habits	90.0%	24.6%
Chronic High Cholesterol	92.1%	20.3%
Healthcare Cost Changes: Utilization	105.3%	19.6%
Healthcare Cost Changes: Insurance	105.2%	18.0%
Routine Screen: Cardiac Stress 2yr	91.3%	17.3%
Sports Injury	93.1%	11.9%
Cancer Screen: Skin Test 2 yr	91.3%	11.6%
Chronic Osteoporosis	93.7%	9.3%
Chronic Asthma	88.5%	8.5%

[45] Truven (Thomson Reuters) – Market Expert

Vulnerable Populations[46]

Vulnerable Populations: Franklin County, VT

Vulnerable populations may face unique health risks and barriers to care, requiring enhanced services and targeted strategies for outreach and case management.

Vulnerable Populations Include People Who[1]	
Have no high school diploma (among adults age 25 and older)	5,697
Are unemployed	1,307
Are severely work disabled	1,029
Have major depression	3,100
Are recent drug users (within past month)	4,445

nda No data available.

[1] The most current estimates of prevalence, obtained from various sources (see the Data Sources, Definitions, and Notes for details), were applied to 2008 mid-year county population figures.

Vulnerable Populations: Grand Isle County, VT

Vulnerable populations may face unique health risks and barriers to care, requiring enhanced services and targeted strategies for outreach and case management.

Vulnerable Populations Include People Who[1]	
Have no high school diploma (among adults age 25 and older)	882
Are unemployed	263
Are severely work disabled	167
Have major depression	529
Are recent drug users (within past month)	738

nda No data available.

[1] The most current estimates of prevalence, obtained from various sources (see the Data Sources, Definitions, and Notes for details), were applied to 2008 mid-year county population figures.

[46] Reference 990 Part V B 1 f
http://communityhealth.hhs.gov/VulnerablePopulations.aspx?GeogCD=50011&PeerStrat=29&state=Vermont&county=Franklin
http://communityhealth.hhs.gov/VulnerablePopulations.aspx?GeogCD=50013&PeerStrat=37&state=Vermont&county=Grand%20Isle

Observations from the Demographic Analysis

The following areas were identified from a comparison of the service area to national averages:

Adverse uses and rates compared to national norms brought forward the following issues impacting 8% to 24% of the population

1. Chronic Asthma, 12% below average, impacts 8.5% of population;
2. Chronic Osteoporosis, 6% below average, impacts 9.3% of population;
3. Not receiving a Cancer Screen Test in the last 2 years, 9% below average, impacts 11.6% of population;
4. Sport Injury, 6% below average, impacts 12% of population;
5. Not obtaining a Routine Cardiac Stress Test, 9% below average, impacts 17% of population;
6. Health Care Cost problem, 5% above average, impacts 18% to 19% of population;
7. Chronic High Cholesterol, 8% below average, impacts 20% of population; and
8. (Lack of) Healthy Eating Habits, 10% below average, impacts 24% of population.

25% or more of the population:

1. Morbid Obese, 5% above average, impacts 27% of population;
2. (Not obtaining) Prostate Screening Test in last 2 years, 6% below average, impacts 30% of population;
3. Pediatrician usage, 12% higher than national average, impacts 33% of population; and
4. Visit to Primary Care Physician, 9% above average, impacts 73% of population.

Appendix G – Local Expert Priority Setting Process[47]

IRS Notice 2011 – 52 stipulates the following:

- A description of how the hospital organization took into account input from persons who represent the broad interest of the community served by the hospital facility;
- The report must identify (and include in the process) any individual providing input who has special knowledge of or expertise in public health by name, title and affiliation;
- The report must identify (and include in the process) any individual providing input who is a "leader" or "representative" of populations, Federal, tribal, regional, State, or local health or other departments or agencies, with … information relevant to the health needs of the community;
- The report must identify (and include in the process) any Leaders, representatives or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served;
- The report may also consult or seek input from healthcare consumer advocates; nonprofit organizations; academic experts; local government officials; community-based organizations, including organizations focused on one or more health issues; health care providers, including community health centers and other providers focusing on medically underserved populations, low-income persons, minority groups, or those with chronic disease needs; private businesses; and health insurance and managed care organizations; and
- A prioritized description of all of the community health needs as well as a description of the process and criteria used in prioritizing such health needs.

This report meets this set of requirements by selecting individuals willing to provide us an evaluation and recommendation among the needs identified by the data being analyzed.

The following individuals agreed to participate in the Community Health Need Assessment as Local Experts:

Name	Position Employer	E-Mail Address
Elizabeth Gamache	Mayor City of St Albans	Elizabeth.gamache@gmail.com
Sonya Rochon	Advocate Voices Against Violence	srochon@cvoeo.org

[47] IRS Schedule H (form 990) Part V B 1 g and h

Name	Position Employer	E-Mail Address
Leonard Stell	Chief Of Police Swanton Police	Leonard.stell@state.vt.us
Kelly Woodward	Victim Advocate Northwest Unit for Special Investigations	kelly.woodward@state.vt.us
Deb Grennon	Director Franklin Grand Isle Bookmobile	fgibookmobile@yahoo.com
Diana I. Langle	Director All About Kids Supervised Visitation Center	dlangle@cvoeo.org
Beth Crane	Executive Director Franklin County Caring Communities	beth@fcccp.org
Robin S. Way	Executive Director C.I.D.E.R.	cidervt@sover.net
Ruth Wallman	Executive Director Lake Champlain Islands Chamber	ruth@champlainislands.com
Odessa Kilby	Case management supervisor CVAA	odessa@cvaa.org
Linda Ryan	Executive Director Samaritan House, Inc.	lindaryan3@comcast.net
Dorey Myers	Public Health Nurse Vermont Department of Health	dorey.myers@state.vt.us
Sue Chase	Executive Director CarePartners Adult Day Center	sue@carepartnersvt.org
Pamela Polhemus	Site Manager Planned Parenthood of NNE	pamp@ppnne.org
Tim Smith	Executive Director FCIDC	tim@fcidc.com

Name	Position Employer	E-Mail Address
Sally Bortz	Executive Director Franklin-Grand Isle United Way	sally@fgiunitedway.org
Judy A. Ashley	District Director Vermont Dept of Health	judy.ashley@state.vt.us
Kristin Prior	Field Services Director State of Vermont Agency of Human Services	kristin.prior@state.vt.us
Janet McCarthy	CEO Franklin County Home Health Agency	Jmccarthy@fchha.org
Kris Lukens-Rose	Director Voices Against Violence	klukensr@cvoeo.org
Helen Riehle	Executive Director Champlain Valley AHEC	hriehle@cvahec.org
Amy Brewer	Health Educator Northwestern Medical Center	abrewer@nmcinc.org

The opinions of the Local Experts were as follows:

Question #1 – Grand Isle and Franklin Counties Compared to all Vermont Counties

In general, Grand Isle County health status compares favorably among Vermont Counties. It generally has values at the Vermont average and ranks 4th in HEALTHY OUTCOMES (with 1st being the best) among the 14 ranked counties.

Franklin County health status generally compares unfavorably among Vermont Counties. It generally has values above the Vermont average and ranks 12th (out of 14) in HEALTHY OUTCOMES.

Among the various HEALTH FACTORS analyzed, the relative positions of both counties show the same pattern; Grand Isle ranks 5th and Franklin ranks 12th.

> PHYSICAL ENVIRONMENTAL FACTORS generally are positive influences on overall county rankings for both counties. The percentage of fast food restaurants and limited access of low income to healthy food are a common concern. Environmental pollution factors are a low concern to both counties.

CLINICAL FACTORS are not a serious depressing factor in scoring the rankings. UNINSURED RATES, PREVENTABLE HOSPITAL STAYS, DIABETIC SCREENING RATES and MAMMOGRAPHY show little difference between the counties. Improvement is possible but would have little impact on improving the ranking. PRIMARY CARE PHYSICIAN access is a problem for both counties and improvement would impact rankings.

HEALTHY BEHAVIORS generally shows the same patterns with Grand Isle at about the Vermont average and Franklin showing excess values. The most important factor, SMOKING, needs to improve in Franklin County; smoking rates are 50% higher than desired goal. The next most important consideration, OBESITY, is a problem for both counties and notably, Franklin leads Vermont values. DRINKING is at the state average for both counties. SEXUAL DISEASE is below the state average for both counties. TEEN BIRTHS (2002 to 2008 data) is not a Grand Isle concern but Franklin has some of the worst values in the State.

SOCIAL AND ECONOMIC FACTORS are generally positive health status factors for both counties. The one notable exception is the high incident of VIOLENT CRIME for Franklin County, where again it sets the upper value for Vermont.

Local Expert Comments and Opinions regarding Question 1

Agree with the above observations = 86.4% (18 experts)

Disagree with some or all of the observations = 13.6% (3 experts)

Comments

- Clarify sexual disease. Is this total of all STI's together? If you break it down by disease type, we have the some of the highest rates of Chlamydia and gonorrhea;
- High rate of domestic and sexual violence in Franklin and Grand Isle counties. Lack of DV/SV informed doctors and nurses;
- The higher incidence of violent crimes is directly related to drug abuse and addiction, particularly opiates. I am working on a protocol for the shelter regarding Suboxone;
- The overall rate of teen pregnancy is high but is driven by the 18-19 year olds. Changes in Grand Isle percentages for many indicators may seem extreme because of the small population size. Dates for Violent Crime data are not given and it would be interesting to note if they have changed in the last two years. There are too many topics in this question to select I agree or I disagree. I may agree with some and disagree with others; and
- While I'm not familiar with the statistics, they seem reasonable based on personal observations.

Question #2 – Grand Isle and Franklin Counties Compared to Peer Counties

The federal government administers a process to allocate all counties into "Peer" groups, groups having similar social, economic and demographic characteristics. Health and wellness observations when Grand Isle and Franklin Counties are compared to their respective national set of Peer Counties and compared to national rates makes some similar and some vastly different observations (Grand Isle and Franklin are not Peer counties and apparently too small a Hispanic population exists to calculate group rates):

UNFAVORABLE OBSERVATIONS when compared to their peers and national averages:

- INFANT MORTALITY;
- WHITE NON-HISPANIC INFANT MORTALITY;
- NEONATAL INFANT MORTALITY;
- CORONARY HEART DISEASE;
- LUNG CANCER;
- SUICIDE;
- BREAST CANCER, Franklin only – no Grand Isle data;
- COLON CANCER, Franklin only – no Grand Isle data;
- LOW BIRTH WEIGHT (<2500g), Grand Isle ONLY, indicator is FAVORABLE for Franklin County;
- VERY LOW BIRTH WEIGHT, Grand Isle ONLY, Franklin County is UNFAVORABLE among Peers but below national average;
- BIRTHS TO WOMEN 40-54, Grand Isle ONLY, Franklin County is UNFAVORABLE among Peers but below national average;
- POST NEONATAL INFANT MORTALITY, Grand Isle ONLY, Franklin County values are FAVORABLE to peers but below US Median values; and
- MOTOR VEHICLE INJURY, Grand Isle ONLY, Franklin County values are FAVORABLE to peers and to National average.

SOMEWHAT A CONCERN observations as rates are unfavorable compared to peer counties but better than national average:

- BIRTHS TO UNMARRIED WOMEN;
- VERY LOW BIRTH WEIGHT (less than 1500 g), Franklin County only, noted above as concern for Grand Isle;
- BIRTHS TO WOMEN 40 to 54, Franklin County only, noted above as concern for Grand Isle;

- PREMATURE BIRTHS, Grand Isle ONLY, Franklin County not a concern; and
- BIRTHS TO WOMEN UNDER 18 (2005 data only,) Grand Isle ONLY, Franklin County not a concern.

SOMEWHAT A CONCERN observations as rates are unfavorable compared to national rates:

- POST NEONATAL INFANT MORTALITY, Franklin County ONLY, Grand Isle presents as a concern as noted above; and
- STROKE, Grand Isle ONLY, Franklin County presents as NOT A CONCERN.

Potential conditions, which are not a health need, because performance is BETTER than Peers. National rates in both counties only include UNINTENTIONAL INJURY. Other BETTER Franklin Co metrics include:

- LOW BIRTH WEIGHT (<2500 grams);
- PREMATURE BIRTHS (<37 weeks);
- BIRTHS TO WOMEN UNDER 18 (2005 data only);
- MOTOR VEHICLE INJURY; and
- STROKE.

Agree with the above observations = 78.3% (18 experts)

Disagree with some or all of the observations = 21.7% (5 experts)

Comments:

- Again, I agree because it seems reasonable, but I have no personal knowledge of the validity of these observations;
- Domestic and sexual violence rates in Franklin and Grand Isle Counties;
- I do not have enough knowledge or insight into specific areas to agree or disagree;
- I do not have the information needed to respond;
- I don't feel as well informed as I probably ought to be on this, but don't have reason to contradict the cited findings;
- I would note that it is likely that the true Hispanic population in Franklin County is unknown given the number of undocumented farm help;
- Instead of "births to unmarried women," it should say, "births to single women." And again, violence against women and children is not a category noted here;
- Not sure about "A. BIRTHS TO UNMARRIED WOMEN" since this may include surrogates, two-parent yet unmarried homes, lesbian, gay, etc.;

- Not sure about the concern regarding unmarried women giving birth. does this recognize two-parent families making the choice not to get married, surrogates and gay couples?
- The numbers from 2005 may not reflect current concerns; and
- Ugh. I hate this survey. Again, depending on the topic and the total number of cases vs. condition – the answer will be different.

Question #3 – Primary Service Area Population Characteristics

The following areas were identified from a comparison of the service area to national averages:

Adverse uses and rates compared to national norms brought forward the following issues impacting 8% to 24% of the population

1. Chronic Asthma, 12% below average, impacts 8.5% of population;

2. Chronic Osteoporosis, 6% below average, impacts 9.3% of population;

3. Not receiving a Cancer Screen Test in the last 2 years, 9% below average, impacts 11.6% of population;

4. Sport Injury, 6% below average, impacts 12% of population;

5. Not obtaining a Routine Cardiac Stress Test, 9% below average, impacts 17% of population;

6. Health Care Cost problem, 5% above average, impacts 18% to 19% of population;

7. Chronic High Cholesterol, 8% below average, impacts 20% of population; and

8. (Lack of) Healthy Eating Habits, 10% below average, impacts 24% of population.

25% or more of the population:

A. Morbid Obese, 5% above average, impacts 27% of population;

B. (Not obtaining) Prostate Screening Test in last 2 years, 6% below average, impacts 30% of population;

C. Pediatrician usage, 12% higher than national average, impacts 33% of population; and

D. Visit to Primary Care Physician, 9% above average, impacts 73% of population.

Agree with the above observations = 91.3% (20 experts)

Disagree with some or all of the observations = 8.7% (2 experts)

Comments:

- Again, not sure about some of the data but nothing to refute it; but this set of data raises the question (assuming I'm reading this correctly): are these higher-than-average visits to pediatricians and Primary Care Physicians netting much result with regard to healthy behaviors and chronic disease prevention?

- How does domestic and sexual violence affect people's physical and mental health?
- Question--is above average pediatrician use or primary care use a negative thing?
- Seems reasonable.

Question #4 – Area Resident Summary Opinions

Respondents overwhelmingly have access to physician, dental and eye professionals and perceive themselves to be in good health. Most survey respondents do not have a mental health advisor. While the local economy is worse than it was a year ago, they have not personally experienced financial problems in accessing medical services. Approximately ¾ of respondents were employed, middle aged, college educated, married and females with a household income over $50,000 and held health insurance.

Over 60% of responses indicated three issues as major problems

A. People making unhealthy food choices – obesity;

B. Not having health insurance; and

C. Mental health related problems – typically access.

Over 70% of responses indicated adult substance abuse problems, prescription drug abuse and drug use among youth as major problems.

About 2/3 of responses perceive a problem with healthcare availability, healthy living and individual/family health problems in the community.

Healthcare availability (access to primary care and to a lesser extent specialty medicine) not only was the most often cited problem, it also is considered the most important to resolve.

Free text response to the question of what is the most important health or medical issue reaffirmed the statistical analysis of major concerns being:

- Access to primary health care;
- Drug abuse;
- Insurance – affordability – cost issues;
- Mental health; and
- Obesity.

Agree with the above observations = 73.9% (16 experts)

Disagree with some or all of the observations = 26.1% (6 experts)

Comments:

- Additionally, dental health is a large component of general health conditions. Access to dental care because of limited resources is a problem;

- Dental issues are a major concern also, the cost;
- Domestic and sexual violence – why are these statistics not being considered?
- I also see access to specialty mental health services as a problem in both counties. In Franklin County, outside of NCSS, there is one private clinical specializing in working with child victims of sexual abuse. In Grand Isle County there are none;
- I would continue to include tobacco use in addition to the above;
- I would note that the local FQHC does not think access to primary care remains an issue due to recruitment efforts; therefore, this may be improving;
- See previous statements;
- Surprised to see obesity at the top of the list. Surprised that domestic violence is not on the list;
- The respondents do not seem to be typical of the Franklin-Grand Isle area, especially Franklin. The 3 major problem areas are interesting, especially mental health;
- Timely access to people with mental health problems is a serious concern; and
- You don't mention if GI and Franklin Counties are reporting different statistics.

Question #5 – Additional Community Health Need Assessment Considerations

Additional observations of Grand Isle and Franklin Counties found:

1. Leading causes of deaths in Vermont are

   #1 Cancer (Grand Isle has highest VT rate and it is significantly above national average);

   #2 Heart Disease (Franklin has highest VT rate but is in line with national average);

   #3 Chronic Lung Disease (Grand Isle has highest VT rate and it is significantly above national average);

   #4 Accidents (both Counties are at about VT average); and

   #5 Stroke (Grand Isle has highest VT rate while Franklin has the lowest VT rate, which is significantly lower than national average).

2. Other Significant Death Rate Observations (listed in sequence of declining rate of deaths):

- Alzheimer, Grand Isle has lowest VT rate, Franklin third to last ranked VT county;
- Diabetes, Franklin top VT county, Grand Isle about at VT average;
- Suicide, Franklin top VT county, Grand Isle ranked 5th;
- Flu & Pneumonia deaths, Grand Isle second to last, Franklin ranked #5 in VT;
- Hypertension deaths, Grand Isle top VT County; and

- Homicide Grand Isle, ranked #1 death rate and Franklin #2.

3. Male and Female life expectancy values for the two counties are the same with Female expectancy being 81.5 years and Male expectancy being 77.4 year, each about 4 years behind the top tier counties in the nation.

4. PALLIATIVE CARE programs exist in Franklin County.

5. Parts of Franklin are DESIGNATED MEDICALLY UNDERSERVED but no designation exists for Grand Isle County.

6. HEART DISEASE DEATHS (based on data older than used in #1 above) rates for both Counties are in the second lowest national quartile.

7. STROKE DEATHS (based on older data than used in #1 above) in Franklin County are in the lowest national quartile while Grand Isle is in the second to lowest national quartile.

8. HYPERTENSION (based on older data than used in #2 above) has a high incidence; both counties are in the highest national quartile

9. DIABETES (based on older data than used in #2 above) prevalence is among the lower values in the nation.

Agree with the above observations = 86.4% (18 experts)

Disagree with some or all of the observations = 13.6% (3 experts)

Comments:

- Do not have enough info to form an opinion;
- Especially Franklin County DESIGNATED MEDICALLY UNDERSERVED;
- Homicide/suicide due to DV;
- I don't understand the definition of "hypertension" deaths. I would imagine that would be included in stroke and heart disease. I also cannot imagine that GI County is NOT medically underserved;
- I have no way of corroborating the above information through experience or otherwise;
- It appears that with only 2 primary care practices covering the entire county of Grand Isle, a designation of medically underserved would also be relevant. Many Grand Isle county residents seek care outside of their county;
- Regardless of a lack of "designation," much of Grand Isle Country remains medically underserved; and
- Stroke death data surprising but suggests that hypertension is well managed in Franklin County?

All the needs were then presented to the Local Experts with the following instructions:

All identified issues are presented in alphabetical order. (In the following 25 points, **bold** text indicates the topic header and *italic* text indicates community need topics grouped into the topic header.) Instructions given to the Local Experts were to please allocate points to identify which are needs, with heaver point allocations to needs you recommend as a priority.

1. **ACCESS/AVAILABILITY TO HEALTHCARE** 2/3 of residents cite a problem; primary care access and specialty medicine access is the most important issue to resolve;
2. **ACCIDENTS** while the fourth leading cause of VT deaths, do not present as a problem; *MOTOR VEHICLE INJURY* favorable in Franklin; *SPORT INJURY* 6% below national average; *UNINTENTIONAL INJURY* better than peer and U.S. values
3. **BIRTHS** – *TO WOMEN AGE 40 TO 54* a Grand Isle concern, somewhat a Franklin concern; *TO UNMARRIED WOMEN* somewhat a concern in both counties; *TEEN BIRTHS* most recent data suggests a Franklin concern
4. **BABY DEATHS** – *INFANT MORTALITY & NEONATAL INFANT MORTALITY* worse than peers and U.S. average; *LOW BIRTH WEIGHT & PREMATURE BABIES & POSTNEONATAL INFANT MORTALITY* a Grand Isle concern, favorable Franklin rates; *VERY LOW BIRTH WEIGHT* a Grand Isle concern, somewhat a Franklin concern; *WHITE NON HISPANIC INFANT MORTALITY* worse than peers and U.S. average
5. **CANCER** #1 VT cause of death, Grand Isle rate highest VT and greatly above U.S. average; *SCREENING TEST* 9% below average; *PROSTATE SCREENING* 6% below average *BREAST & COLON CANCER* a Franklin concern, no Grand Isle data; *LUNG CANCER* a concern for both counties;
6. **CHRONIC ASTHMA** rate 12% below average;
7. **CHRONIC HIGH CHOLESTEROL** rate 8% below U.S. average;
8. **CHRONIC LUNG DISEASE** third leading VT cause of death, Grand Isle highest VT rate and greatly above U.S. average;
9. **CHRONIC OSTEOPOROSIS** 6% below U.S. average;
10. **CORONARY HEART DISEASE** second leading VT cause of death; Franklin highest VT rate, worse than peers and somewhat worse than U.S. average, older data has heart disease death rates in second lowest U.S. quartile; *CARDIAC STRESS TESTING* 9% below U.S. average
11. **DIABETES** prevalence among lower values in U.S.;
12. **HEALTH INSURANCE/UNINSURED** second of top three major concerns by +60% of residents, *COST PROBLEMS* 5% above U.S. average;
13. **HIGH BLOOD PRESSURE** Grand Isle top VT death rate, both counties in highest U.S. quartile
14. **HOMICIDE** Grand Isle top VT rate, Franklin #2 VT rate
15. **MENTAL HEALTH** the third of top concerns by +60% of residents, expressed as access problem; *SUBSTANCE ABUSE* a problem expressed by +70% of residents, prescription drug abuse and youth drug use are major problems;

16. **OBESITY** top resident concern; *HEALTHY EATING HABITS* 10% below U.S. average; *MORBID OBESE* rates 5% above U.S. average; number of *FAST FOOD* restaurants is high; *LOW INCOME ACCESS TO HEALTHY FOOD* a minor concern;
17. **PALLIATIVE CARE** programs exist in Franklin;
18. **PHYSICAL ENVIRONMENTAL FACTORS** not a concern;
19. **PHYSICIAN** visits to primary care 9% above U.S. average; Pediatrician use 12% above U.S. average; parts of Franklin designated *MEDICALLY UNDERSERVED*;
20. **PREMATURE DEATHS** Grand Isle favorable but Franklin unfavorable; *LIFE EXPECTANCY* for females is 81.5 years, for males 77.4 years, both about 4 years behind top U.S. values solutions however, may lie with other needs;
21. **SEXUALLY TRANSMITTED DISEASE** not a concern;
22. **SMOKING** Grand Isle below VT average, Franklin above VT average
23. **STROKE** fifth VT cause of death, Grand Isle highest VT rate while Franklin has lowest VT rate;
24. **SUICIDE** Franklin highest VT rate, Grand Isle above VT average
25. **Points Reserved** to address ideas presented below (where topics and point allocations were considered the same as one of the preceding needs, any allocated points were combined with the appropriate need):
    - Youth Substance Abuse;
    - Drug Abuse of pain killers;
    - Substance Abuse; and
    - Domestic and spousal abuse.

The result from the point allocation process is shown on the following page.

Priority Ranking of Community Health Needs by Local Experts	Allocated Points	# Experts Allocating Points	Cumulative Allocated Points	Point Break From Higher Priority
1. MENTAL HEALTH (15)	274	16	15%	
2. ACCESS / AVAILABILITY TO HEALTHCARE (1)	243	15	28.7%	31
3. OBESITY (15)	204	15	40.1%	39
4. SMOKING (22)	137	12	47.7%	67
5. CANCER (5)	132	11	55.0%	5
6. HEALTH INSURANCE / UNINSURED (12)	128	13	62.1%	4
7. SUICIDE (24)	85	9	66.8%	43
8. CORONARY HEART DISEASE (10)	73	9	70.9%	12
9. CHRONIC LUNG DISEASE (8)	65	9	74.5%	8
10. HIGH BLOOD PRESSURE (13)	64	9	78.1%	1
11. DOMESTIC AND SEXUAL ABUSE (NA)	60	2	81.4%	4
12. SUBSTANCE ABUSE INCLUDING YOUTH (NA)	55	4	84.4%	5
13. STROKE (23)	42	6	86.8%	13
14. DIABETES (11)	41	7	89.1%	1
15. HOMICIDE (14)	39	6	91.2%	2
16. PHYSICIAN (19)	33	5	93.1%	6
17. JOBS (NA)	25	1	94.4%	8
18. PALLIATIVE CARE (17)	22	5	95.7%	3
19. BABY DEATHS (4)	17	5	96.6%	5
20. BIRTHS (3)	15	4	97.4%	2
21. CHRONIC ASTHMA (6)	13	4	98.2%	2
22. PHYSICAL ENVIRONMENTAL FACTORS (22)	11	4	98.8%	2
23. ACCIDENTS (2)	10	4	99.3%	1
24. CHRONIC HIGH CHOLESTEROL (7)	5	3	99.6%	5
25. CHRONIC OSTEOPOROSIS (9)	4	3	99.8%	1
26. SEXUALLY TRANSMITTED DISEASE (21)	2	3	99.9%	2
27. PREMATURE DEATH / LIFE EXPECTANCY (20)	1	3	100.0%	1
Total	1,800	18		

Results were dichotomized into two groups defined as "High Priority" and "Low Priority." The criteria used for allocating a need into the High Priority as opposed to the Low Priority were employed in the following sequence of decisions:

- The rank order established by the Local Expert point allocation totals could not be changed;
- In the development of implementation planning, if a proposed implementation action would be directed to responding to multiple needs, then the individual needs could be merged with the final ranking being the sum of the Local Expert given point allocations for the individual needs;
    - In this process, the hospital administrative team combined:
        - Mental Health with Substance Abuse;
        - Access-Availability to Healthcare with Physicians; and
        - Chronic Lung Disease with Chronic Asthma.
- The desired result was to have the High Priority identified needs represent a majority of the points being allocated. Operationally, this criterion was satisfied if the aggregate points of all High Priority needs exceeded 50% of the allocated points;

- The desired result was to have the High Priority identified needs represent needs as identified by a majority of the Local Experts who were allocating points. Operationally, this criterion was satisfied if 9 or more Local Experts allocated any points to the need; and
- The break point between High Priority and Low Priority was an examination of results to determine where there was a sizable gap in the total allocated points from one need to the next lower need. In the table of results from the Local Experts with needs combined by hospital administration, a large point gap in the sequence occurs between Need #11 (High Blood Pressure) and Need #12 (Stroke). This became the break point for defining High Priority Community Needs and Low Priority Community Needs.
    - Large potential break point candidates between needs 2 and 3, 3 and 4, 4 and 5 were not selected because the total point allocation in each instance was less than half of all allocated points; and
    - The large break point potential candidate between needs 8 and 9 was not selected because needs 9, 10 and 11 still represented needs identified by at least half of the Local Experts offering opinions.

At this point, the numeric reference to the needs was revised from an alphabetical sequence value (as shown in parentheses following the need in the above table) to a rank order as determined by the Local Experts.

Accordingly, the final rank order of Community Health Needs results is presented on the following page.

Final Priority Ranking of Community Health Needs	# Experts Allocating Points	Allocated Points	Percent of Total Allocated Points	Point Break From Higher Priority	Cumulative Allocated Points	High vs. Low Priority
1. Mental Health & Substance Abuse (16)	17	284	15.78%		15.78%	High Priority
2. Access/Availability to Healthcare& Physicians (15)	15	243	13.50%	41	29.28%	
3. Obesity	14	194	10.78%	49	40.06%	
4. Smoking	12	137	7.61%	57	47.67%	
5. Cancer	11	132	7.33%	5	55.00%	
6. Health Insurance / Uninsured	13	128	7.11%	4	62.11%	
7. Suicide	9	85	4.72%	43	66.83%	
8. Domestic & Sexual Abuse	4	85	4.72%	-	71.56%	
9. Coronary Heart Disease	9	73	4.06%	12	75.61%	
10.Chronic Lung Disease & (21) Chronic Asthma	9	65	3.61%	8	79.22%	
11.High Blood Pressure	9	64	3.56%	1	82.78%	
12.Stroke	6	42	2.33%	22	85.11%	Low Priority
13.Diabetes	7	41	2.28%	1	87.39%	
14.Homicide	5	39	2.17%	2	89.56%	
15.Physicians	4	33	1.83%	6	91.39%	
16.Substance Abuse	2	30	1.67%	3	93.06%	
17.Jobs	1	25	1.39%	5	94.44%	
18.Palliative Care	4	22	1.22%	3	95.67%	
19.Baby Deaths	4	17	0.94%	5	96.61%	
20.Births	4	15	0.83%	2	97.44%	
21.Chronic Asthma	4	13	0.72%	2	98.17%	
22.Physical Environmental Factors	2	11	0.61%	2	98.78%	
23.Accidents	4	10	0.56%	1	99.33%	
24.Chronic High Cholesterol	3	5	0.28%	5	99.61%	
25.Chronic Osteoporosis	3	4	0.22%	1	99.83%	
26.Sexually Transmitted Disease	1	2	0.11%	2	99.94%	
27.Premature Death/Life Expectancy	1	1	0.06%		100.00%	
Total	18	1,800	100.0%			

This list was provided to the administrative team for their use in determining if the hospital held a "High Responsibility" or a "Low Responsibility" in responding to each need. The determination of a need being a high or a low responsibility was made by comparing the need to the mission and vision of the hospital along with a determination if the hospital offered services or capabilities required to improve conditions represented by the need.

Northwestern Medical Center made the following determinations:

High Priority Needs where Northwestern Medical Center holds High Responsibility

2. Access/Availability to Healthcare & Physicians;

3. Obesity;

4. Smoking;

5. Cancer;

9. Coronary Heart Disease;

10. Chronic Lung Disease & Chronic Asthma; and

11. High Blood Pressure.

High Priority Needs where Northwestern Medical Center holds Low Responsibility

1. Mental Health & Substance Abuse;

6. Health Insurance/Uninsured;

7. Suicide; and

8. Domestic & Sexual Abuse.

Low Priority Needs where Northwestern Medical Center holds High Responsibility

12. Stroke;

13. Diabetes;

16. Palliative Care;

18. Births; and

21. Chronic High Cholesterol.

Low Priority Needs where Northwestern Medical Center holds Low Responsibility

14. Homicide;

15. Jobs;

17. Baby Deaths;

19. Physical Environmental Factors;

20. Accidents;

22. Chronic Osteoporosis;

23. Sexually Transmitted Disease; and

24. Premature Death/Life Expectancy.

Appendix H

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

Illustrative IRS Schedule H (form 990) Part V B[48]

Community Health Need Assessment Answers

1. ***During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8***

   Illustrative Answer – Yes

   If "Yes," indicate what the Needs Assessment describes (check all that apply):

   a. ***A definition of the community served by the hospital facility;***
   b. ***Demographics of the community;***
   c. ***Existing health care facilities and resources within the community that are available to respond to the health needs of the community;***
   d. ***How the data was obtained;***
   e. ***The health needs of the community;***
   f. ***Primary and chronic disease needs and health issues of uninsured persons, low-income persons and minority groups;***
   g. ***The process for identifying and prioritizing community health needs and services to meet the community health needs;***
   h. ***The process for consulting with persons representing the community's interests;***
   i. ***Information gaps that limit the hospital facility's ability to assess all of the community's health needs; and***
   j. ***Other (describe in Part VI).***

   Illustrative Answer – check a. through i. Answers available in this report are found as follows:

   1. a. – See Footnotes #17 (page 10) & #43 (page 92);

   1. b. – See Footnotes #18 (page 11), #19 (page 11), #20 (page 11), #25 (page 52), # 44 (page 93) & # 45 page (95);

   1. c. – See Footnote #21 (page 18);

[48] Questions are drawn from 12/15/2011 Draft Forms and may have changed at the time when the hospital is to make its 990 h filing

1. d. – See Footnotes #10 (page 6), #25 (page 52), #26 (page 54), #30 (page 71), #32 (page 77), #33 (page 77), #35 (page 80), #37 (page 82), #40 (page 87) & #41 (page 88);

1. e. – See Footnotes #15 (page 7);

1. f. – See Footnotes #13 (page 7), #29 (page 59), #31 (page 74), #34 (page 79), #38 (page 83), #39 (page 85) & #46 (page 96);

1. g. – See Footnote #16 (page 8) & #47 (page 98);

1. h. – See Footnote #11 (page 7) & #47 (page 98);

1. i. – See Footnote #9 (page 6); and

1. j. – No response needed.

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

Illustrative Answer – 2012

See Footnote #1 (Title page)

3. ***In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted***

Illustrative Answer – Yes

See Footnotes #12 (page 7), #14 (page 7)

4. ***Was the hospital facility's Need Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI.***

Illustrative Answer – No

5. ***Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)***

    a. ***Hospital facility's website***
    b. ***Available upon request from the hospital facility***
    c. ***Other (describe in Part VI)***

Illustrative Answer – check a. and b.

The hospital will need to obtain Board approval of this report, document the date of approval and take action to make the report available as a download from its web

site. It also may be prudent to place a notice in a paper of general circulation within the service area noting the report is available free upon request.

6. ***If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):***

    a. ***Adoption of an implementation strategy to address the health needs of the hospital facility's community;***
    b. ***Execution of an implementation strategy;***
    c. ***Participation in the development of a community-wide community benefits plan;***
    d. ***Participation in the execution of a community-wide community benefits plan***
    e. ***Inclusion of a community benefit section in operational plans;***
    f. ***Adoption of a budget for provision of services that address the needs identified in the Needs Assessment;***
    g. ***Prioritization of health needs in its community;***
    h. ***Prioritization of services that the hospital facility will undertake to meet the needs in its community; and***
    i. ***Other (describe in Part VI).***

    Illustrative Answer – check a, b, f, g, and h.

    6. a. – See footnote #22 (page 38);

    6. b. – See footnote #22 (page 38);

    6. f. – See footnotes #6 (page 4) and #24 (page 43);

    6. g. – See footnote #16 (page 8); and

    6. h. – See footnote #16 (page 8).

7. ***Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs?***

    Illustrative Answer – Yes

    Part VI suggested documentation – See Footnote #23 (page 43)