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**LITTLETON REGIONAL HEALTHCARE  
LITTLETON, NEW HAMPSHIRE**

**2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND  
IMPLEMENTATION PLAN**

**ADOPTED BY BOARD RESOLUTION (DATE)<sup>1</sup>**



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<sup>1</sup> Response to Schedule H (Form 990) Part V B 2

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Dear Community Resident:

Littleton Regional Healthcare (LRH) welcomes you to review this document as we strive to meet the health and medical needs in our community. All not-for-profit hospitals are required to develop this report in compliance with the Accountable Care Act.

The “2013 Community Health Needs Assessment” identifies local health and medical needs and provides a plan to indicate how the Health Center will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, LRH, are meeting our obligations to efficiently deliver medical services.

LRH will conduct this effort at least once every three years. As you review this plan, please see if, in your opinion, we have identified the primary needs and if our intended response should make appropriate needed improvements.

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

The 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; for most purposes, they may be ignored. Of greater importance, however, is the potential for this report to guide our actions and the efforts of others to make needed health and medical improvements.

Please think about how to help us improve the health and medical services our area needs. I invite your response to this report. We all live and work in this community together and our collective efforts can make living here more enjoyable and healthier.

Thank you.

Respectfully,

Warren K. West, CEO

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## EXECUTIVE SUMMARY

## Executive Summary

Littleton Regional Healthcare (LRH) 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 LRH 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<sup>2</sup>. 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<sup>3</sup>.

### Project Objectives

Littleton Regional Healthcare (LRH) partnered with QHR for the following<sup>4</sup>:

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

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<sup>2</sup> Part 3 Treasury/IRS – 2011 – 52 Notice ... Community Health Needs Assessment Requirements...

<sup>3</sup> 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>

<sup>4</sup> 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.<sup>5</sup>

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<sup>5</sup> Section 6652

## 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 Grafton County, 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.<sup>6</sup>

The data displays used in our analysis are presented in the Appendices. Data sources include:<sup>7</sup>

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Grafton County compared to all NH counties	November 6, 2012	2002 to 2010

<sup>6</sup> Response to Schedule H (Form 990) Part V B 1 i

<sup>7</sup> Response to Schedule H (Form 990) Part V B 1 d



Web Site or Data Source	Data Element	Date Accessed	Data Date
www.communityhealth.hhs.gov	Assessment of health needs of Grafton County compared to its national set of “peer counties”	November 6, 2012	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital’s primary service area, at a zip code level, based on classifying the population into various socio-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, trends and socio-economic characteristics;	November 6, 2012	2012
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	November 6, 2012	2012
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	November 6, 2012	2012
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	November 6, 2012	1989 through 2009
www.dataplace.org	To determine availability of specific health resources	November 6, 2012	2005
www.cdc.gov	To examine area trends for heart disease and stroke	November 6, 2012	2007 to 2009
www.CHNA.org	To identify potential needs among a variety of resource and health need metrics	February 15, 2013	2003 to 2010
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	February 15, 2013	2013
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	February 28, 2013	2010 published 11/29/12

In addition, we deployed a Community Health Needs Assessment survey within the local population for any resident to complete.<sup>8</sup>

We received community input from 164 area residents; survey responses started Tuesday, June 26, 2012 at 2:29 p.m. and ended with the last response on Monday, August 6, 2012 at 3:39 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<sup>9</sup>; and

Information analysis augmented by local opinions showed how Grafton County relates 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<sup>10</sup>.

When the analysis was complete, we put the information and summary conclusions before our local group of experts<sup>11</sup> 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.<sup>12</sup> Consultation with local experts occurred again via an internet based survey (explained below) during the period beginning Friday, August 31, 2012 at 8:37 a.m. and ending Sunday, September 23, 2012 at 12:47 p.m.

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 LRH 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.

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<sup>8</sup> Response to Schedule H (Form 990) Part V B 1 h

<sup>9</sup> Part response to Schedule H (Form 990) Part V B 3

<sup>10</sup> Response to Schedule H (Form 990) Part V B 1 f

<sup>11</sup> Part response to Schedule H (Form 990) Part V B 3

<sup>12</sup> Response to Schedule H (Form 990) Part V B 1 e

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 LRH 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 LRH 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<sup>13</sup>.

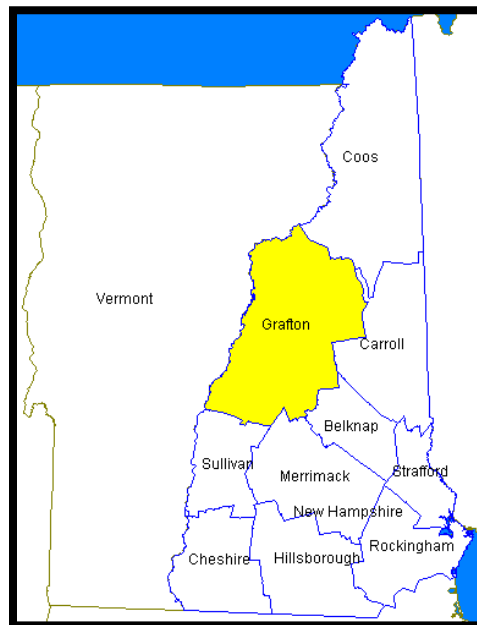
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<sup>13</sup> Response to Schedule H (Form 990) Part V Section B 6 g, h and Part V B 1 g

## FINDINGS

## Findings

### Definition of Area Served by the Hospital Facility<sup>14</sup>



Littleton Regional Healthcare, in conjunction with QHR, defines for this report the service area as Grafton County in New Hampshire which includes the following ZIP codes:

03215 Waterville Valley	03217 Ashland	03222 Bristol
03223 Campton	03238 Glencliff	03240 Grafton
03241 Hebron	03245 Holderness	03251 Lincoln
03262 North Woodstock	03264 Plymouth	03266 Rumney
03274 Stinson Lake	03279 Warren	03282 Wentworth
03285 Thornton	03293 Woodstock	03561 Littleton
03574 Bethlehem	03580 Franconia	03585 Lisbon
03585 Lyman	03586 Sugar Hill	03740 Bath
03741 Canaan	03748 Enfield	03749 Enfield Center
03750 Etna	03755 Hanover	03756 Dartmouth Hitchcock
03765 & 6 Lebanon	03765 Haverhill	03768 Lyme
03769 Lyme Center	03771 Monroe	03774 North Haverhill
03777 Orford	03779 Piermont	03780 Pike
03784 West Lebanon	03785 Woodsville	

<sup>14</sup> Responds to IRS Form 990 (h) Part V B 1 a

In 2011, the Hospital received 65.5% of its patients from this area, although pragmatically as Littleton is close to the northern border of the County and Grafton is a large county, its true service area is confined to the northern portions and extends into adjoining counties.

## Demographic of the Community<sup>15</sup>

The 2012 population for Grafton County is estimated to be 90,847<sup>16</sup>, and is expected to grow at a rate (4.7%) faster than the national rate of growth, projecting a 2017 population of 95,080. This population growth is at a faster rate than for New Hampshire as a whole (3.2%).

According to the population estimates utilized by Truven, provided by The Neilson Company, the 2012 median age for the County is 39.9 years, younger than the New Hampshire median age (40.4 years) but older than the national median age (36.8 years). The 2012 Median Household Income for the area is \$52,729, which is lower than the New Hampshire median income of \$59,470 but higher than the national median income of \$49,599. Median Household Wealth and Median Home Values likewise are below State and above national values. Grafton's unemployment rate as of August, 2012 was 4.4%<sup>17</sup>, which is lower than the statewide rate of 5.7%, and considerably better than the national civilian unemployment rate of 8.1%.

The portion of the population in the County over 65 is 15.9%, above the New Hampshire average of 13.5%. The portion of the population of women of childbearing age is 19.9%, somewhat higher than the New Hampshire average of 19.5%. In the County this population is anticipated to increase 1%, whereas for New Hampshire as a whole, the female population age 15 to 44 is anticipated to decline at a rate of just over 2%.

Demographics Expert 2.7												
2012 Demographic Snapshot												
Area: Grafton County NH												
Level of Geography: ZIP Code												
DEMOGRAPHIC CHARACTERISTICS												
		Selected Area	USA							2012	2017	% Change
2000 Total Population		81,921	281,421,906			Total Male Population				44,707	46,731	4.5%
2012 Total Population		90,847	313,095,504			Total Female Population				46,140	48,349	4.8%
2017 Total Population		95,080	325,256,835			Females, Child Bearing Age (15-44)				18,047	18,234	1.0%
% Change 2012 - 2017		4.7%	3.9%									
Average Household Income		\$66,356	\$67,315									
POPULATION DISTRIBUTION				HOUSEHOLD INCOME DISTRIBUTION								
Age Distribution						Income Distribution						
Age Group	2012	% of Total	2017	% of Total	USA 2012 % of Total	2012 Household Income	HH Count	% of Total	USA % of Total			
0-14	13,632	15.0%	13,900	14.6%	20.2%	<\$15K	3,895	10.5%	13.0%			
15-17	3,614	4.0%	3,310	3.5%	4.3%	\$15-25K	3,966	10.7%	10.8%			
18-24	11,961	13.2%	12,412	13.1%	9.7%	\$25-50K	10,213	27.6%	26.7%			
25-34	10,799	11.9%	11,045	11.6%	13.5%	\$50-75K	8,480	23.0%	19.5%			
35-54	24,150	26.6%	23,013	24.2%	28.1%	\$75-100K	4,295	11.6%	11.9%			
55-64	12,247	13.5%	14,313	15.1%	11.4%	Over \$100K	6,088	16.5%	18.2%			
65+	14,444	15.9%	17,087	18.0%	12.9%							
Total	90,847	100.0%	95,080	100.0%	100.0%	Total	36,937	100.0%	100.0%			
EDUCATION LEVEL				RACE/ETHNICITY								
Education Level Distribution						Race/Ethnicity Distribution						
2012 Adult Education Level	Pop Age 25+	% of Total	USA % of Total			Race/Ethnicity	2012 Pop	% of Total	USA % of Total			
Less than High School	1,741	2.8%	6.3%			White Non-Hispanic	83,482	91.9%	62.8%			
Some High School	3,739	6.1%	8.6%			Black Non-Hispanic	836	0.9%	12.3%			
High School Degree	19,054	30.9%	28.7%			Hispanic	1,736	1.9%	17.0%			
Some College/Assoc. Degree	15,595	25.3%	28.5%			Asian & Pacific Is. Non-Hispanic	2,859	3.1%	5.0%			
Bachelor's Degree or Greater	21,511	34.9%	27.8%			All Others	1,934	2.1%	2.9%			
Total	61,640	100.0%	100.0%			Total	90,847	100.0%	100.0%			
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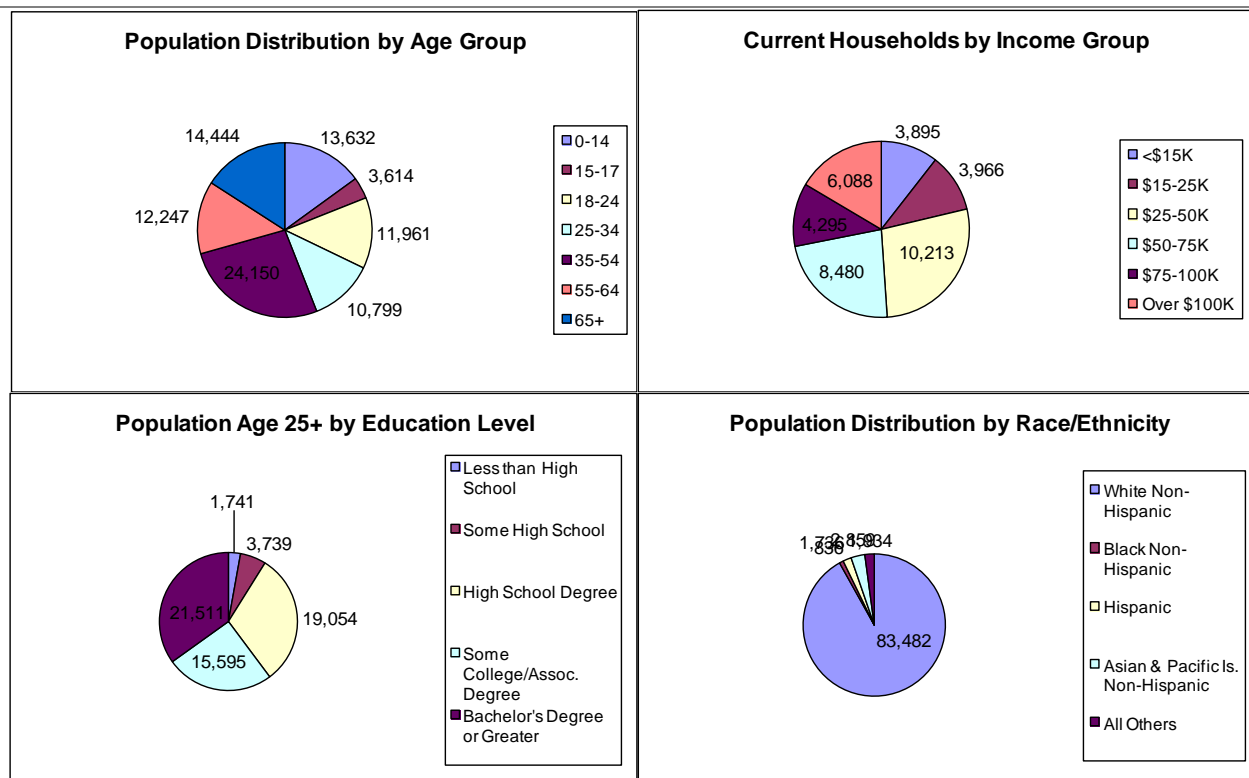
© 2012 The Nielsen Company, © 2012 Thomson Reuters. All Rights Reserved

<sup>15</sup> Responds to IRS Form 990 (h) Part V B 1 b

<sup>16</sup> All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner

<sup>17</sup> <http://research.stlouisfed.org/fred2/series/VTGRAN3URN> ;

<http://research.stlouisfed.org/fred2/series/VTFRAN1URN>



The population also was examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to discern the following table of probable lifestyle and medical conditions present in the population. Items with red text are viewed as statistically important adverse potential findings. Items with blue text are viewed as statistically important potential beneficial findings. Items with black text are viewed as either not statistically different from the national normal situation or not being a favorable nor an unfavorable consideration in our use of the information.

Health Service Topic	Demand as % of National	% of Population Effected	Health Service Topic	Demand as % of National	% of Population Effected
<b>Weight / Lifestyle</b>			<b>Heart</b>		
BMI: Morbid/Obese	99.0%	25.3%	Routine Screen: Cardiac Stress 2yr	93.5%	14.6%
Vigorous Exercise	101.9%	51.9%	Chronic High Cholesterol	98.0%	21.9%
Chronic Diabetes	99.2%	10.3%	Routine Cholesterol Screening	99.1%	49.7%
Healthy Eating Habits	100.2%	29.6%	Chronic High Blood Pressure	102.4%	26.9%
Very Unhealthy Eating Habits	90.1%	2.5%	Chronic Heart Disease	107.5%	9.0%
<b>Behavior</b>			<b>Routine Services</b>		
I Will Travel to Obtain Medical Care	100.1%	29.8%	FP/GP: 1+ Visit	102.4%	90.3%
I Follow Treatment Recommendations	97.1%	39.3%	Used Midlevel in last 6 Months	106.3%	44.5%
I am Responsible for My Health	97.0%	63.7%	OB/Gyn 1+ Visit	98.7%	43.7%
<b>Pulmonary</b>			Ambulatory Surgery last 12 Months	106.8%	20.5%
Chronic COPD	100.8%	6.8%	<b>Internet Usage</b>		
Tobacco Use: Cigarettes	103.1%	26.7%	Use Internet to Talk to MD	77.6%	11.3%
Chronic Allergies	104.8%	20.2%	Facebook Opinions	86.3%	8.9%
<b>Cancer</b>			Looked for Provider Rating	95.1%	13.7%
Mammography in Past Yr	103.5%	47.0%	<b>Misc</b>		
Cancer Screen: Colorectal 2 yr	105.4%	24.8%	Charitable Contrib: Hosp/Hosp Sys	104.2%	24.9%
Cancer Screen: Pap/Cerv Test 2 yr	95.8%	57.7%	Charitable Contrib: Other Health Org	101.4%	39.6%
Routine Screen: Prostate 2 yr	100.5%	32.0%	HSA/FSA: Employer Offers	101.0%	52.4%
<b>Orthopedic</b>			<b>Emergency Service</b>		
Chronic Lower Back Pain	99.7%	22.5%	Emergency Room Use	98.0%	33.2%
Chronic Osteoporosis	108.2%	10.5%	Urgent Care Use	98.1%	23.1%



## Leading Causes of Death

Cause of Death			Rank among all counties in NH (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
NH Rank	Grafton Co. Rank	Condition		NH	Grafton Co.	
1	1	Heart Disease	9 of 10	150.1	178.8	Lower than expected
2,8,9,14,18,25,27,29,31,33,34,35	2	Cancer	10 of 10	170.4	171.1	As expected
4	3	Lung	10 of 10	44.5	40.4	As expected
15, 20, 28	4	Accidents	8 of 10	34.3	34.2	Lower than expected
3	5	Stroke	9 of 10	33.3	34.1	Lower than expected
6	6	Alzheimer's	4 of 10	24.3	26.5	As expected
7	7	Diabetes	10 of 10	18.3	15.6	Lower than expected
11	8	Flu - Pneumonia	8 of 10	12.8	15.3	Lower than expected
10	9	Kidney	5 of 10	11.1	11.5	Lower than expected
12	10	Suicide	6 of 10	11.7	11.2	As expected
19	11	Parkinson's	3 of 10	6.9	7.3	As expected
24	12	Liver	7 of 10	8.4	7.0	Lower than expected
22	13	Blood Poisoning	10 of 10	8.3	5.2	Lower than expected
13	14	Hypertension	8 of 10	4.9	4.3	Lower than expected
Not Ranked	15	Homicide	7 of 10	---	1.6	Lower than expected

## Primary and Chronic Disease Needs and Health Issues of Uninsured Persons, Low-Income Persons, and Minority Groups

Some information is available to describe the size and composition of various uninsured persons, low income persons, minority groups, and other vulnerable population segments. Specific studies

identifying needs of such groups, distinct from the general population at a county unit of analysis, are not readily available from secondary sources.<sup>18</sup>

The National Healthcare Disparities Report results from a Congressional directive to the Agency for Healthcare Research and Quality (AHRQ). This production is an annual report to track disparities related to "racial factors and socioeconomic factors in priority populations." The emphasis is on disparities related to race, ethnicity, and socioeconomic status. The directive includes a charge to examine disparities in "priority populations," which are groups with unique health care needs or issues that require special attention.<sup>19</sup>

Nationally, this report observes the following trends:

Measures for which Blacks were worse than Whites and are getting better:

- Diabetes – Hospital admissions for short-term complications of diabetes per 100,000 population;
- HIV and AIDS – New AIDS cases per 100,000 population age 13 and over; and
- Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.

Measures for which Blacks were worse than Whites and staying the same:

- Cancer – Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over ; breast cancer deaths per 100,000 female population per year; adults age 50 and over who ever received colorectal cancer screening; colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over; colorectal cancer deaths per 100,000 population per year;
- Diabetes – Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes;
- Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year; Children ages 19-35 months who received all recommended vaccines;
- Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months; people age 12 and over treated for substance abuse who completed treatment course;
- Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
- Supportive and Palliative Care – High-risk long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;

<sup>18</sup> Response to Schedule H (Form 990) Part V B 1 i

<sup>19</sup> <http://www.ahrq.gov/qual/nhdr10/Chap10.htm> 2010

- Timeliness – Adults who needed care right away for an illness, injury, or condition in the last 12 months who got care as soon as wanted; emergency department visits where patients left without being seen; and
- Access – People with a usual primary care provider; people with a specific source of ongoing care.

Measures for which Asians were worse than Whites and getting better:

- Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
- Patient Safety – Adult surgery patients who received appropriate timing of antibiotics.

Measures for which Asians were worse than Whites and staying the same:

- Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and
- Access – People with a usual primary care provider.

Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and staying the same:

- Heart Disease – Hospital patients with heart failure who received recommended hospital care;
- HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
- Respiratory Diseases – Hospital patients with pneumonia who received recommended hospital care;
- Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement;
- Supportive and Palliative Care – Hospice patients who received the right amount of medicine for pain; high-risk, long-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; and
- Access – People under age 65 with health insurance.

Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and getting worse:

- Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
- Patient safety – Adult surgery patients who received appropriate timing of antibiotics.

Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and getting better:

- Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;

- Lifestyle Modification – Adult current smokers with a checkup in the last 12 months who received advice to quit smoking; adults with obesity who ever received advice from a health provider about healthy eating; and
- Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.

Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and staying the same:

- Cancer – Women age 40 and over who received a mammogram in the last 2 years; adults age 50 and over who ever received colorectal cancer screening;
- Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
- Heart Disease – Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge; hospital patients with heart failure who received recommended hospital care;
- HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
- Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months;
- Respiratory Disease – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
- Lifestyle Modification – Adults with obesity who ever received advice from a health provider to exercise more;
- Supportive and Palliative Care – Long-stay nursing home residents with physical restraints; high-risk, long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
- Patient Safety – Adult surgery patients who received appropriate timing of antibiotics;
- Timeliness – Adults who needed care right away for an illness, injury, or condition in the last 12 months who got care as soon as wanted;
- Patient Centeredness – Adults with ambulatory visits who reported poor communication with health providers; children with ambulatory visits who reported poor communication with health providers; and
- Access – People under age 65 with health insurance; people under age 65 who were uninsured all year; people with a specific source of ongoing care; people with a usual

primary care provider; people unable to get or delayed in getting needed care due to financial or insurance reasons

Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and getting worse:

- Maternal and Child Health – Children ages 3-6 who ever had their vision checked by a health provider.

We asked in the community survey about such unique needs and reviewed their response to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received to identify unique population needs to which we should respond. We asked if there were any particular group having needs and only 18% of responses gave any priority, only seven respondents ranked it as the top priority, of importance to develop a response to their needs. Literally, we received a handful of responses from the 164 participants, concluding such needs were not dominant considerations and topics presented were not materially different from considerations for the public at large. Specific comments as quoted by participants included:

- Senior Health Issues such as Alzheimer's, Diabetes, and Heart Health.
- I think that obesity is a vital health issue that we need to address, especially in children. If you help someone drop weight you immediately impact a myriad of other risk factors and conditions. Over the long term the person will see improved health. Unfortunately there is no easy fix for this problem. To attack it would require more than just the Band-Aid approach that is currently used.
- I would say probably mental, especially those who are very non-functional. I'm not talking about a wealthy person lying on a sofa complaining about his life, but the real mental cases milling aimlessly about the streets or living in the woods. Dental would be a second big issue.
- In home care for elderly - low cost clinic.
- Elderly healthcare access and pediatric healthcare access at affordable rates.
- Dental healthcare (the lack of), the elderly population and their health concerns and financial problems with people out of work and affording healthcare.
- Affordable health care as some residents don't have insurance.
- Affordable health care. Concerns about the future health care for young and old.
- Affordable care for the uninsured.
- Access to affordable health care and health care coverage.
- Access to affordable healthcare and the ability to pay the increasing cost of health insurance.

### Access to Care: Grafton County, NH

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

<b>Uninsured individuals (age under 65)<sup>1</sup></b>	<b>8,808</b>
<b>Medicare beneficiaries<sup>2</sup></b>	
Elderly (Age 65+)	12,352
Disabled	2,179
<b>Medicaid beneficiaries<sup>2</sup></b>	<b>8,936</b>
<b>Primary care physicians per 100,000 pop<sup>2</sup></b>	<b>275.8</b>
<b>Dentists per 100,000 pop<sup>2</sup></b>	<b>64.0</b>
<b>Community/Migrant Health Centers<sup>3</sup></b>	<b>Yes</b>
<b>Health Professional Shortage Area<sup>3</sup></b>	<b>No</b>

nda No data available.

<sup>1</sup> The Census Bureau. Small Area Health Insurance Estimates Program, 2006.

<sup>2</sup> HRSA. Area Resource File, 2008.

<sup>3</sup> HRSA. Geospatial Data Warehouse, 2009.

### Vulnerable Populations: Grafton County, NH

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<sup>1</sup>

<b>Have no high school diploma (among adults age 25 and older)</b>	<b>7,139</b>
<b>Are unemployed</b>	<b>1,497</b>
<b>Are severely work disabled</b>	<b>1,532</b>
<b>Have major depression</b>	<b>6,202</b>
<b>Are recent drug users (within past month)</b>	<b>7,991</b>

nda No data available.

<sup>1</sup> 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.

## Findings

Upon completion of the CHNA, QHR identified several issues within the Littleton Regional Healthcare community:

### Conclusion from Public Input to Community Health Needs Assessment

164 area residents participated in a survey asking opinions about their perception of local health care needs. In descending order of opinion, ten topics were identified as being of "Major Concern" or "Most Important Issue to Resolve":

1. Not having health insurance 75% listed as a major concern, with support of "Insurance Problems" being a secondary issue in the written comments.
2. People making unhealthy food choices 73% listed as a major concern, with support of Obesity being a secondary issue in the written comments.
3. Mental Health Issues 63% listed as a major concern, but it appears it was not enough of a problem to be ranked as a major problem needing attention.
4. Diabetes 55% listed as a major concern.
5. Youth Drug Use 55% listed as a major concern.
6. Youth smoking / tobacco use 53% reported as a major concern, with written comments citing an issue with tobacco use.
7. Adult abuse of alcohol and/or drugs was noted by 52% of responses as a concern.
8. Cancer was listed as being a major concern by 51% of responses.
9. Pulmonary was prominently noted as a written major issue needing attention and this was an unaided response as pulmonary conditions was not listed as a topic for survey participants to statistically cite as a problem.
10. Children Healthcare was written as a secondary issue to resolve, but specific aspects of children, teen births, vaccination, alcohol use, and, bullying did not receive a statistical majority of responses citing any concern. (This point may be viewed as support for above point #6.)

71% of participants reported a problem in the last two years with healthy living. 68% reported a problem in the last two years with an individual or family health matter. 59% reported a problem with the availability of health resources. Average days lost in the last month due to illness was reported as 3.4 days, with 53% reporting no days lost and 4% reporting all 30 days lost. Average days lost in the last month due to mental illness were 1.7 days, but 71% reported 0 days lost and one person reported all thirty days lost.

The most important issue to resolve was noted as keeping people healthy. A minority of people left the County for healthcare. When residents left, they primarily went to Dartmouth for oncology services.

Participants generally ranked their health as good (7.5 on a scale from 1 to 10, with 10 being the best). 86% had a personal physician and a similar percentage had a dentist. Only 10% had a mental health advisor. 59% of participants were residents of Littleton, Bethlehem or Lisbon, with the remainder residing in eighteen neighboring zip codes. The typical respondent was a non-Hispanic, white; married female age 35 to 54 with at least some college education experience. All income groups were represented in the survey, other than the less than \$5,000 household income. 43% were in a household having income in the range of \$50,000 to \$99,999. 83% were employed, 16% were retired. Allowing for multiple responses, 85% cited having private health insurance, 16% had Medicare and 2%, three people, had no insurance. 13% had at least one child 4 or younger in the household and 35% had at least one child between the ages of 5 and 17 in the household.

## Summary of Observations from Grafton County Compared to All New Hampshire Counties

In general, Grafton County residents are among the healthiest in New Hampshire.

In a health status classification termed "Health Outcomes", Grafton ranks number 3 among the 10 ranked counties (best being #1). On the beneficial side of the ledger, Low Birth Weight births among Grafton mothers is 6.3%, a value lower than the state average and approaching national goals. Premature Death rate (death prior to age 75) in Grafton County is better than the national goal. Self Reported health status measures show Grafton residents having values better than state averages and approach national goals.

In another health status classification "Health Factors", Grafton County is the best among New Hampshire Counties. Although Grafton typically has values better than state average, conditions where improvement remains to achieving national goals include:

- Adult Smoking
- Excessive Drinking
- Sexually Transmitted Disease
- Uninsured
- Inadequate Social Support
- Children in single parent households
- Percent of restaurants which are fast food.

## Summary of Observations from Grafton County Peer Comparisons

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



The federal government administers a process to allocate all counties into "Peer" groups. County "Peer" groups have similar social, economic and demographic characteristics. Health and wellness observations when Grafton is compared to its national set of Peer Counties and compared to national rates make the following observations:

UNFAVORABLE observations occurring at rates worse than national AND worse than among Peers

- BIRTHS TO WOMEN AGE 40 TO 54
- BREAST CANCER (female)

SOMEWHAT A CONCERN observations because occurrence is better than national average BUT worse than the Peer group average

- NEONATAL INFANT MORTALITY
- CORONARY HEART DISEASE
- UNINTENTIONAL INJURY

BETTER performance than Peers and National rates:

- INFANT MORTALITY MEASURES Low Birth Weight (<2500 grams); Very Low Birth Weight (<1500g); Premature Births; Infant Mortality; White Non-Hispanic Infant Mortality; Post-Neonatal Infant Mortality;
- BIRTHS TO WOMEN UNDER 18
- BIRTHS TO UNMARRIED WOMEN
- COLON CANCER
- LUNG CANCER
- MOTOR VEHICLE INJURY
- STROKE
- SUICIDE

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

Grafton County in 2012 comprises 90,847 residents. Since 2000 it has experienced population increase and anticipates continued faster than average growth through the next five years. The population is 91.9% non-Hispanic White. Asian & Pacific Island non-Hispanics constitute 3.1% of the population as the largest minority population. 15.9% of the population is age 65 or older. This is a considerably larger population segment than the elderly comprise elsewhere in New Hampshire or to the national average. 19.9% of the women are in the childbirth population segment. This segment is the same as elsewhere in NH and close to the national average. The median income and household wealth is below the NH average but exceeds the national averages.

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

Only one metric impacted more than 25% of the population and is statistically significantly different from the national average. It was:

- Used mid-level in the last 6 months 6% above average by 48% of the population, this is not a positive or an adverse finding.

Situations and Conditions statistically significantly different from the national average but impacting less than 25% of the population include:

- Used Ambulatory Surgery in last 6 months 7% above average impacting 20% of population, this is not a positive or an adverse finding.
- Obtaining a Routine Cardiac Stress Test in last 2 years 16% below average impacting 19% of population, an adverse finding.
- Used Internet to talk to Physician 22% below average impacting 15% of the population, this is not a positive or an adverse finding.
- Using Facebook to Express Service Opinions 14% below average impacting 14% of population, also not a positive or an adverse finding.
- Chronic Osteoporosis incident is 8% above average impacting 10% of the population, an adverse finding.
- Chronic Heart Disease 8% above average impacting 9% of the population, an adverse finding.
- Very Unhealthy Eating Habits 10% below average impacting 2% of the population, a beneficial finding.

## Key Conclusions from Consideration of the Other Statistical Data Examinations

Additional observations of Grafton County found:

- Palliative Care (programs focused not on curative actions but designed to relieve disease symptoms pain and stress arising from serious illness) four programs exist in the County.
- Among the leading causes of death, Grafton has a significantly lower death rate in 10 of the 15 leading causes of death. Ranking the causes of death in Grafton finds the leading causes to be the following (in descending order of occurrence):
  1. Heart Disease (as a rate of death, Grafton ranks #9 of 10 NH counties and significantly lower than expected)
  2. Cancer (as a rate of death, Grafton has the lowest death rate among NH counties, but the rate is at expected national rates)
  3. Lung Disease (as a rate, Grafton has the lowest NH death rate from this cause)
  4. Accidents (Grafton ranks as #8 among NH counties but is considered a significantly lower than expected death rate)

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5. Stroke (Ranked #9 among NH counties and significantly lower than expected)

6. Alzheimer's (#4 highest county rate in NH)

7. Diabetes (Ranked last among NH Counties as cause of death and significantly lower than national expectations)

- According to a Center for Disease Control and Prevention (CDC), the incident of Heart Disease Mortality during 2007 through 2009 is in the second highest national classification of deaths. The hospitalization rate is in the lowest county classification, but in the highest classification for discharging Medicare beneficiaries to their home.
- The incident of Stroke deaths is at about the national average.
- According to a different CDC report, diabetes as a rate of occurrence, not deaths, is in the second lowest decile, indicating it not a concern.
- Life expectancy for both Men and Women has increased, placing both in the highest national quintile. Male life expectancy is equal to the top 10 best international country rates. Life expectancy for Women, however, is 10 years behind the 10 best international country rates.
- 11.6% of Grafton residents live in poverty but only 4.1% have food stamps.
- Fast food restaurants exist at 143.7/100,000, which places it in the highest national range. Pharmacies exist at a rate of 16.2/100,000, which places it in the second highest national classification. General Practitioners exist at a rate of 1.2 per 100,000, or at about the national average rate.

## EXISTING HEALTH CARE FACILITIES, RESOURCES AND IMPLEMENTATION PLAN

## Significant Needs

We used the priority ranking of area health needs by the local expert advisors to organize the search for locally available resources as well as the response to the needs by Littleton Regional Healthcare. The following list:

- Identifies the rank order of each identified Significant Need;
- Presents the factors considered in developing the ranking;
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term;
- Identifies Littleton Regional Healthcare current efforts responding to the need;
- Establishes the Implementation Plan programs and resources Littleton Regional Healthcare will devote to attempt to achieve improvements;
- Documents the Leading Indicators Littleton Regional Healthcare will use to measure progress;
- Presents the Lagging Indicators Littleton Regional Healthcare believes the Leading Indicators will influence in a positive fashion, and;
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, LRH is the major hospital in the northern portion of the service area. LRH is a 25 bed critical access hospital located in Littleton, NH. The next closest facilities include:

- Cottage Hospital – 25 bed critical access hospital, 22 miles (34 minutes from LRH) in Woodsville, NH
- Weeks Medical Center – 25 bed critical access hospital, 21 miles (36 minutes from LRH) in Lancaster, NH
- Speare Memorial Hospital – 25 bed critical access hospital, 49 miles (54 minutes from LRH) in Plymouth, NH
- Dartmouth-Hitchcock Medical Center – 372 bed acute care referral facility, 66 miles (1 hour and 20 minutes from LRH) in Lebanon, NH
- Lakes Regional General Hospital – 110 bed acute care facility, 73 miles (1 hour and 28 minutes from LRH) in Laconia, NH
- In Vermont, the closest hospital is Northeastern Vermont Regional Hospital – 25 bed critical access hospital, 22 miles (25 minutes from LRH) in St Johnsbury, VT

All data items analyzed to determine significant needs are “Lagging Indicators”, measures presenting

results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast the Littleton Regional Healthcare Implementation Plan utilizes “Leading Indicators”. Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application Leading Indicators also must be within the ability of the hospital to influence and measure.

**1. OBESITY/OVERWEIGHT** – secondary resident concern; VERY UNHEALTHY EATING HABITS 10% better than expected ; OBESITY noted as secondary residential concern ;FAST FOOD in highest national classification of % of restaurants; MAKING UNHEALTHY FOOD CHOICES 2nd highest resident concern

**PROBLEM STATEMENT:** Increase obesity reduction efforts, including an emphasis on healthy lifestyles and healthy eating.

**HOSPITAL SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:<sup>20</sup>**

- LRH employs a full time Clinical Dietician and a part time Certified Diabetes Educator. Both work with patients to educate them on healthy eating and healthy lifestyles.
- LRH offers a series of wellness classes including Yoga, Aerobics, and Bone Builders. The purpose of the wellness classes is to encourage activities and exercise.
- LRH offers a walking trail on hospital campus (open to the public) another example of encouraging activities and wellness for individuals and families.
- LRH Employee Wellness Program provides employees with healthy lifestyle information and choices.
- Provide space for weekly Weight Watchers® program.
- LRH provides outreach to area elementary schools to education students on healthy eating. This is conducted by two of LRH’s registered nurses, one of which works in the LRH North Country Pediatrics practice.
- LRH Food & Nutrition Services provide healthy eating choices for each meal – to patients and visitors to LRH. Because of the affordable cost to eat at LRH, this number continues to increase.

**HOSPITAL IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:<sup>21</sup>**

- LRH will continue to offer nutritional counseling to patients and their families.
- LRH will continue to provide diabetes education to patients and their families on the importance of maintaining a healthy weight to control diabetes.
- Increase the number of fitness classes offered at LRH.
- Allocate resources to offer weekly Weight Watchers® classes at Littleton Regional Healthcare.

<sup>20</sup> This section of each need and the subsequent table presents the existing resources in response to IRS Form 990 h Part V B 1 c

<sup>21</sup> This section of each need presents the Implementation strategy that addresses each of the community health needs Reference to Schedule H (Form 990) Part V B 6 a., 6 b.

- LRH Food & Nutrition is participating in the NH Heal Program, a statewide project concerned about the rising obesity epidemic and the impact on health and wellness. HEAL is a healthy eating and active living intervention.

**ANTICIPATED RESULTS FROM HOSPITAL IMPLEMENTATION PLAN:**

- LRH expects to see a reduction in obesity in community members and staff.
- LRH expects to see an increase in community members participating in fitness and wellness classes.
- LRH will continue to offer free wellness fairs that will include a healthy eating and lifestyle component.

**LEADING INDICATORS HOSPITAL WILL USE TO MEASURE PROGRESS:**

- Number of outpatient clinical nutritionist sessions. 2012 = 177 value.
- Number of diabetes education sessions. 2012 = 150 value.
- Number of participants in Weight Watchers®. 2012 = 15 – 18 value.
- Number of employees counseled through employee wellness program. 2012 = 145 value.
- Number of fitness classes offered at LRH. 2012 = 4 value.

**LAGGING INDICATOR HOSPITAL WILL USE TO IDENTIFY IMPROVEMENT:**

- Reduction in the percent of Grafton County residents who come under the obesity category – 24% - National benchmark at 25%.
- Reduce the number of Grafton County residents who are physically inactive – 20% - National benchmark at 21%.

<b>Other Local Resources include the following:</b>
• Common Sense Fitness – 9 Eames Way, Littleton, NH 03561, 603-444-2772
• Evergreen Sports Center – 2572 US Route 302, Lisbon, NH 03585, 603-838-6511
• Fitness Authority – 564 Meadow Street, Littleton, NH 03561, 603-259-1810
• Weight Watchers – LRH New Medical Office Building Conference Room, 600 St. Johnsbury Road, Littleton, NH 03561, 603-444-7762 (Carrie Way, RN, and group contact).

**2. HEALTHCARE COST, QUALITY & COVERAGE** – Healthcare cost, quality and coverage is considered a significant need, and is one that LRH has developed the following Implementation Plan to address. Top listed concern by residents with “Insurance Problems” a secondary problem; percent of uninsured a health status issue not achieving national goal levels. According to the U.S. Census Bureau, Small Area Health Insurance Estimates - 2012, 14.3% percent of individuals under the age of 65 are uninsured or underinsured.

**PROBLEM STATEMENT:** There is a need to increase primary and specialty care, and to improve access to care for the uninsured or underinsured.

**HOSPITAL SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH recruited two pediatricians, two primary care (family medicine/internal medicine) physicians to meet the growing needs of the region served.

- LRH recruited physicians in the following specialty areas: urology, pulmonology, gastroenterology, rheumatology and orthopaedics to continue to expand specialty services.
- LRH offers free or discounted care to patients who may qualify for financial assistance.

#### **HOSPITAL IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- In 2012, LRH provided \$2,764,678 in charity care for individuals who were unable to pay for services. In fiscal year 2013, LRH expects to provide \$3,773,020 in charity care by end of year annualized.
- Provide specialty service coverage at area rural hospitals to increase access to specialty coverage beyond LRH's service area.
- Allocate resources to support charity care for the uninsured or underinsured. In 2012, LRH committed 2.37% of total gross patient service revenue to charity care in 2012, and expects this to increase to 2.9% in 2013.
- Focus on engaging health care users to improve outcomes and reduce health care costs, making healthcare provided by LRH more affordable.
- Providing a schedule of educational seminars to patients and interested residents.
- Providing free health screenings to patients who may not have access to healthcare.

#### **ANTICIPATED RESULTS FROM HOSPITAL IMPLEMENTATION PLAN:**

- **Contain healthcare rate increases not to exceed 4% annually.**
- Reduce the number of patients unable to access care due to their inability to pay.

#### **LEADING INDICATORS LRH WILL USE TO MEASURE PROGRESS:**

- Amount of charity care provided to uninsured and underinsured. 2012 = \$2,764,678 value.
- Number of patients who utilized charity care. 2012 = 1,892 value.

#### **LAGGING INDICATOR LRH WILL USE TO IDENTIFY IMPROVEMENT:**

- Uninsured/Underinsured patients in Grafton County according to the NH State Health Profile/NH DHHS, Division of Public Health Services – 19.4 percent of residents in the North Country region which includes Grafton and Coos counties. See a reduction in this percentage

#### **Other Local Resources include the following**

- ACHS – Ammonoosuc Community Health Services, a FQHC - Federally Qualified Health Center a special designation signifying the health center meets certain criteria and receives federal benefits.

3. **CANCER** – 2<sup>nd</sup> cause of death (but rate is lowest of NH counties); at expected national rates; major resident concern; outmigration to DHMC for treatment. LUNG CANCER and COLON



CANCER rates better than national peer averages; BREAST CANCER above national and peer average rates.

**PROBLEM STATEMENT:** Access and availability to early detection and treatment resources needed to enhance with emphasis on reducing breast cancer.

**HOSPITAL SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH recruited a Dartmouth Hitchcock Oncologist/Hematologist who provides service at LRH two days per week. Infusion services are available Monday – Friday.
- LRH moved the Oncology, Hematology & Infusion Center to a space three times its size – the new 3,800 square foot center provides a more comfortable atmosphere for patients and their families. The space will allow LRH to treat additional patients from within the region we serve.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

Increase community outreach for mammography services.

- Through a generous gift from a local spa, Fresh Salon and Day Spa, LRH has funds available for women in need of breast cancer screenings, mammograms and education.
- Fund raised through the Fresh Salon and Day Spa allowed LRH to purchase 100 copies of the 7<sup>th</sup> Edition of Breast Cancer Treatment Handbook – Understanding the disease, treatments, emotions and recovery from breast cancer, Judy C. Kneece, RN, OCN. These books are then given to patients who present with breast cancer.
- Host an LRH Goes Pink Event annually to educate women about breast cancer prevention, detection and treatment.
- Seek Federal and State grants to utilize funds that may be available for breast and cervical cancer screening.
- Continue to partner with area agencies who respond to the needs of women who have recently been diagnosed with breast cancer.

**ANTICIPATED RESULTS FROM HOSPITAL IMPLEMENTATION PLAN:**

- As patient volume needs indicate, LRH will consider increasing the number of days the Oncologist/Hematologist provides service at LRH.

**LEADING INDICATORS HOSPITAL WILL USE TO MEASURE PROGRESS:**

- Number of mammograms performed. 2012 = 2,380 value.
- Number of colonoscopies performed. 2012 = 768 value. Please note there will be a decrease in this number due to one gastroenterologist moving his services off site.

**LAGGING INDICATOR HOSPITAL WILL USE TO IDENTIFY IMPROVEMENT:**

- Track number of mammography's performed annually to ensure that the number served increases each year.
- Track number of colonoscopies performed annually to ensure that the number served increases each year.

Other Local Resources include the following
<ul style="list-style-type: none"> <li>Dartmouth Hitchcock Medical Center – 1 Medical Center Drive, Lebanon, NH 03756, 603-653-9000 (mainline), 800-639-6918 (cancer helpline).</li> </ul>
<ul style="list-style-type: none"> <li>DHMC – Norris Cotton Cancer Center, St. Johnsbury, VT, 802-473-4100</li> </ul>
<ul style="list-style-type: none"> <li>New Hampshire Breast Coalition, 18 Belle Lane, Lee, NH 0-3861, 603-659-3482.</li> </ul>
<ul style="list-style-type: none"> <li>Fresh Salon and Day Spa, Main Street, Littleton, NH 03561, (603) 259-3400</li> </ul>

**4. ALCOHOL ABUSE** – a concern by 52% of respondents; excessive drinking rate does not achieve national goal level.

**PROBLEM STATEMENT:** Additional resources need to become available to address this need.

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH offers emergency medical treatment and referral service.
- LRH provides conference room space for Alcohol Anonymous meetings that are held weekly. The cost of the space is valued at \$16.01 per sq. ft., 738 sq. ft. used weekly, with a value of \$1,188.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- LRH does not intend to develop and implementation plan for this need for the following reason(s):
  - Lack of expertise of competency (i.e., certain professional credential required and no such individual is in our immediate service area.
  - A lack of identified interventions to address the need.
  - Need is addressed by other organization or facility.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- LRH does not intend to develop and implementation plan for this need for the following reason(s):

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRSS:**

- None, as LRH will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations listed below.

**LAGGING INDICATOR HOSITAL WILL USE TO IDENTIFY IMPROVEMENT:**

- None

Other Local Resources include the following
<ul style="list-style-type: none"> <li>Alcoholics Anonymous – Littleton Regional Healthcare Conference Center, Conference Room 1 &amp; 2, 600 St. Johnsbury Road, Littleton, NH 03561, 800-593-3330 (NH Area Assembly)</li> </ul>
<ul style="list-style-type: none"> <li>Center for New Beginnings – 229 Cottage Street, Littleton, NH 03561, 603-444-6465</li> </ul>
<ul style="list-style-type: none"> <li>Littleton Police Department – 2 Kittridge Lane, Littleton, NH 03561, 603-444-7711</li> </ul>
<ul style="list-style-type: none"> <li>New Hampshire AL-ANON – First Congressional Church, 189 Main Street, Littleton, NH 03561, 603-645-9518 (New Hampshire AL-ANON)</li> </ul>

<ul style="list-style-type: none"> <li>• New Hampshire Department of Health and Human Services, Bureau of Drug and Alcohol Services – 129 Pleasant Street, Concord, NH 03301, 603-271-6110</li> </ul>
<ul style="list-style-type: none"> <li>• North Country Health Consortium – 262 Cottage Street, Suite 230, Littleton, NH 03561, 603-259-3700</li> </ul>
<ul style="list-style-type: none"> <li>• Tri-County Community Action Program, Alcohol and Other Drug Services – 361 School Street, Berlin, NH 03570, 603-752-7914</li> </ul>

**5. DRUG USE / YOUTHS** – 55% of residents list as major concern.

**PROBLEM STATEMENT:** Substance Abuse services oriented to youth need to increase as community problem awareness capabilities are enhanced.

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH offers emergency medical treatment and referral service

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- LRH does not intend to develop and implementation plan for this need for the following reason(s):
  - Lack of expertise of competency (i.e., certain professional credential required and no such individual is in our immediate service area.
  - A lack of identified interventions to address the need.
  - Need is addressed by other organization or facility.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- None

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRSS:**

- None, as LRH will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations listed below.

**LAGGING INDICATOR HOSITAL WILL USE TOP IDENTIFY IMPROVEMENT:**

- None

Other Local Resources include the following
<ul style="list-style-type: none"> <li>• North Country Health Consortium – Littleton Alcohol Tobacco and Other Drugs (ATOD) Task Force 262 Cottage Street, Suite 230, Littleton, NH 03561, 603-259-3700</li> </ul>
<ul style="list-style-type: none"> <li>• Littleton Police Department – 2 Kittridge Lane, Littleton, NH 03561, 603-444-7711</li> </ul>
<ul style="list-style-type: none"> <li>• New Hampshire Department of Health and Human Services, Bureau of Drug and Alcohol Services – 129 Pleasant Street, Concord, NH 03301, 603-271-6110</li> </ul>
<ul style="list-style-type: none"> <li>• Tri-County Community Action Program, Alcohol and Other Drug Services – 361 School Street, Berlin, NH 03570, 603-752-7914</li> </ul>
<ul style="list-style-type: none"> <li>• White Mountain Christian Church Teen Center, 70 Reddington Street, Littleton, NH 03561, 603-444-6517</li> </ul>
<ul style="list-style-type: none"> <li>• Center for New Beginnings – 229 Cottage Street, Littleton, NH 03561, 603-444-6465</li> </ul>
<ul style="list-style-type: none"> <li>• Boys &amp; Girls Club of the North Country – 2572 US Route 302, Lisbon, NH 03585, 603-838-5954</li> </ul>

**6. MENTAL HEALTH / SUICIDE** – Suicide rate better than national and peer averages; SELF REPORTED health status better than NH average approaching national goal level; mental health listed as 3rd ranked concern by residents, but does not appear as a ranked problem needing attention; only 10% report having a mental health professional advisor.

**PROBLEM STATEMENT:** There is a shortage of available, affordable mental health resources. An enhanced strategy is needed to implement proven Suicide Prevention techniques.

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH offers emergency medical treatment and referral service.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- LRH does not intend to develop and implementation plan for this need for the following reason(s):
  - Lack of expertise of competency (i.e., certain professional credentials required and no such individual is in our immediate service area.
  - A lack of identified interventions to address the need.
  - Need is addressed by other organization or facility.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- None

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRSS:**

- None, as LRH will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations listed below.

**LAGGING INDICATOR HOSITAL WILL USE TOP IDENTIFY IMPROVEMENT:**

- None

Other Local Resources include the following
<ul style="list-style-type: none"><li>• White Mountain Mental Health – 29 Maple Street, Littleton, NH 03561, 603-444-5358</li></ul>
<ul style="list-style-type: none"><li>• Center for New Beginnings – 229 Cottage Street, Littleton, NH 03561, 603-444-6465</li></ul>
<ul style="list-style-type: none"><li>• National Alliance on Mental Illness (NAMI) – All Saint’s Parish, 35 School Street, Littleton, NH 03561, 603-823-5374 (Annette Charbonneau, local contact), 800-242-6264 (NAMI)</li></ul>
<ul style="list-style-type: none"><li>• New Hampshire Department of Health and Human Services, Bureau of Behavioral Health – 129 Pleasant Street, Concord, NH 03301, 603-271-5000</li></ul>

**7. SMOKING** – rate does not achieve national goal level; youth smoking / tobacco use reported by 53% of residents as major concern, written comments cite an issue with tobacco use

**PROBLEM STATEMENT:** The number of local residents who smoke need to decline.

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH is a smoke-free campus.
- LRH offers patients a smoking cessation program, and access to resources to assist.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- LRH does not intend to develop and implementation plan for this need for the following reason(s):
  - Lack of expertise of competency (i.e., certain professional credential required and no such individual is in our immediate service area.
  - A lack of identified interventions to address the need.
  - Need is addressed by other organization or facility.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- A decrease in patients who smoke.

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRSS:**

- None

**LAGGING INDICATOR HOSITAL WILL USE TOP IDENTIFY IMPROVEMENT:**

- None.

Other Local Resources include the following
<ul style="list-style-type: none"><li>• American Lung Association of New Hampshire – 1800 Elm Street, Unit D, Manchester, NH 03104, 603-369-3977</li></ul>
<ul style="list-style-type: none"><li>• The New Hampshire Tobacco Hotline – <a href="http://www.trytostopnh.org">www.trytostopnh.org</a>, 800-784-8669</li></ul>
<ul style="list-style-type: none"><li>• North Country Health Consortium – 262 Cottage Street, Littleton, NH 03561, 603-259-3700</li></ul>

**8. CORONARY HEART DISEASE** – leading cause of death; however, low Grafton rate ranks it #9 among NH 10 counties; lower than expected rate nationally; another study shows rate 8% above expectations; rate exceeds peer average; another study places heart disease mortality in second highest national classification; hospitalization rate in lowest national classification; Medicare patients discharged to home in highest national classification

**PROBLEM STATEMENT:** The number of heart related deaths needs to decline. Diagnostic and medical treatment resources need to be maintained. Prevention efforts should be pursued on a broader scale.

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH provides free blood pressure and cholesterol screenings to community members in the regions served.
- LRH provides free blood pressure and cholesterol screenings to community organizations.
- Track number of employees who participate in employee wellness programs.
- LRH promotes exercise through on-campus fitness classes.
- LRH promotes exercise education in the LRH Health E-News monthly electronic newsletter distributed to patients and internally.
- There are currently two cardiologists on the Medical Staff at LRH. A full time independent practitioner and part time DHMC provider, both serve patients at LRH.
- LRH offers smoking cessation information to all patients upon discharge.

- LRH provides resources to support Phase III Cardiac Rehabilitation services and education. LRH provides two-classer per day, led by a registered nurse certified in advanced health and fitness.
- LRH's Cardiac Rehabilitation Services provides a community wide free educational service through distribution and availability of health and wellness educational materials.
- LRH Gale Medical Library – Patient and Family Center provides access to free health related information.

#### **LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- Market wellness programs to companies throughout the regions serviced by LRH.
- Implement a “Healthy Eating Program” for patients, visitors and employees.
- Implement a Senior Citizen Free Screening for Coronary Health.

#### **ANTICIPATED RESULTS FROM HOSPITAL IMPLEMENTATION PLAN:**

- Improved rate of deaths related to cardiac issues.

#### **LEADING INDICATORS LRH WILL USE TO MEASURE PROGRESS:**

- Number of community members who participated in free cardiac related health screenings provided by LRH (Women's Health Conference). 2012 = 150 value.
  - Compare numbers annually as they are collected to ensure LRH continues to provide maximum coverage.
- Number of patient visits in LRH cardiac rehabilitation. 2012 = 2,185 value.
- Number of patients who received cardiac stress testing. 2012 = 293 value.
- Number of patients who received a Halter monitor for cardiac rhythm assessment in a 24-hour period. 2012 = 164 value.
- Number of Echocardiograms performed at LRH. 2012 = 301 value.
- Number of EKG's performed at LRH. 2012 = 1,030 value.

#### **LAGGING INDICATOR LRH WILL USE TO IDENTIFY IMPROVEMENTS:**

- Grafton County Rate of death per 100,000 due to heart disease moves closer to the state rate; 2012 value = State – 150.1; LRH – 178.1.

Other Local Resources include the following	
•	American Heart Association of NH – 2 Wall Street, Manchester, NH 03101, 603-669-5833
•	New England Heart Institute at Catholic Medical Center – 100 McGregor Street, Manchester, NH 03102, 603-669-0413
•	Ammonoosuc Community Health Services – 25 Mt. Eustis Road, Littleton, NH 03561, 603-444-2464
•	Dartmouth Hitchcock Medical Center – 1 Medical Center Drive, Lebanon, NH 03756, 603-650-5000

#### **Other Identified Needs**

**9. POVERTY** – 11.6% of residents live in poverty; only 4.1% have food stamps



**PROBLEM STATEMENT:** A determination is needed to identify and implement actions to reduce the number of residents living in poverty or otherwise without resources.

**Other Local Resources identified during the CHNA process include the following**

- Affordable Housing Education and Development (AHEAD) – 161 Main Street, Littleton, NH 03561, 603-444-1377
- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464
- Town of Littleton Welfare Office – 125 Main Street, Suite 200, Littleton, NH 03561, 603-444-3996

**10. PALLIATIVE CARE** – (focus on relief from serious illness rather than curative) programs and HOSPICE (end of life) 4 programs in county

**PROBLEM STATEMENT:** Palliative services should be maintained as appropriate in the County

**Other Local Resources identified during the CHNA process include the following**

- North Country Home Health & Hospice Agency – 536 Cottage Street, Littleton, NH 03561, 603-444-5317
- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464

**11. SOCIAL SUPPORT** – inadequate does not achieve national goals

**Problem Statement:** Efforts are needed to reduce poor family support, increase contact with others, and enhance involvement in community like in order to decrease risk factors associated with increased morbidity and early mortality.

**Other Local Resources identified during the CHNA process include the following**

- Granite State Independent Living – 76 Main Street, Littleton, NH 03561, 603-228-9680.
- Tri-County Community Action Program, Head Start of Littleton – 646 Union Street, Littleton, NH 03561, 603-444-6022
- Lafayette Center – 93 Main Street, Franconia, NH 03580, 603-23-5502
- Morrison Nursing Home – 6 Terrace Street, Whitefield, NH 03598, 603-837-2514
- North Country Health Consortium – 262 Cottage Street, Littleton, NH 03561. 603-259-3700

**12. PHYSICIANS** – Physician supply at about national average; midlevel use above national average; internet consultations below national utilization; ambulatory surgery above national average use

**PROBLEM STATEMENT:** An adequate supply of primary and specialty physicians is needed to allow the majority of health care services to be met without extensive travel.

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- Physician recruitment development plan.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

1. In 2012, LRH committed financial resources to bring on two full time internal medicine physicians and two pediatricians.
- LRH also committed to recruiting the following specialists: Oncology/Hematology, Pulmonology, Sleep Medicine, Urology, Gastroenterology, Rheumatology and Orthopaedics.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- Continual education provided to assist clinical personnel, and patients with subjects related to end-of-life care.

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRESS:**

- In an effort to share resources, LRH will bring a dermatologist to LRH who is employed by DHMC. He will provide services for the region served by LRH.
- LRH may recruit an endocrinologist in 2014.

**LAGGING INDICATOR HOSITAL WILL USE TOP IDENTIFY IMPROVEMENT:**

- Increase the presence of primary care and specialty care through a sharing of resources with other area hospitals, i.e., urological services provided at Weeks Hospital; ENT services at NVRH; Orthopaedic services at five locations of The Alpine Clinic

**Other Local Resources identified during the CHNA process include the following**

- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464

**13. PREVENTION** – routing stress test 16% below average; vaccination not a concern

**PROBLEM STATEMENT:** Educational resources about disease conditions, risk evaluation and proven prevention self administered activity should be increased.

**LHR SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH offers a variety of health and wellness educational fairs both on-site and throughout the communities served.
- LRH offers a monthly wellness newsletter LRH Health E-News that contains health related information and resources.
- LRH's Gale Medical Library - Anna Connor Patient and Family Resource Center is a resource center for the communities served by LRH and contains information on a wide range of preventive medicine.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- Increase community outreach offering free health and wellness fairs to include preventative medicine.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- Increased utilization of free screenings and information available.

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRSS:**

- Number of people who attend health and wellness fairs. 2012 = 350 value (WHC only).
- Number of people who subscribe to the LRH Health E-News. 2012 = 1,689 value.
- Number of articles provided to patients who visit the Gale Medical Library – Anna Connors Patient and Family Resource Center. 2012 = 313 Value.



**LAGGING INDICATOR HOSITAL WILL USE TOP IDENTIFY IMPROVEMENT:**

- Decrease the routing stress results of 2012; = 16% below average

**Other Local Resources identified during the CHNA process include the following**

- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464
- North Country Health Consortium – 262 Cottage Street, Littleton, NH 03561, 603-259-3700

**14. CHILD HEALTHCARE** – residents note as a secondary problem needing to be solved, specific issues not receiving majority support as a major child health problems include: vaccination; alcohol use; bullying; teen births

**PROBLEM STATEMENT:** Parenting resources about child and adolescent health issues need to increase in order to prevent development of problems.

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH hired two full time and one part time pediatrician.
- LRH hired an internal medicine physician who specializes in adolescent services.
- LRH partners with the New Hampshire Department of Health and Human Services – Immunization Program to ensure that pediatric patients receive immunizations.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- Actively participate in the NH Immunization Program.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- In 2013, LRH received certification from the NH Immunization Program for having more than 90% of babies up to two years old vaccinated on time.
  - Monitor results annually as they are collected.

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRSS:**

- LRH will actively engage in implementation efforts related to immunization, but will monitor and support the efforts taken by others, including the organizations listed below in other efforts.

**LAGGING INDICATOR HOSITAL WILL USE TOP IDENTIFY IMPROVEMENT:**

- Number of babies from infancy to two years immunized increased annually to reach 100%.

**Other Local Resources identified during the CHNA process include the following**

- New Hampshire Department of Health and Human Services – Immunization Program - 129 Pleasant Street, Concord, NH, 03301-3852
- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464
- Affordable Housing Education and Development (AHEAD) – 161 Main Street, Littleton, NH 03561, 603-444-1377
- Town of Littleton Welfare Office – 125 Main Street, Suite 200, Littleton, NH 03561, 603-444-3996

**15. MATERNAL AND CHILD HEALTH** – BIRTHS TO WOMEN AGE 40 TO 54 – rates worse than national and peer averages; BIRTHS TO UNMARRIED WOMEN & TO WOMEN UNDER AGE 18 – rates are better than national and peer averages; INFANT MORTALITY – VERY LOW BIRTH WEIGHT, INFANT MORTALITY, WHITE non HISPANIC INFANT MORTALITY, POST-NEONATAL INFANT MORTALITY, LOW BIRTH WEIGHT (also below NH average and approach national goal levels), PREMATURE BIRTHS – all better than national and peer rate averages; NEONATAL INFANT MORTALITY – worse than peer rate average

**PROBLEM STATEMENT:** Educational and treatment resources for maternal and child health including expecting advanced age women need to increase and preventive efforts to reduce neonatal infant mortality also needs enhancement.

**Other Local Resources identified during the CHNA process include the following**

- New Hampshire Department of Health and Human Services - 129 Pleasant Street, Concord, NH, 03301-3852
- Dartmouth Hitchcock Medical Center – 1 Medical Center Drive, Lebanon, NH 03756, 603-650-5000
- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464

**16. DIABETES** – 7th cause of death; lowest NH rate; residents cite as major concern; rate is in 2nd lowest national decile of all counties indicating it is not a problem

**PROBLEM STATEMENT:** Diabetic education and treatment resources should be expended to continue to reduce the impact of this disease.

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- LRH provides diabetes education services to patients. In 2012, LRH's certified diabetes educator counseled 150 patients.
- LRH provides fitness and wellness classes to encourage healthy activities.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- Increase community outreach on diabetes education and management.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- Increased utilization of diabetes education provided by a certified diabetes educator.

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRESS:**

- Number of diabetes education sessions provided.
  - Compare numbers from each year as they are collected.

**LAGGING INDICATOR HOSPITAL WILL USE TO IDENTIFY IMPROVEMENT:**

- Increase number of patients served.

**Other Local Resources identified during the CHNA process include the following**

- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464

- American Diabetes Association – 10 Speen Street, Framingham, MA 01701, 617-482-4580

**17. SINGLE PARENT HOUSEHOLDS** – number of children in such living environments do not approach national desired goal levels.

**PROBLEM STATEMENT:** Efforts are needed to support single parents.

**Other Local Resources identified during the CHNA process include the following**

- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464
- New Hampshire Catholic Charities – 41 Cottage Street, Littleton, NH 03561, 603-444-7727

**18. ACCIDENTS** – 4th cause of death; (but rate is lower than all but 2 NH counties); lower than expected rate; MOTOR VEHICLE INJURY better than national or peer average; UNINTENTIONAL INJURY worse than peer average

**PROBLEM STATEMENT:** A determination is needed to identify and implement actions to reduce the number of accidental injuries and deaths.

**Other Local Resources identified during the CHNA process include the following**

- Dartmouth Hitchcock Medical Center – 1 Medical Center Drive, Lebanon, NH 03756, 603-650-5000
- Littleton Police Department – 2 Kittridge Lane, Littleton, NH 03561, 603-444-7711
- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464

**19. CHRONIC COPD / (LUNG DISEASE) / PULMONARY** – 3rd cause of death; lowest rate among NH counties; noted as a major problem needing resolution by area residents.

**PROBLEM STATEMENT:** Efforts to reduce death from pulmonary conditions need to be enhanced.

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- Increase community outreach on chronic obstructive pulmonary disease.
- Offer free spirometry screenings at wellness fairs.
- Offer free spirometry screenings to area businesses.
- Offer free spirometry screening to LRH employees.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- LRH hired a full time pulmonologist in 2012.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- Increased education and awareness on chronic pulmonary obstructive pulmonary disease.

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRSS:**

- Number of spirometry tests performed internally and externally.
  - Compare numbers from each year as they are collected.

**LAGGING INDICATOR HOSITAL WILL USE TOP IDENTIFY IMPROVEMENT:**

- Continued education and screenings to reduce the number of deaths related to COPD.

**Other Local Resources identified during the CHNA process include the following**

- American Lung Association of New Hampshire – 1800 Elm Street, Unit D, Manchester, NH 03104, 603-369-3977

**20. LIFE EXPECTANCY** – men and women in highest (best) national quintile; Male life expectancy equal to top international comparisons; Female life expectancy 10 years behind top performing international comparisons **PREMATURE DEATH** rate better than national goal.

**Problem Statement:** Efforts to determine causes of death prior to age 75 needs to be identified and appropriate actions initiated

**Other Local Resources identified during the CHNA process include the following**

- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464

**21. ALZHEIMER'S** – 6th cause of death; 4th highest county rate in NH.

**PROBLEM STATEMENT:** Resources designed to enhance awareness of Alzheimer's and support memory impairments should increase

**Other Local Resources identified during the CHNA process include the following**

- Alzheimer's Association of New Hampshire – 5 Bedford Farms Drive, Bedford, NH 03110, 603-606-6590
- Tri-County Community Action Program, North Country Elders Program – 610 Sullivan Street, Berlin, NH 03570, 603-752-3010

**22. SEXUALLY TRANSMITTED DISEASE** – rate does not achieve national goal level.

**PROBLEM STATEMENT:** More residents need awareness of sexually transmitted diseases including condition management education and treatment.

**Other Local Resources identified during the CHNA process include the following**

- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464
- New Hampshire Department of Health and Human Services Sexually Transmitted Disease & HIV Prevention Program – 29 Hazen Drive, Concord, NH 03301, 603-271-4502
- Littleton School District (SAU 84) – 102 School Street, Littleton, NH 03561, 603-444-5215

**23. CHRONIC OSTEOPOROSIS** – above national average rate of occurrence.

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

**LRH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:**

- There are five orthopaedic surgeons on LRHs medical staff, each one performing procedures on major body parts including hips, knees, shoulders, and all upper extremities.

**LRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:**

- LRH provides bone density screening to patients.
- LRH physicians take into consideration lifestyle, medications, and age when assessing if a bone density scan is necessary.
- LRH offers Bone Builders a proven exercise routine to improve and in some cases reverse osteoporosis and osteopenia.

**ANTICIPATED RESULTS FROM LRH IMPLEMENTATION PLAN:**

- Decrease in the number of patients who present with osteoporosis.

**LEADING INDICATOR LRH WILL USE TO IDENTIFY PROGRSS:**

- Number of bone density scans done annually.
  - Compare numbers each year as they are collected.

**LAGGING INDICATOR HOSITAL WILL USE TOP IDENTIFY IMPROVEMENT:**

- Decrease in the number of patients presenting with chronic osteoporosis; 2012 rate 10.5% of the national average rate of 108.2%.

**Other Local Resources identified during the CHNA process include the following**

- ACHS – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464

**24. STROKE** – 5th cause of death; rate ranks the County as second worse in NH; rate lower than expected; historically, rate is above national average; rate is better than national and peer averages.

**PROBLEM STATEMENT:** The number of local residents having strokes should decline.

**Other Local Resources identified during the CHNA process include the following**

- Ammonoosuc Community Health Services – 25 Mount Eustis Road, Littleton, NH 03561, 603-444-2464
- Dartmouth Hitchcock Medical Center – 1 Medical Center Drive, Lebanon, NH 03756, 603-650-5000

## Overall Community Need Statement and Priority Ranking Score:

### Significant Needs where LRH Has an Implementation Plan

1. OBESITY/OVERWEIGHT
2. HEALTHCARE COST, QUALITY & COVERAGE
3. CANCER
8. CORONARY HEART DISEASE

### Significant Needs where LRH Does Not Have an Implementation Plan<sup>22</sup>

4. ALCOHOL ABUSE
5. DRUG USE / YOUTHS
6. MENTAL HEALTH / SUICIDE
7. SMOKING

### Other Identified Needs where LRH Has an Implementation Plan

12. PHYSICIANS
13. PREVENTION
14. CHILD HEALTHCARE
16. DIABETES
19. CHRONIC COPD / (LUNG DISEASE) / PULMONARY
23. CHRONIC OSTEOPOROSIS (bone disease)

### Other Identified Needs where LRH Does Not Have an Implementation Plan

9. POVERTY
10. PALLIATIVE CARE
11. SOCIAL SUPPORT
15. MATERNAL and CHILD HEALTH
17. SINGLE PARENT HOUSEHOLDS
18. ACCIDENTS
20. LIFE EXPECTANCY
21. ALZHEIMER'S
22. SEXUALLY TRANSMITTED DISEASE
24. STROKE

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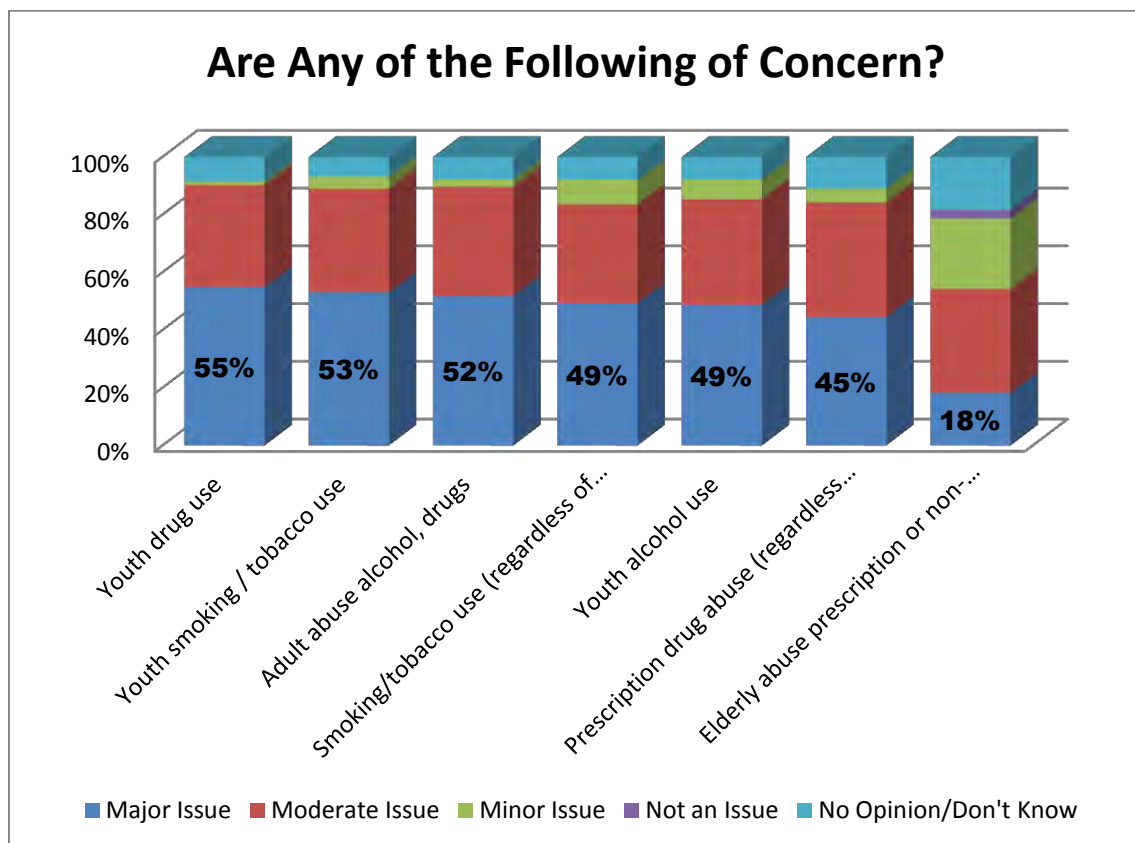
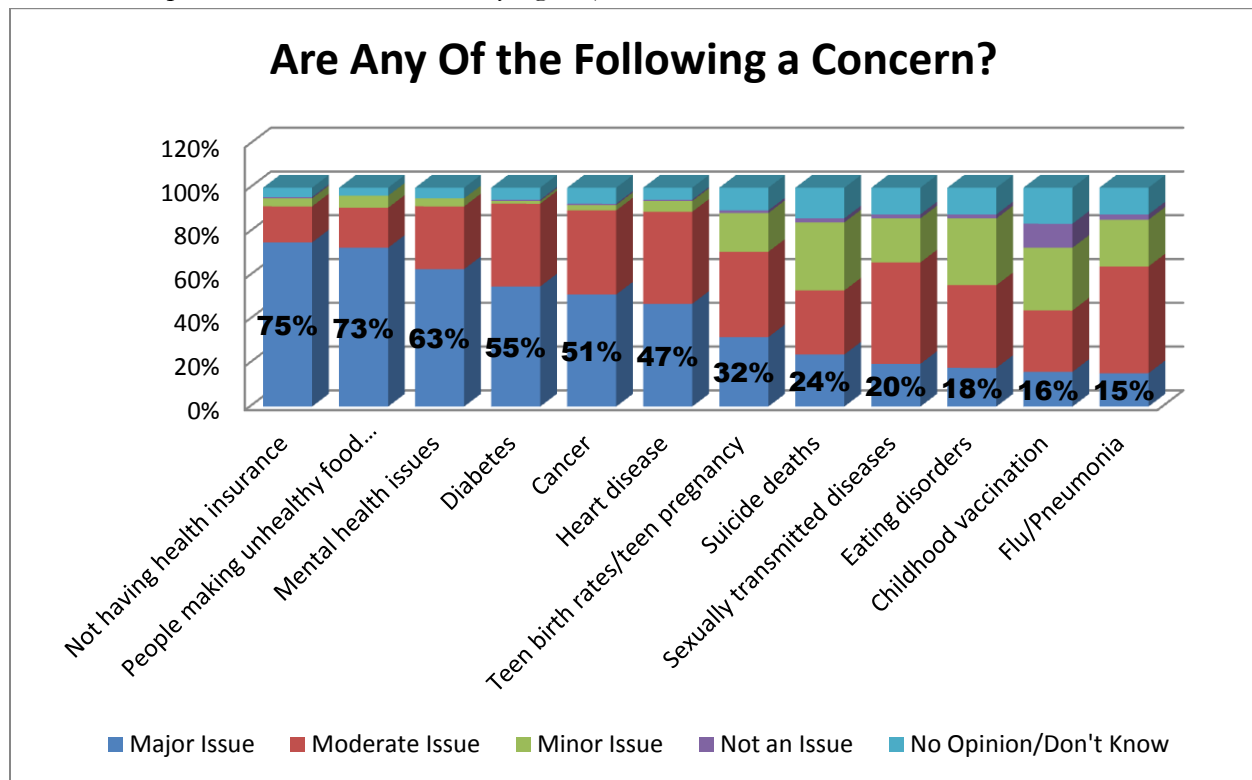
<sup>22</sup> Provides reference to specific Significant Needs without Implementation Plan reasoning IRS Form 990 h Part V B 7

## APPENDICES

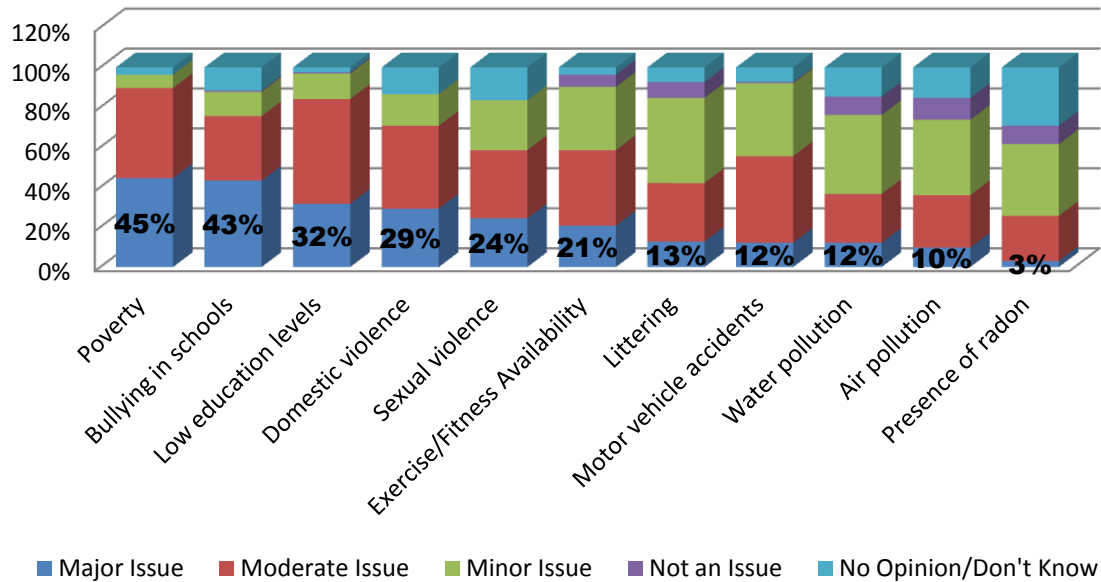




The second question focused on identifying major concerns:

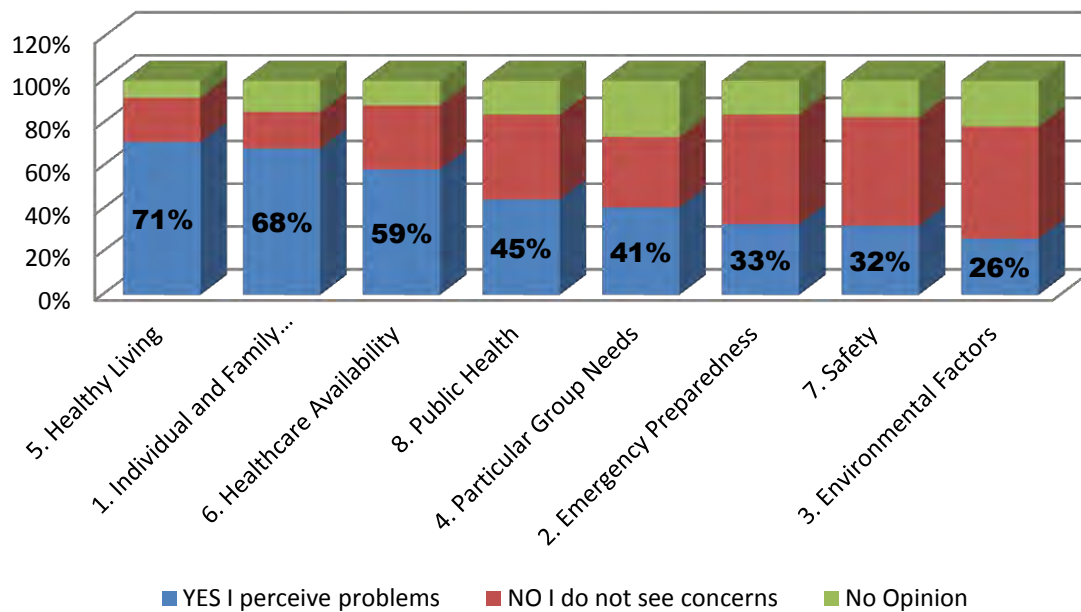


## Are Any of the Following of Concern?

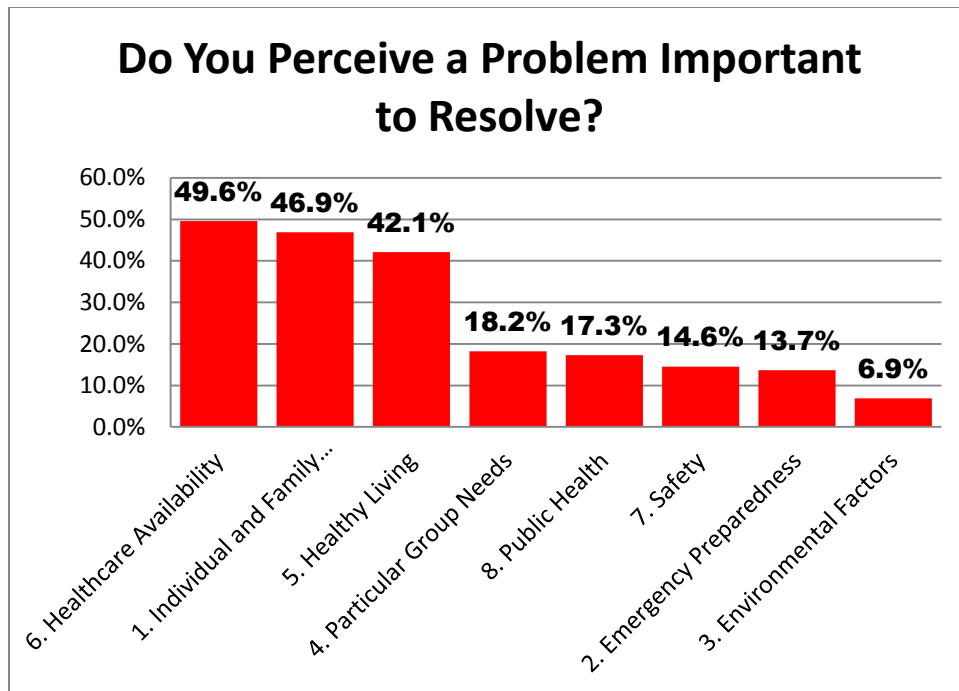


We then asked about the experiences of the area resident.

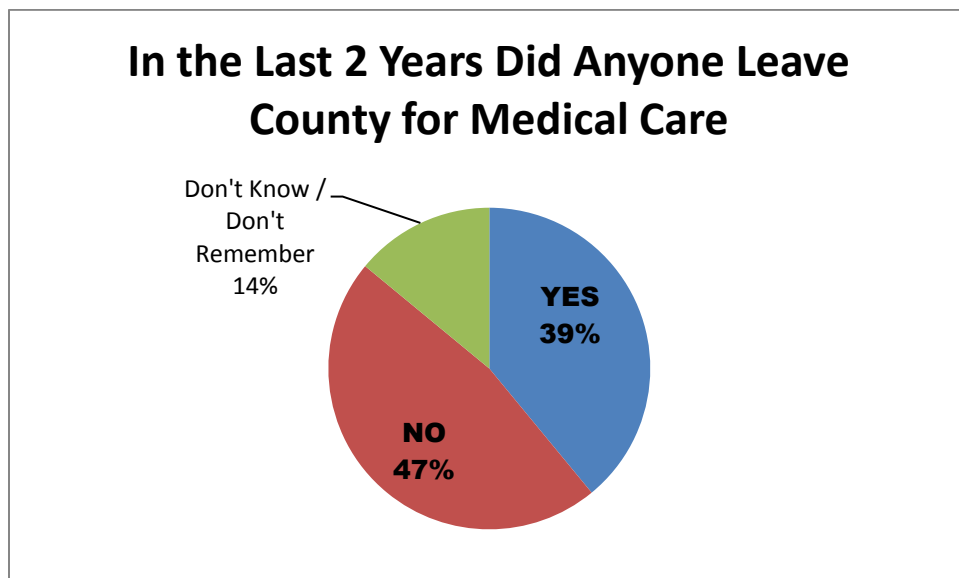
## During the Last 2 Years, Have You Experienced a Problem?







We asked if people left the area in search of care and received the following information.



- 
- Proprietary

- I just can't emphasize enough on how the drugs are out of control in this county. I am also very disappointed in the health insurance offered in a healthcare facility. I don't always make needed appointments because the deductible is so high and hard to reach when you need regular appointments. I don't need any surgeries at this time, so meeting my deductible is hard;
- I just want to say even though our premiums are low, I have a \$3000 deductible on top of my premiums. My husband has a \$500 deductible;
- I think if a person has an immediate family member with celiac disease, there should be more paid for efforts to do genetic testing, especially if they present with some classic symptoms;
- I think that the people that you need to survey will not have access to this particular survey. Using the Internet does not allow the lower income and or elderly to participate. Also, the marital status question is an example of a question that does not acknowledge today's society, where many households live in a committed relationship without marriage;
- I think the hospitals have a unique opportunity for directing people into the right direction for preventing disease and encouraging wellness;
- In my opinion, health care should cover all preventative procedures, office visits, etc. It makes more sense to pay now than to pay later;
- Increase psychiatrist care in the area;
- It's important to provide required health services without requiring citizens to drive long distances, not only due to the price of fuel, but also, due to the ever increasing demands for employee productivity and limited time off available for those that are employed ("over-employed") and access for elderly cared for by the adult offspring (sandwich generation) is becoming a much larger issue in this rural community. The demands on the middle age middle class are increasing to crisis levels, causing families to avoid basic care that is recommended and received by those that are unemployed or on public assistance;
- Monthly payment plan options for people with high deductible insurance. I tried to set up a payment plan and was told it was NOT enough money and was refused. Plus, I have medical bills at 4 different treatment locations - all in collections!
- MORE AFFORDABLE HEALTH CARE INSURANCE WITH LESS PREMIUMS;
- Need to go to Dartmouth for surgeries or critical care;
- None;
- Sometimes the providers we have access to are not always what I would consider grade "A" quality. In many cases, the specialty clinics provide one person to cover, and then the next choice is 30-40 miles away, and that is one choice only. In order to receive a choice in your

own health care, you need to drive over 100 miles to an area you are not familiar with. Facilities need to either start hiring grade "A" providers, or hire more of a specialty in general;

- Survey assumes health insurance. What of those who cannot afford insurance but need health care?
- The word 'affordable' is used in one of the questions when describing daycare. It is affordable as long as my husband and I work. The daycare is over half my paycheck every two weeks!
- There is insufficient mental health treatment/resources in this community;
- This survey does not address households with long-term unemployment. My partner has been out of work for three years. Even though my income is adequate, it has been draining to absorb the loss of income and continue to meet expenses that were incurred when my partner was fully employed. There are many people in this community who have lost income and are struggling to meet financial commitments with less income. This has a dramatic affect on accessing health care services and health promoting activities;
- This survey was entirely too long and that is why you probably will not get as many returned as you would like; and
- Your survey references "mental health counselor". You need to be aware that lack of access to a psychiatric physician cannot be bridged or replaced by access to a psychologist or mental health counselor (PhD or LDAC or MSW). We have no lack of access to non-physician mental health (plenty at WMMH, ACHS and Center for New Beginnings), but we have very poor access to psychiatry. Reference letter from medical director for WMMH Dr. Eric Van Leuven 9/26/11 outlining decrease in availability to psychiatry, sent to all area medical staff. Your survey should include specific questions about access to a psychiatrist.

## Appendix B – Process to Identify and Prioritize Community Need<sup>24</sup>

Answer Options	Number of Local Experts Responding	Response Total	Percent of Response	Cummulative Response	Point Break from Prior Response	Priority Determination
1. OBESITY/OVERWEIGHT	16	250	11.9%			<b>High Priority</b>
2. HEALTHCARE COST, QUALITY & CO	15	180	8.6%	20.5%	70	
3. CANCER	14	142	6.8%	27.2%	38	
4. ALCOHOL ABUSE	14	140	6.7%	33.9%	2	
5. DRUG USE / YOUTHS	14	138	6.6%	40.5%	2	
6. MENTAL HEALTH / SUICIDE	12	127	6.0%	46.5%	11	
7. SMOKING	12	127	6.0%	52.6%		
8. CORONARY HEART DISEASE	12	119	5.7%	58.2%	8	
9. POVERTY	11	102	4.9%	63.1%	17	<b>Low Priority</b>
10. PALLIATIVE CARE	11	97	4.6%	67.7%	5	
11. SOCIAL SUPPORT	11	94	4.5%	72.2%	3	
12. PHYSICIANS	8	88	4.2%	76.4%	6	
13. PREVENTION	10	82	3.9%	80.3%	6	
14. CHILD HEALTHCARE	10	78	3.7%	84.0%	4	
15. MATERNAL and CHILD HEALTH	6	64	3.0%	87.0%	14	
16. DIABETES	9	51	2.4%	89.5%	13	
17. SINGLE PARENT HOUSEHOLDS	7	46	2.2%	91.7%	5	
18. ACCIDENTS	9	38	1.8%	93.5%	8	
19. CHRONIC COPD / (LUNG DISEASE)	8	30	1.4%	94.9%	8	
20. LIFE EXPECTANCY	7	28	1.3%	96.2%	2	
21. ALZHEIMER'S	7	24	1.1%	97.4%	4	
22. SEXUALLY TRANSMITTED DISEASES	7	24	1.1%	98.5%		
23. CHRONIC OSTEOPOROSIS (bone di	6	17	0.8%	99.3%	7	
24. STROKE	6	14	0.7%	100.0%	3	
<b>Total</b>		2100	100%			

### Individuals Participating as Local Expert Advisors

Local Expert Elaine Belanger  
Organization North Country Health Consortium  
Position Public Health Program Coordinator  
Contact Information ebelanger@nchcnh.org  
Area of Expertise Public Health

Local Expert Ray Burton  
Organization Elected Official  
Position County Commissioner, Executive Councilor- District One  
Contact Information ray.burton@myfairpoint.net  
Area of Expertise served 34 years and Councilor and 22 years as County Commissioner

Local Expert Elaine Bussey  
Organization North Country Home health & Hospice Agency  
Position Executive Director  
Contact Information ebussey@nchha.com  
Area of Expertise Home Health & Hospice

Local Expert Sue Manah Buteau  
Organization North Country Home Health & Hospice Agency  
Position Bereavement Counselor and Hospice Volunteer Coordinator  
Contact Information sbuteau@nchha.org  
Area of Expertise hospice and bereavement

<sup>24</sup> Responds to IRS Schedule H (990) Part V B 1. g. and V B 1. h.



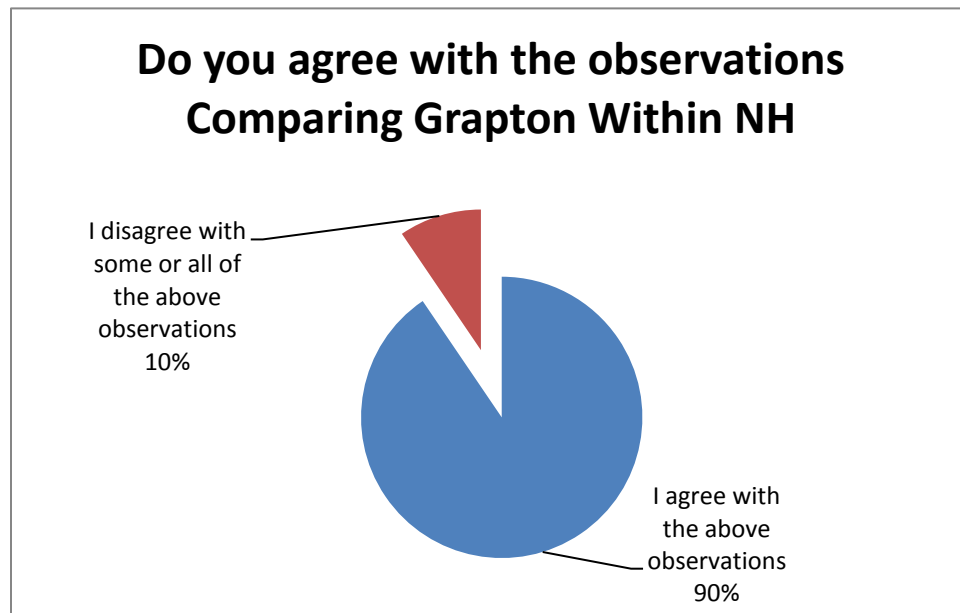
Local Expert	Gail Clark
Organization	LRH
Position	Dir of Mkt & Comm Relations
Contact Information	gclark@littletonhospital.org
Area of Expertise	Community Wellness
Local Expert	William K. Demers Jr.
Organization	Sau 84, Hugh Gallen Career and Technical Center
Position	Health Science Technologies Instructor
Contact Information	bdemers@littletonschools.org
Area of Expertise	College and career readiness for health related jobs
Local Expert	Monica Erwin
Organization	CGI Employee Benefits Group
Position	Account Executive
Contact Information	merwin@cgibenefitsgroup.com
Area of Expertise	employee benefits
Local Expert	Nancy Frank
Organization	North Country Health Consortium
Position	Executive Director
Contact Information	nfrank@nchcnh.org
Area of Expertise	public health
Local Expert	Amy Holmes
Organization	North Country Health Consortium
Position	Community & Public Health Director
Contact Information	aholmes@nchcnh.org
Area of Expertise	wellness & prevention efforts, emergency preparedness
Local Expert	Russ Gaitskill
Organization	Garnet Hill
Position	CEO
Contact Information	rgaitskill@garnethill.com
Area of Expertise	large employer
Local Expert	Gordie Johnk
Organization	Lafayette Regional School
Position	Principal
Contact Information	gjohnk@lafayetteregional.org
Area of Expertise	Principal of a local elementary school and resident of the area for the past 32 years.
Local Expert	Inga Johnson
Organization	North Country Home Health and Hospice Agency
Position	Director of Hospice & Palliative Care Services
Contact Information	ijohnson@nchha.com
Area of Expertise	Hospice and Palliative Care

Local Expert	Phil Lawson
Organization	ACHS
Position	MD
Contact Information	phil.lawson@achs-inc.org
Area of Expertise	clinical care
Local Expert	Michele Leonard
Organization	Lafayette Regional School
Position	RN
Contact Information	mleonard@lafayetteregional.org
Area of Expertise	school nurse
Local Expert	Joe Mercieri
Organization	Littleton Fire Department
Position	Chief
Contact Information	jmercieri@littletonfirerescue.org
Area of Expertise	Public Safety/Emergency Management
Local Expert	Kathleen Metz
Organization	American Cancer Society
Position	Community Executive
Contact Information	kathy.metz@cancer.org
Area of Expertise	Non profit/health
Local Expert	Gail Minor-Babin
Organization	Gallen Career & Technical Center
Position	LNA Program Coordinator, Health Science Technologies Teacher
Contact Information	gminorbabin@littletonschools.org
Area of Expertise	Nursing Education - Occupational Health
Local Expert	Edward D Shanshala II
Organization	Ammonoosuc Community Health Services, Inc.,
Position	CEO
Contact Information	Ed.Shanshala@ACHS-Inc.ORG
Area of Expertise	FQHC, Academic Medical Center, Home Health and Hospice, Pharmacology Research
Local Expert	Chad Stearns
Organization	Littleton Area Chamber of Commerce
Position	Executive Director
Contact Information	cstearns@littletonareachamber.com
Area of Expertise	community leader
Local Expert	Paul J. Smith
Organization	Littleton Police Department
Position	Chief of Police
Contact Information	chief@littletonpd.org
Area of Expertise	Law Enforcement

Local Expert	Amy Venezia
Organization	ACHS
Position	Patient Navigator
Contact Information	amy.venezia@achs-inc.org
Area of Expertise	area resources for patients

### Advice Received from Local Experts

Q. Do you agree with the observations formed about the comparison of Grafton County to all other New Hampshire counties?



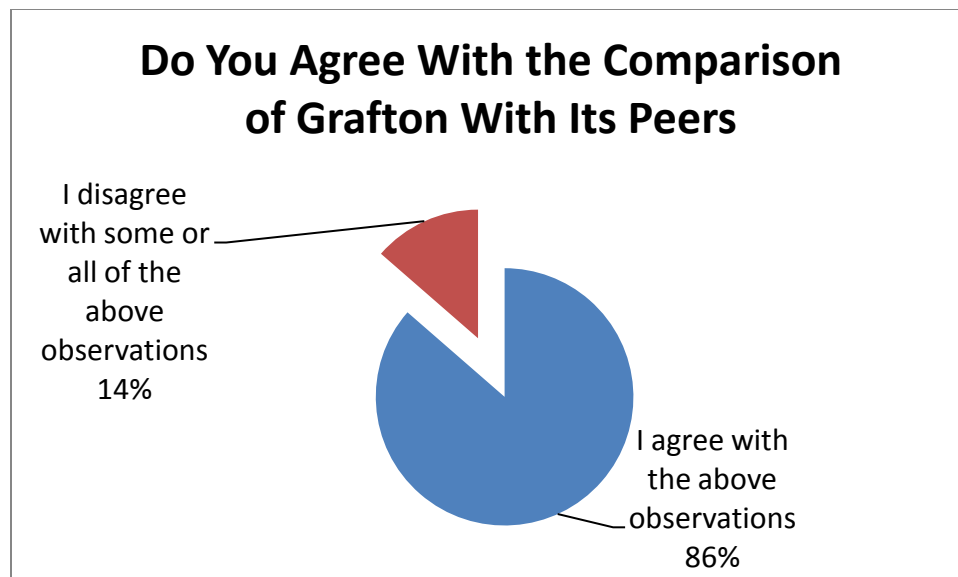
#### Clarifying Comments

- Alcohol and illegal drug use should be added to the list;
- Grafton County as a whole is considered to be doing very well; however, Northern Grafton County has some gaps, as listed above;
- I agree somewhat, but I get lots of requests for those who are down and out with a lack of housing, and sometimes with no food. Thanks to food pantries and community action agencies.
- I agree with the above mentioned health factors ; however the following conditions certainly need improvement: Adult Obesity and Physical Inactivity;
- I believe that the results of the above survey findings would be significantly different if Grafton County were divided into northern and southern regions;
- I believe that underlying a significant number of chronic health issues is an underlying body mass index that is not optimal in combination with an increasingly sedentary population. Although this has significant quality of life and health care associated costs, this cannot be

solved solely within the realm of healthcare provision that will for the most part be reactionary rather than proactive. This will take individual accountability, community effort on the whole, and a one less bite, one more step approach;

- There are small hospitals in Grafton County serving a mixed (including very low income) population. Figures may be somewhat distorted by the fact that Dartmouth Hitchcock Medical Center is in a more affluent area serving greater numbers of people;
- There is a large variance between the health of those in the Hanover area (elevated socioeconomic status) and those in the North Country (Littleton catchment). I suspect that much of the north of the notch population except the Franconia/Sugar Hill area may be closer to Coos County in terms of health outcomes, but this is washed out from the overall Grafton county averages; and
- There is limited community supports for these issues in Grafton County.

Q. Do you agree with the observations formed about the comparison of Grafton County to its Peer counties?

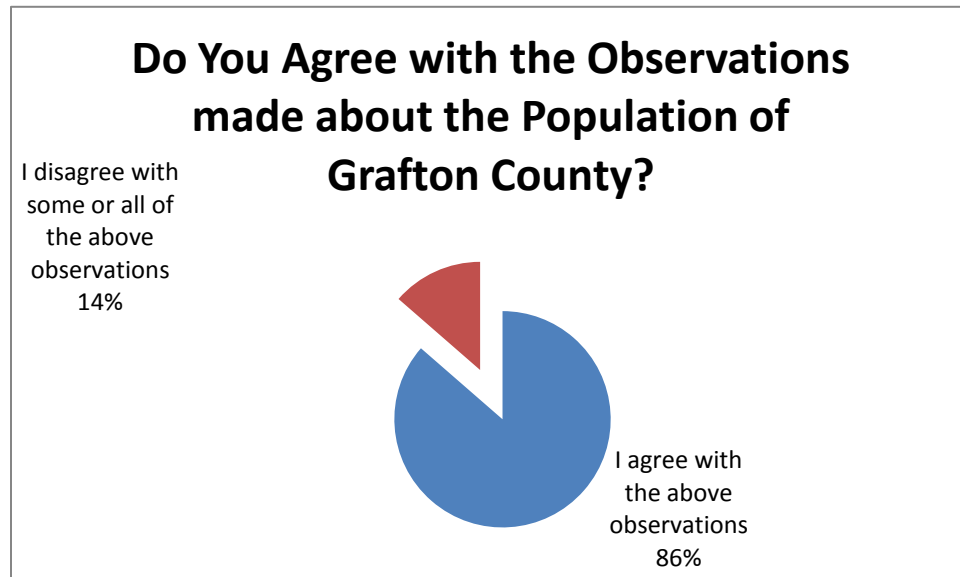


Clarifying Comments:

- It is unclear what the concerns are with births for women ages 40 - 54, and as such, it is not certain the validity nor a resolution if the concern is valid. I think it is important to consider Grafton County carefully, as there may be a "Lebanon affect," whereby the population of southern and northern Grafton County may not be similar for comparison purposes and northern Grafton may more appropriately model that of Coos County;
- Lack of resources in the area;
- See other note. I agree these are likely accurate but do not reflect our catchment in the Littleton area; and

- The majority of the families that I see are young women (under 25) unmarried with multiple children.

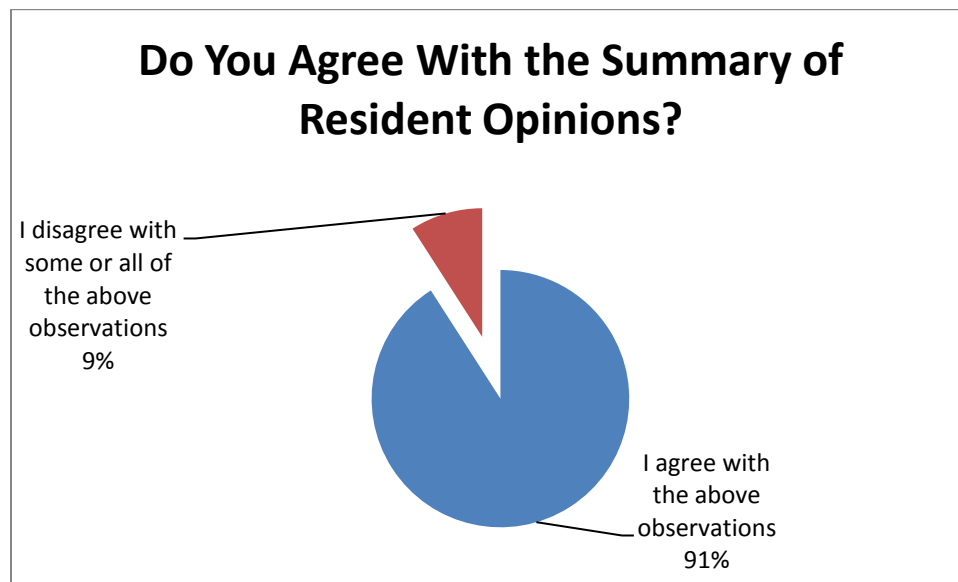
Q. Do you agree with the observations formed about the population characteristics of Grafton County?



Clarifying comments:

- A large sector of the rural population is overweight;
- There is a lack of Primary care services in the area that offer evening or weekend coverage;
- Obtaining a routine stress test being below the national average is NOT an adverse finding; it is a positive finding in my opinion. I suspect using the Internet to talk to a physician is an adverse finding; and
- Until all residents have access to health care coverage, we will continue to see the same issues.

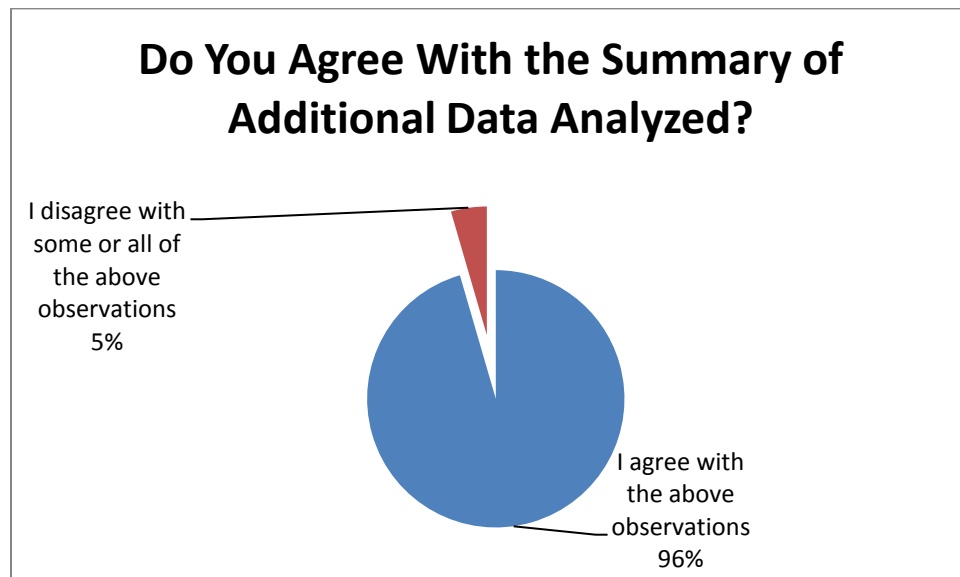
Q. Do you agree with the observations formed about the opinions from local residents?



Clarifying Comments:

- "Insurance problems" is not adequately identified or defined (Is the problem with the coverage, acquiring pharmaceuticals, high deductibles per the number of physicians accepting the insurance from this particular provider?);
- Dartmouth is in Grafton County - These findings are accurate. I am surprised such a large number have a dentist since lack of dental care is a significant issue in the Littleton area;
- I believe that the number of uninsured residents in the county is much greater than 2% as noted above;
- I hear that drugs are everywhere..but have no evidence and health insurance is too expensive --only for the wealthy or those who work in public employment or a company that can afford it;
- Lack of health insurance is not a major concern, but high deductibles and co-pays and lack of affordable laboratory services is a concern.; and
  - One of our major insurers (blue cross) does not have a favorable contract with LRH for labs
- There is a lack of specialty medical services in the area.

Q. Do you agree with the observations formed about the additional data analyzed about Grafton County?



Clarifying Comments:

- Again: there is great variance between the south of the county and the north of the county;
- Issue is the quality of health care providers given the location;
- Stroke deaths may be related to the time it takes to obtain "Stroke" appropriate care and challenging dilemma:
  - Again obesity and smoking are at least two precursors that may explain some of the outcomes;
  - Again this is in part a facet of personal choice and personal accountability; and
  - Healthcare can provide access and support to services, however it takes individuals to cause the change.
- There is a lack of community education on healthcare issues.

## Appendix C – Illustrative Schedule H (Form 990) Part V B Potential Response<sup>25</sup>

### Community Health Need Assessment Answers

1. *During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If “No,” skip to line 9*

**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*
- 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 #14 (page 10)
- 1. b. – See Footnotes #15 (page 11)
- 1. c. – See Footnote #20 (page 27)
- 1. d. – See Footnotes #7 (page 5)
- 1. e. – See Footnotes #12 (page 7)
- 1. f. – See Footnotes #10 (page 7)

<sup>25</sup> Questions are drawn from 2012 Schedule H Forms (as of July 11, 2013) and may have changed at the time when the hospital is to make its 990 h filing



- 1. g. – See Footnote #13 (page 8) & #24 (page 54)
- 1. h. – See Footnote #8 (page 7), #23 (page 45) & #24 (page 53)
- 1. i. – See Footnote #6 (page 5) & #18 (page 15)
- 1. j. – No response needed

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

Illustrative Answer – 2013

See Footnote #1 (Title page)

**3. *In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? 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 #9 (page 7), #11 (page 7)

**4. *Was the hospital facility’s CHNA 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 CHNA report 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 then 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 that addresses each of the community health needs identified through the CHNA***
- b. *Execution of an implementation strategy***

- c. Participation in the development of a community-wide community plan*
- d. Participation in the execution of a community-wide 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 CHNA*
- 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*
- i. Other (describe in Part VI)*

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

- 6. a. – See footnote #21 (page 27)
- 6. b. – See footnote #21 (page 27)
- 6. g. – See footnote #13 (page 8)
- 6. h. – See footnote #13 (page 8)

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

Illustrative Answer – No

Part VI suggested documentation – See Footnote #22 (page 43)

- 8. a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?**
- b If “Yes” to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?**
- c If “Yes” to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities?**

Illustrative Answer – No