

# Copley Hospital

*Morrisville, VT*

## Community Health Needs Assessment and Implementation Strategy

Adopted by Board Resolution 9/17/2018





Dear Community Member:

At Copley Hospital, we have spent more than 85 years providing high-quality compassionate healthcare to our community. The “2018 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how Copley Hospital will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

Copley Hospital will conduct this effort at least once every three years. The report produced three years ago is also available for your review and comment. As you review this plan, please see if, in your opinion, we have identified the primary needs of the community and if you think our intended response will lead to needed improvements.

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

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

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

Thank You,

Art Mathisen  
Chief Executive Officer  
Copley Hospital

---

TABLE OF CONTENTS

Executive Summary..... 1

Approach..... 3

    Project Objectives..... 4

    Overview of Community Health Needs Assessment ..... 4

    Community Health Needs Assessment Subsequent to Initial Assessment ..... 5

Community Characteristics ..... 11

    Definition of Area Served by the Hospital ..... 12

    Customer Segmentation..... 15

    Leading Causes of Death..... 18

    Priority Populations ..... 21

    Social Vulnerability ..... 22

    Summary of Survey Results on Prior CHNA ..... 23

    Comparison to Other State Counties..... 25

    Comparison to Peer Counties..... 29

    Community Benefit..... 32

Implementation Strategy ..... 33

    Significant Health Needs..... 34

    Other Needs Identified During CHNA Process..... 53

    Overall Community Need Statement and Priority Ranking Score ..... 54

Appendix ..... 55

    Appendix A – Community Survey Results..... 56

    Appendix B – Written Commentary on Prior CHNA (Round 1) ..... 67

    Appendix C – Identification & Prioritization of Community Needs (Round 2) ..... 91

    Appendix D – National Healthcare Quality and Disparities Report..... 103

    Appendix E – Illustrative Schedule H (Form 990) Part V B Potential Response ..... 113

# EXECUTIVE SUMMARY

## EXECUTIVE SUMMARY

Copley Hospital (the "Hospital") has performed a Community Health Needs Assessment (CHNA) to determine the health needs of the local community, develop an implementation plan to outline and organize how to meet those needs, and fulfill federal requirements.

Data was gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. The hospital conducted a total of three (3) surveys. The first was a survey of a select group of Local Experts to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. At the same time, the hospital invited community members to participate in a survey to identify health needs and challenges facing the community. The third survey was distributed to the same group of Local Experts and had them review the data gathered from the secondary sources and prioritize the Significant Health Needs for the community.

The 2018 Significant Health Needs for Copley Hospital's Service Area are:

1. Preventative Care – 2015 Significant Need
2. Mental Health
3. Chronic Health Conditions – 2015 Significant Need
4. Substance Use/Abuse
5. Reducing Cost of Healthcare – 2015 Significant Need
6. Housing Insecurity

The Hospital has developed implementation strategies for four of the six needs (Preventative Care, Mental Health, Chronic Health Conditions, and Substance Use/Abuse) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

# APPROACH

## APPROACH

Copley Hospital is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of “Community Benefit” under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA helps the hospital identify and respond to the primary health needs of its residents.

This study is designed to comply with standards required of a not-for-profit hospital.<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
- 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

Copley Hospital partnered with Quorum Health Resources (Quorum) to:<sup>4</sup>

- Complete a CHNA report, compliant with Treasury – IRS
- Provide the Hospital with information required to complete the IRS – 990 H schedule
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

## Overview of Community Health Needs Assessment

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

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

---

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

<sup>3</sup> As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 schedule h instructions i990sh—dft(2) and tax form

<sup>4</sup> Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule h (Form 990) V B 6 b

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

Specifically, the IRS requires:

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

## Community Health Needs Assessment Subsequent to Initial Assessment

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

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

---

<sup>5</sup> Section 6652



- (1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;*
- (2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and*
- (3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.<sup>6</sup>*

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

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

To complete a CHNA:

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

- (1) A definition of the community served by the hospital facility and a description of how the community was determined;*
- (2) a description of the process and methods used to conduct the CHNA;*
- (3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*
- (4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and*
- (5) a description of resources potentially available to address the significant health needs identified through the CHNA.*

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

---

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

*assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA.”<sup>7</sup>*

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

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

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

- (1) Public Health** – Persons with special knowledge of or expertise in public health
- (2) Departments and Agencies** – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
- (3) Priority Populations** – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition
- (4) Chronic Disease Groups** – Representative of or member of Chronic Disease Group or Organization, including mental and oral health
- (5) Broad Interest of the Community** – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations

**Other** (please specify)

The methodology also takes a comprehensive approach to assess community health needs by performing several independent data analyses based on secondary source data, augmenting this with Local Expert Advisor<sup>9</sup> opinions, and resolving any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. The methodology relies on secondary source data, and most secondary sources use the county as the smallest unit of

---

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

<sup>8</sup> Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) B 3 h

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

analysis. The Hospital asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.<sup>10</sup>

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

Data sources include:<sup>11</sup>

Website or Data Source	Data Element	Date Accessed	Data Date
<a href="http://www.countyhealthrankings.org">www.countyhealthrankings.org</a>	Assessment of health needs of Lamoille, Orleans and Caledonia Counties compared to all State counties	February 21, 2018	2010-2017
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	February 20, 2018	2017
<a href="http://www.healthvermont.gov/">http://www.healthvermont.gov/</a>	To identify the Social Vulnerability Index value	February 22, 2018	2011-2015
<a href="http://www.worldlifeexpectancy.com/usa-health-rankings">www.worldlifeexpectancy.com/usa-health-rankings</a>	To determine relative importance among 15 top causes of death	February 22, 2018	2016

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

- Copley Hospital deployed a CHNA “Round 1” survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to

<sup>10</sup> Response to Schedule h (Form 990) Part V B 3 i

<sup>11</sup> The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the “methods of collecting” the data. Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) Part V B 3 d

criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. The Hospital received community input from 78 Local Expert Advisors. Survey responses started February 19, 2018 and ended with the last response on March 12, 2018. A community survey was also completed in the same time period as the Local Expert Surveys and received 172 responses. Information gained from the community survey can be found in Appendix A.

- While the Round 1 survey was open to the Local Experts, a Community Survey was solicited to the Copley Hospital's service area residents to help understand the overall health needs and challenges facing the local population to ensure the appropriate health needs were identified for the 2018 CHNA. The survey was open to any area resident over 18 years of age. 172 surveys were completed.
- Information analysis augmented by local opinions showed how Lamoille, Orleans and Caledonia counties relate to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.<sup>12</sup>
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - The top three priority populations in the area are residents of rural areas, low-income groups, and children

When the Round 1 survey and data analysis was complete, the Hospital put the information and summary conclusions before our Local Expert Advisors<sup>13</sup> who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.<sup>14</sup> Consultation with Local Experts occurred again via an internet-based survey (explained below) beginning March 26, 2018 and ending April 9, 2018. 58 of the original 78 Local Expert Advisors responded to the Round 2 survey.

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.<sup>15</sup>

Through the 'Wisdom of Crowds' process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While a small number of Local Expert Advisors indicated the data conclusions were not completely accurate, the vast majority of comments agreed with our findings.<sup>16</sup> A summary of all needs identified by any of the analyzed data sets was developed. The Local Experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

---

<sup>12</sup> Response to Schedule h (Form 990) Part V B 3 f

<sup>13</sup> Response to Schedule h (Form 990) Part V B 3 h

<sup>14</sup> Response to Schedule h (Form 990) Part V B 3 h

<sup>15</sup> Response to Schedule h (Form 990) Part V B 5

<sup>16</sup> See detailed comments in Appendix C – Identification & Prioritization of Community Needs (Round 2)

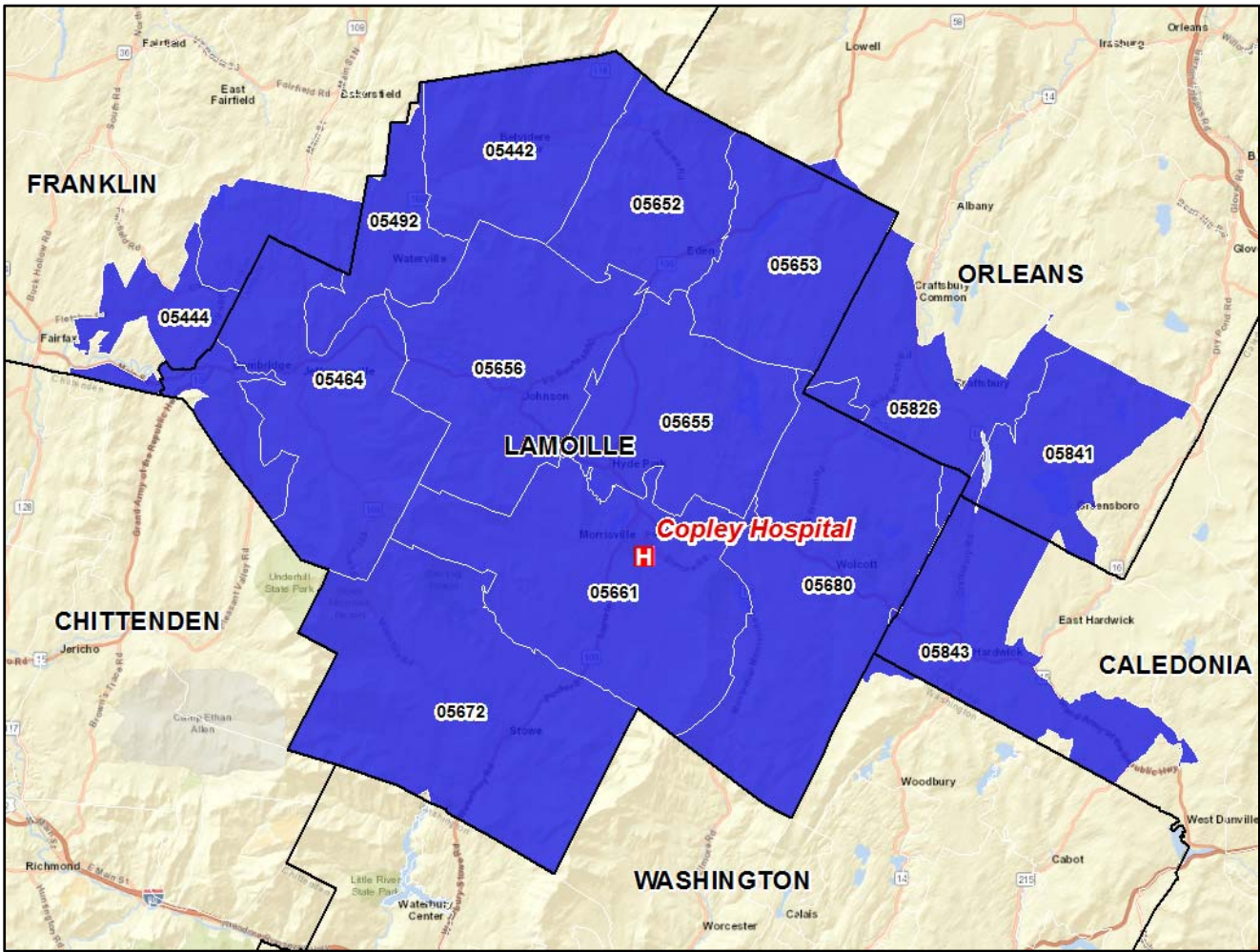
The ranked need were divided into two groups: “Significant” and “Other Identified Needs.” Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency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

---

<sup>17</sup> Response to Schedule h (Form 990) Part V B 3 g

## COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital<sup>18</sup>



Copley Hospital, defines its service area as Lamoille, and parts of Orleans and Caledonia counties in Vermont, which includes the following ZIP codes:<sup>19</sup>

05442 – Belvidere	05444 – Cambridge	05464 – Jeffersonville	05492 – Waterville	05652 – Eden
05653 – Eden Mills	05655 – Hyde Park	05656 – Johnson	05657 – Elmore	05661 – Morristown
05662 – Moscow	05665 – N. Hyde Park	05672 – Stowe	05680 – Wolcott	05826 – Craftsbury
05841 – Greensboro	05843 – Hardwick	05864 – Stannard		

In 2016, the Hospital received 67% of its patients from this area.<sup>20</sup>

<sup>18</sup> Responds to IRS Schedule h (Form 990) Part V B 3 a  
<sup>19</sup> The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below  
<sup>20</sup> IBM Watson Health MEDPAR patient origin data for the hospital; Responds to IRS Schedule H (Form 990) Part V B 3 a



## Demographics of the Community<sup>21 22</sup>

	Copley Hospital's Service Area	Vermont	U.S.
2017 Population <sup>23</sup>	30,387	625,678	325,139,271
% Increase/Decline	1.5%	0.1%	3.8%
Estimated Population in 2022	30,849	626,494	337,393,059
% White, non-Hispanic	94.4%	92.8%	60.8%
% Hispanic	1.8%	2.0%	18.0%
Median Age	47.3	37.2	38.2
Median Household Income	\$53,086	\$59,175	\$56,873
Unemployment Rate	1.3%	2.3%	4.2%
% Population >65	16.7%	18.2%	15.5%
% Women of Childbearing Age	18.5%	18.3%	19.6%

2017 Benchmarks Area: Copley Hospital - CHNA 2018 Level of Geography: ZIP Code									
Area	2017-2022 % Population Change	Median Age	Population 65+ % of Total Population	% Change 2017-2022	Females 15-44 % of Total Population	% Change 2017-2022	Median Household Income	Median Household Wealth	Median Home Value
USA	3.8%	38.2	15.5%	17.5%	19.6%	1.6%	\$56,873	\$61,832	\$198,020
Vermont	0.1%	37.2	18.2%	14.2%	18.3%	-1.3%	\$59,175	\$79,590	\$232,454
Selected Area	1.5%	47.3	16.7%	17.7%	18.5%	0.1%	\$53,086	\$72,063	\$225,365

<sup>21</sup> Responds to IRS Schedule H (Form 990) Part V B 3 b

<sup>22</sup> The tables below were created by IBM Watson Health

<sup>23</sup> All population information, unless otherwise cited, sourced from IBM Watson Health (formally Truven Health Analytics)



2017 Demographic Snapshot Area: Copley Hospital - CHNA 2018 Level of Geography: ZIP Code									
DEMOGRAPHIC CHARACTERISTICS									
	Selected Area	USA		2017	2022	% Change			
2010 Total Population	29,551	308,745,538	Total Male Population	15,109	15,326	1.4%			
2017 Total Population	30,387	325,139,271	Total Female Population	15,278	15,523	1.6%			
2022 Total Population	30,849	337,393,057	Females, Child Bearing Age (15-44)	5,623	5,630	0.1%			
% Change 2017 - 2022	1.5%	3.8%							
Average Household Income	\$68,411	\$80,853							
POPULATION DISTRIBUTION			HOUSEHOLD INCOME DISTRIBUTION						
Age Distribution						Income Distribution			
Age Group	2017	% of Total	2022	% of Total	USA 2017 % of Total	2017 Household Income	HH Count	% of Total	USA % of Total
0-14	5,156	17.0%	4,916	15.9%	18.8%	<\$15K	1,399	11.1%	11.8%
15-17	1,150	3.8%	1,198	3.9%	3.9%	\$15-25K	1,404	11.1%	10.1%
18-24	2,935	9.7%	3,061	9.9%	9.8%	\$25-50K	3,240	25.7%	22.9%
25-34	3,548	11.7%	3,472	11.3%	13.4%	\$50-75K	2,501	19.8%	17.4%
35-54	8,050	26.5%	7,659	24.8%	25.7%	\$75-100K	1,610	12.8%	12.1%
55-64	4,465	14.7%	4,561	14.8%	12.9%	Over \$100K	2,467	19.5%	25.7%
65+	5,083	16.7%	5,982	19.4%	15.5%				
Total	30,387	100.0%	30,849	100.0%	100.0%	Total	12,621	100.0%	100.0%
EDUCATION LEVEL						RACE/ETHNICITY			
Education Level Distribution					Race/Ethnicity Distribution				
2017 Adult Education Level	Pop Age 25+	% of Total	USA % of Total		Race/Ethnicity	2017 Pop	% of Total	USA % of Total	
Less than High School	562	2.7%	5.8%		White Non-Hispanic	28,681	94.4%	60.8%	
Some High School	1,158	5.5%	7.7%		Black Non-Hispanic	273	0.9%	12.4%	
High School Degree	6,515	30.8%	27.8%		Hispanic	537	1.8%	18.0%	
Some College/Assoc. Degree	5,662	26.8%	29.1%		Asian & Pacific Is. Non-Hispanic	193	0.6%	5.7%	
Bachelor's Degree or Greater	7,249	34.3%	29.6%		All Others	703	2.3%	3.2%	
Total	21,146	100.0%	100.0%		Total	30,387	100.0%	100.0%	

## Customer Segmentation<sup>24</sup>

Claritas Prizm uses Census data, sources of demographic and consumer information, and 30 years of annual consumer surveys to classify all U.S. households into 68 demographically and behaviorally distinct groups. These segments represent clusters of at least 250 households that have comparable characteristics and exhibit similar behaviors. The top segments in Copley Hospital's Service Area are:

Claritas Prizm Segments	Characteristics	
<b>Segment #1 (24.8%) Country Strong</b>	<ul style="list-style-type: none"> <li>• Urbanicity: Rural</li> <li>• Income: Lower Mid (Scale)</li> <li>• Household Technology: Below Average</li> <li>• Income Producing Assets: Below Avg</li> <li>• Age Ranges: Age &lt;55</li> </ul>	<ul style="list-style-type: none"> <li>• Presence of Kids: Family Mix</li> <li>• Homeownership: Mostly Owners</li> <li>• Employment Levels: Blue Collar Mix</li> <li>• Education Levels: High School</li> </ul>
<b>Segment #2 (22.9%) Fast-Track Families</b>	<ul style="list-style-type: none"> <li>• Urbanicity: Rural</li> <li>• Income: Upscale</li> <li>• Household Technology: Average</li> <li>• Income Producing Assets: High</li> <li>• Age Ranges: Age 35-54</li> </ul>	<ul style="list-style-type: none"> <li>• Presence of Kids: Family Mix</li> <li>• Homeownership: Mostly Owners</li> <li>• Employment Levels: Management and Professional</li> <li>• Education Levels: College Graduate</li> </ul>
<b>Segment #3 (15.2%) Red, White, &amp; Blue</b>	<ul style="list-style-type: none"> <li>• Urbanicity: Rural</li> <li>• Income: Lower Income</li> <li>• Household Technology: Below Average</li> <li>• Income Producing Assets: Low</li> <li>• Age Ranges: Age &lt;55</li> </ul>	<ul style="list-style-type: none"> <li>• Presence of Kids: Family Mix</li> <li>• Homeownership: Mix</li> <li>• Employment Levels: Mix</li> <li>• Education Levels: High School</li> </ul>
<b>Segment #4 (14.4%) Young &amp; Rustic</b>	<ul style="list-style-type: none"> <li>• Urbanicity: Rural</li> <li>• Income: Lower Income</li> <li>• Household Technology: Below Average</li> <li>• Income Producing Assets: Low</li> <li>• Age Ranges: Age &lt;55</li> </ul>	<ul style="list-style-type: none"> <li>• Presence of Kids: Family Mix</li> <li>• Homeownership: Mix</li> <li>• Employment Levels: Mix</li> <li>• Education Levels: High School</li> </ul>
<b>Segment #5 (10.1%) Big Sky Families</b>	<ul style="list-style-type: none"> <li>• Urbanicity: Rural</li> <li>• Income: Upper Mid(Scale)</li> <li>• Household Technology: Average</li> <li>• Income Producing Assets: Above Avg</li> <li>• Age Ranges: Age 35-54</li> </ul>	<ul style="list-style-type: none"> <li>• Presence of Kids: Mostly w/Kids</li> <li>• Homeownership: Mostly Owners</li> <li>• Employment Levels: Management and Professional</li> <li>• Education Levels: College Graduate</li> </ul>

<sup>24</sup> IBM Watson Health Household Targeter

Each of the 68 Claritas Prizm segments exhibits prevalence toward specific health behaviors. In the second column of the chart below, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

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

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			Cancer		
<b>BMI: Morbid/Obese</b>	<b>110%</b>	<b>33.7%</b>	<b>Cancer Screen: Skin 2 yr</b>	<b>88.6%</b>	<b>9.5%</b>
Vigorous Exercise	97.0%	55.4%	Cancer Screen: Colorectal 2 yr	102.1%	21.0%
Chronic Diabetes	96.0%	15.0%	<b>Cancer Screen: Pap/Cerv Test 2 yr</b>	<b>90.9%</b>	<b>43.8%</b>
<b>Healthy Eating Habits</b>	<b>94.8%</b>	<b>22.1%</b>	<b>Routine Screen: Prostate 2 yr</b>	<b>87.5%</b>	<b>24.8%</b>
Ate Breakfast Yesterday	96.6%	76.4%	Orthopedic		
<b>Slept Less Than 6 Hours</b>	<b>109.9%</b>	<b>15.0%</b>	Chronic Lower Back Pain	97.1%	30.0%
<b>Consumed Alcohol in the Past 30 Days</b>	<b>81.7%</b>	<b>43.9%</b>	<b>Chronic Osteoporosis</b>	<b>111.9%</b>	<b>11.3%</b>
Consumed 3+ Drinks Per Session	101.9%	28.7%	Routine Services		
Behavior			FP/GP: 1+ Visit	100.8%	82.0%
Search for Pricing Info	84.3%	22.6%	<b>NP/PA Last 6 Months</b>	<b>110.7%</b>	<b>45.9%</b>
I am Responsible for My Health	101.6%	91.8%	<b>OB/Gyn 1+ Visit</b>	<b>88.5%</b>	<b>34.0%</b>
I Follow Treatment Recommendations	101.4%	78.0%	Medication: Received Prescription	98.1%	59.5%
Pulmonary			Internet Usage		
<b>Chronic COPD</b>	<b>122.9%</b>	<b>6.6%</b>	Use Internet to Look for Provider Info	82.2%	32.8%
<b>Chronic Asthma</b>	<b>107.2%</b>	<b>12.7%</b>	Facebook Opinions	95.6%	9.6%
Heart			Looked for Provider Rating	79.1%	18.6%
Chronic High Cholesterol	97.2%	23.7%	Emergency Services		
<b>Routine Cholesterol Screening</b>	<b>90.2%</b>	<b>40.0%</b>	Emergency Room Use	97.5%	33.9%
<b>Chronic Heart Failure</b>	<b>124.7%</b>	<b>5.1%</b>	Urgent Care Use	91.4%	30.1%

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

- BMI: Morbid/Obese = 10.0% above average, impacting 33.7%
- Routine Cholesterol Screening = 9.8% below average, impacting 40.0%
- Cancer Screen: Pap/Cerv Test 2 yr = 9.1% below average, impacting 43.8%
- OB/Gyn 1+ Visit = 11.5% below average, impacting 34.0%

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

- Consumed Alcohol in the Past 30 Days = 18.3% below average, impacting 43.9%
- NP/PA Visit in the Last 6 Months = 10.7% above average, impacting 45.9%

## Leading Causes of Death<sup>25</sup>

### Lamoille County:

Cause of Death			Rank among all counties in VT  (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
VT Rank	Lamoille County Rank	Condition		VT	Lamoille County	
25	1	Cancer	8 of 14	158.4	181.1	Higher than expected
27	2	Heart Disease	8 of 14	158.8	178.4	Higher than expected
29	3	Lung	6 of 14	41.3	49.1	Higher than expected
21	4	Accidents	6 of 14	54.8	46.5	As expected
46	5	Stroke	7 of 14	29.2	38.9	As expected
26	6	Diabetes	1 of 14	20.5	33.2	Higher than expected
15	7	Alzheimer's	2 of 14	35.8	31.5	As expected
18	8	Suicide	9 of 14	17.3	14.8	As expected
51	9	Flu - Pneumonia	2 of 14	7.0	13.7	As expected
16	10	Hypertension	2 of 14	9.0	8.1	As expected
41	11	Liver	7 of 14	8.9	7.4	Lower than expected
5	12	Parkinson's	8 of 14	9.3	7.1	As expected
51	13	Kidney	10 of 14	3.6	6.2	Lower than expected
N/A	14	Homicide	1 of 14	N/A	3.5	Lower than expected
50	15	Blood Poisoning	13 of 14	3.4	3.1	Lower than expected

<sup>25</sup> [www.worldlifeexpectancy.com/usa-health-rankings](http://www.worldlifeexpectancy.com/usa-health-rankings)

**Caledonia County:**

Cause of Death			Rank among all counties in VT  (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
VT Rank	Caledonia County Rank	Condition		VT	Caledonia County	
27	1	Heart Disease	6 of 14	158.8	185.5	Higher than expected
25	2	Cancer	6 of 14	158.4	183.5	Higher than expected
29	3	Lung	9 of 14	41.3	46.0	Higher than expected
21	4	Accidents	11 of 14	54.8	41.9	Lower than expected
46	5	Stroke	9 of 14	29.2	38.1	As expected
15	6	Alzheimer's	7 of 14	35.8	29.1	As expected
26	7	Diabetes	7 of 14	20.5	23.4	As expected
18	8	Suicide	2 of 14	17.3	17.6	Higher than expected
51	9	Flu - Pneumonia	8 of 14	7.0	12.1	As expected
5	10	Parkinson's	1 of 14	9.3	11.7	Higher than expected
41	11	Liver	5 of 14	8.9	7.9	Lower than expected
16	12	Hypertension	3 of 14	9.0	7.5	As expected
51	13	Kidney	11 of 14	3.6	5.7	Lower than expected
50	14	Blood Poisoning	10 of 14	3.4	4.3	Lower than expected
N/A	15	Homicide	5 of 14	N/A	2.2	Lower than expected

**Orleans County:**

Cause of Death			Rank among all counties in VT (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
VT Rank	Orleans County Rank	Condition		VT	Orleans County	
27	1	Heart Disease	5 of 14	158.8	190.5	Higher than expected
25	2	Cancer	7 of 14	158.4	181.5	Higher than expected
21	3	Accidents	1 of 14	54.8	60.1	Higher than expected
29	4	Lung	5 of 14	41.3	52.7	Higher than expected
46	5	Stroke	12 of 14	29.2	35.0	As expected
15	6	Alzheimer's	4 of 14	35.8	30.5	As expected
26	7	Diabetes	5 of 14	20.5	23.8	As expected
18	8	Suicide	6 of 14	17.3	15.2	Higher than expected
51	9	Flu - Pneumonia	11 of 14	7.0	10.8	Lower than expected
5	10	Parkinson's	2 of 14	9.3	10.7	Higher than expected
41	11	Liver	3 of 14	8.9	9.1	As expected
16	12	Hypertension	6 of 14	9.0	6.7	Lower than expected
50	13	Blood Poisoning	6 of 14	3.4	5.6	Lower than expected
51	14	Kidney	12 of 14	3.6	5.5	Lower than expected
NA	15	Homicide	4 of 14		2.3	Lower than expected

## Priority Populations<sup>26</sup>

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

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

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:<sup>27</sup>

- The top three priority populations in the area are residents of rural areas, low-income groups, and children

---

<sup>26</sup> <http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/index.html> Responds to IRS Schedule h (Form 990) Part V B 3 i

<sup>27</sup> All comments and the analytical framework behind developing this summary appear in Appendix B

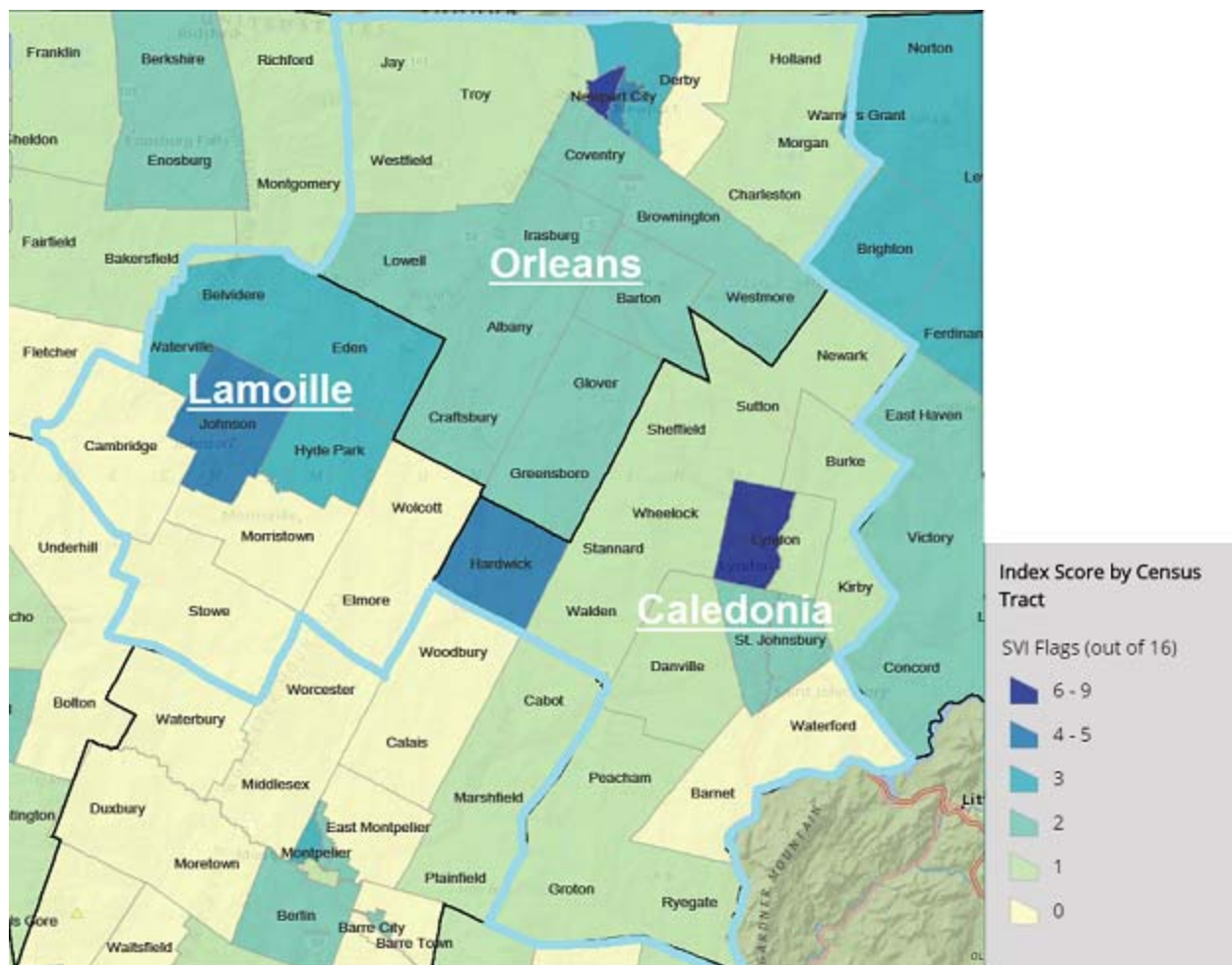


## Social Vulnerability<sup>28</sup>

The SVI tool can be consulted in the event of an emergency, either natural or man-made, to identify populations that may need more assistance. This SVI draws together 16 different measures of vulnerability in three different themes: socioeconomic vulnerability, demographic vulnerability, and housing/transportation vulnerability. For every measure, census tracts above the 90th percentile, or the most vulnerable 10%, are assigned a flag. The overall vulnerability index is created by counting the total number of flags in each census tract.

The darker blue categories on this map are census tracts where there are more flagged socioeconomic variables, while the lighter yellow categories have fewer.

- Lamoille County - upper region of the county has 4 to 9 SVI flags, while the lower region has 0
- Caledonia County - mix of SVI flags across the county, but mostly 0 and 1 SVI flags
- Orleans County - mix of SVI flags, but mostly 1 and 3 SVI flags



<sup>28</sup> <https://ahs-vt.maps.arcgis.com/apps/MapSeries/index.html?appid=9478be15d6d4410f8eef8d420711310b>

## Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 78 individuals provided feedback on the 2015 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix B. Results of the Community Survey can be found in Appendix A.

Commenter characteristics:

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
(1) <b>Public Health Expertise</b>	23	33	56
(2) <b>Departments and Agencies</b> – with relevant data/information regarding health needs of the community served by the hospital	28	29	57
(3) <b>Priority Populations</b>	22	29	51
(4) Representative/Member of a <b>Chronic Disease Group</b> or Organization	9	38	47
(5) Represents the <b>Broad Interest of the Community</b>	60	6	66
Other (please specify)			6
Answered Question			76
Skipped Question			2

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

- Reducing Cost of Healthcare
- Chronic Health Conditions
- Preventative Care

Copley Hospital received the following responses to the question: **“Should the hospital continue to consider the needs identified as most important in the 2015 CHNA as the most important set of health needs currently confronting residents in the county?”**

	Yes	No	No Opinion
<b>Reducing the Cost of Healthcare</b>	62	7	0
<b>Chronic Health Conditions</b>	67	2	0
<b>Preventative Care</b>	69	0	0
Answered Question	70		
Skipped Question	8		

Copley Hospital received the following responses to the question: **“Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?”**

	Yes	No	No Opinion
Reducing the Cost of Healthcare	61	8	0
Chronic Health Conditions	67	2	0
Preventative Care	67	3	0
Answered Question	70		
Skipped Question	8		

## Comparison to Other State Counties<sup>29</sup>

To better understand the community, Copley Hospital's Service Area counties have been compared to all 14 counties in the state of Vermont across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

In the chart below, the county's rank compared to all counties is listed along with any measures in each area that are **worse than** the state average and U.S. Best (90<sup>th</sup> percentile).

### Lamoille County:

	Lamoille	Vermont	U.S. Best
Health Outcomes			
Overall Rank <i>(best being #1)</i>	3/14		
Health Behaviors			
Overall Rank <i>(best being #1)</i>	7/14		
Access to exercise opportunities	69%	72%	91%
Alcohol-impaired driving deaths	42%	33%	13%
Teen Births <i>(per 1,000 females age 15-19)</i>	19	17	17
Clinical Care			
Overall Rank <i>(best being #1)</i>	10/14		
Population to Primary Care Physicians	1,090:1	890:1	1,040:1
Population to Dentist	1,800:1	1,530:1	1,320:1
Preventable Hospital Stays	45	39	36
Mammography Screening	64%	68%	71%
Social & Economic Factors			
Overall Rank <i>(best being #1)</i>	8/14		
Unemployment	4.7%	3.7%	3.3%
Injury Deaths*	78	74	53

<sup>29</sup> [www.countyhealthrankings.org](http://www.countyhealthrankings.org)

Physical Environment			
Overall Rank ( <i>best being #1</i> )	10/14		
Driving Alone to Work	79%	75%	72%
Long Commute – Driving Alone	37%	30%	15%

\*Per 100,000 population

#### Caledonia County:

	Caledonia	Vermont	U.S. Best
Health Outcomes			
Overall Rank ( <i>best being #1</i> )	5/14		
Premature Death (deaths prior to age 75)*	5,600	5,500	5,200
Health Behaviors			
Overall Rank ( <i>best being #1</i> )	10/14		
Adult Smoking	17%	16%	14%
Adult Obesity	28%	24%	26%
Physical Inactivity	20%	19%	19%
Access to exercise opportunities	53%	72%	91%
Alcohol-impaired driving deaths	46%	33%	13%
Teen Births ( <i>per 1,000 females age 15-19</i> )	20	17	17
Clinical Care			
Overall Rank ( <i>best being #1</i> )	4/14		
Population to Primary Care Physicians	1,110:1	890:1	1,040:1
Diabetes Monitoring	90%	91%	91%
Mammography Screening	66%	68%	71%
Social & Economic Factors			
Overall Rank ( <i>best being #1</i> )	10/14		
Some College	54%	66%	72%
Unemployment	4.8%	3.7%	3.3%
Children in Poverty	18%	14%	12%

Violent Crime*	142	121	62
<b>Physical Environment</b>			
Overall Rank ( <i>best being #1</i> )	8/14		
Severe Housing Problems	18%	17%	9%
Driving Alone to Work	77%	75%	72%
Long Commute – Driving Alone	31%	30%	15%

\*Per 100,000 population

#### Orleans County:

	Orleans	Vermont	U.S. Best
<b>Health Outcomes</b>			
Overall Rank ( <i>best being #1</i> )	14/14		
Premature Death (deaths prior to age 75)*	7,000	5,500	5,200
<b>Health Behaviors</b>			
Overall Rank ( <i>best being #1</i> )	14/14		
Adult Smoking	17%	16%	14%
Adult Obesity	29%	24%	26%
Physical Inactivity	25%	19%	19%
Access to exercise opportunities	54%	72%	91%
Alcohol-impaired driving deaths	48%	33%	13%
Teen Births ( <i>per 1,000 females age 15-19</i> )	32	17	17
<b>Clinical Care</b>			
Overall Rank ( <i>best being #1</i> )	13/14		
Population to Primary Care Physicians	1,230:1	890:1	1,040:1
Population to Dentist	3,390:1	1,530:1	1,320:1
Population to Mental Health Providers	490:1	260:1	360:1
Preventable Hospital Stays	44	39	36
Diabetes Monitoring	90%	91%	91%
Mammography Screening	62%	68%	71%

Social & Economic Factors			
Overall Rank <i>(best being #1)</i>	13/14		
Some College	51%	66%	72%
Unemployment	5.8%	3.7%	3.3%
Children in Poverty	20%	14%	12%
Children in Single-Parent Households	37%	31%	21%
Violent Crime*	128	121	62
Injury Deaths*	103	74	53
Physical Environment			
Overall Rank <i>(best being #1)</i>	12/14		
Driving Alone to Work	79%	75%	72%

\*Per 100,000 population

## Comparison to Peer Counties<sup>30</sup>

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile).

In the below charts, Copley Hospital's Service Area counties are compared to peer counties, Vermont average and the U.S. average, but only areas where each county is Better or Worse than their peer counties are listed. (The list and number of peer counties used in each ranking may differ.)

### Lamoille County:

	Lamoille	Peer Ranking	Vermont	U.S. Average
<b>Health Outcomes</b>				
<b>Better</b>				
Premature Death (deaths prior to age 75)*	5,100	3/36	5,500	5,200
<b>Health Behaviors</b>				
<b>Worse</b>				
Excessive Drinking	20%	29/36	20%	12%
Alcohol-Impaired Driving Deaths	42%	25/36	33%	13%
Sexually Transmitted Infections*	291.2	28/32	357.0	145.5
Teen Births ( <i>per 1,000 females ages 15-19</i> )	19	29/35	17	17
<b>Clinical Care</b>				
<b>Better</b>				
Uninsured	7%	1/34	6%	8%
Ratio of Population to Mental Health Providers	290:1	2/34	260:1	360:1
Diabetes Monitoring	93%	1/35	91%	91%
<b>Social &amp; Economic Factors</b>				
<b>Better</b>				
Some College Attendance	66%	4/36	66%	72%
Children in Poverty	14%	1/36	14%	12%
Violent Crimes*	56	2/36	121	62

<sup>30</sup> [www.countyhealthrankings.org](http://www.countyhealthrankings.org)



	Lamoille	Peer Ranking	Vermont	U.S. Average
<b>Worse</b>				
Injury Deaths*	119	33/34	74	53
<b>Physical Environment</b>				
<b>Worse</b>				
Long Commute – Driving Alone	37%	27/36	30%	15%

\*Per 100,000 population

#### Caledonia County:

	Caledonia	Peer Ranking	Vermont	U.S. Average
<b>Health Outcomes</b>				
<b>Better</b>				
Premature Death (deaths prior to age 75)*	5,600	3/36	5,500	5,200
<b>Health Behaviors</b>				
<b>Worse</b>				
Access to Exercise Opportunities	53%	31/36	72%	91%
Alcohol-Impaired Driving Deaths	46%	32/36	33%	13%
Sexually Transmitted Infections*	343.4	33/36	357.0	145.5
<b>Clinical Care</b>				
<b>Better</b>				
Uninsured	7%	1/34	6%	8%
Ratio of Population to Mental Health Providers	330:1	5/34	260:1	360:1
<b>Social &amp; Economic Factors</b>				
<b>Better</b>				
Unemployment	4.8%	7/36	3.7%	3.3%
Children in Poverty	14%	1/36	14%	12%

\*Per 100,000 population

Orleans County:

	Orleans	Peer Ranking	Vermont	U.S. Average
<b>Health Outcomes</b>				
<b>Worse</b>				
Premature Death (deaths prior to age 75)*	7,000	19/25	5,500	5,200
<b>Health Behaviors</b>				
<b>Worse</b>				
Adult Smoking	17%	27/28	16%	14%
Adult Obesity	29%	25/27	24%	26%
Physical Inactivity	25%	29/30	19%	19%
Access to Exercise Opportunities	54%	27/30	72%	91%
Sexually Transmitted Infections*	316.5	23/30	357.0	145.5
Teen Births ( <i>per 1,000 females ages 15-19</i> )	32	23/29	17	17
<b>Clinical Care</b>				
<b>Better</b>				
Uninsured	8%	3/30	6%	8%
Diabetes Monitoring	90%	3/29	91%	91%
<b>Worse</b>				
Ratio of Population to Dentist	2,320:1	29/36	1,539:1	1,320:1
Preventable Hospital Stays	44	23/29	39	36
<b>Social &amp; Economic Factors</b>				
<b>Worse</b>				
Some College Attendance	51%	29/30	66%	72%
Unemployment	5.8%	24/29	3.7%	3.3%
Children in Single-parent Households	37%	24/30	31%	21%
Injury Deaths*	103	24/30	74	53
<b>Physical Environment</b>				
<b>Worse</b>				
Driving Alone to Work	79%	30/30	75%	72%

\*Per 100,000 population

## Community Benefit

*“Community health improvement services” means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.*

*“Community benefit operations” means:*

- *activities associated with community health needs assessments, administration, and*
- *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

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

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

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

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

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.
- Copley Hospital provided \$8 million in community benefits in FY 2015.

# IMPLEMENTATION STRATEGY

## Significant Health Needs

Copley Hospital 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 Copley Hospital.<sup>31</sup> 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 Copley Hospitals current efforts responding to the need including any written comments received regarding prior Copley Hospital implementation actions
- Establishes the Implementation Strategy programs and resources Copley Hospital will devote to attempt to achieve improvements
- Documents the Leading Indicators Copley Hospital will use to measure progress
- Presents the Lagging Indicators Copley Hospital 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, Copley Hospital is the major hospital in the service area. Copley Hospital is a 25-bed, acute care medical facility located in Morrisville, VT. The next closest facilities are outside the service area and include:

- Central Vermont Medical Center – Berlin, VT; 34.5 miles (49 minutes)
- Northeastern Vermont Regional Hospital – St. Johnsbury, VT; 40.7 miles (57 minutes)
- North Country Hospital – Newport, VT; 43.9 miles (64 minutes)
- Gifford Medical Center – Randolph, VT; 55.8 miles (70 minutes)
- Littleton Regional Hospital – Littleton, NH; 55.5 miles (72 minutes)
- Cottage Hospital – Woodsville, NH; 61.9 miles (80 minutes)
- Porter Medical Center – Middlebury, VT; 72.3 miles (103 minutes)

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 Copley Hospital Implementation Strategy uses “Leading Indicators.” Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading

---

<sup>31</sup> Response to IRS Schedule h (Form 990) Part V B 3 e

Indicators also must be within the ability of the hospital to influence and measure.

## 1. Preventative Care – 2015 Significant Need

### Local expert comments received on previously adopted implementation strategy:

*See Appendix B for full list of comments*

### Copley Hospital services, programs, and resources available to respond to this need include:<sup>32</sup>

- Screening availability at Copley Hospital's Women Center  
[Note: Screening defined as screening for substance abuse, mental health, adverse childhood events, smoking, food insecurity, housing, BP and BMI. Note: Adverse childhood events screening is performed by the provider, with referrals made to the social worker at TWC].
- Prevention education/awareness promoted through hospital's social media through collaborative community blog LiveWellLamoille.com.
- Social worker working with inpatients and emergency department patients to screen and provide referrals.  
[Note: Screening defined as screening for substance abuse, mental health, smoking, food insecurity and housing].

### Additionally, Copley Hospital plans to take the following steps to address this need:

- Prevention/education awareness program – through the launch of RISE VT-Lamoille due FY2019.
- Evaluate options to increase transportation assistance to improve access to care.
- Place Referral and Resource Specialist in emergency department; continue focus on “super-utilizers” in emergency department and Inpatient population.
- Develop a standardized Fall Risk Screening tool in FY2019 for targeted populations 65+  
Implementation with targeted population in FY2020-FY2021.
- 100% of targeted patient population in the emergency department will be screened for chronic health conditions and social determinants of health (SDOHS)  
[Note: Screening defined as screening for substance abuse, mental health, adverse childhood events, smoking, food insecurity, housing, and BP].
- The Women's Center provides dental health referral options as part of pre-natal care.
- 100% of targeted patient population in outpatient clinics will routinely receive blood pressure screening.

### Anticipated results from Copley Hospital Implementation Strategy

---

<sup>32</sup> This section in each need for which the hospital plans an implementation strategy responds to Schedule h (Form 990) Part V Section B 3 c

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

**The strategy to evaluate Copley Hospital intended actions is to monitor change in the following Leading Indicator:**

- Number of patients receiving transportation from the hospital via RCT or other arranged transportation:  
Number transported, number by town or county
- RISE VT-Lamoille – Number of program sign-ups, number of people, number of events
- Standardized Fall Risk Assessment Tool developed in FY2019, implemented in FY2020  
Number of fall risk screenings of targeted population completed
- Number of people referred to social workers, numbers of referrals made, and broken out by area; i.e. to SDOHS, PCPs, mental health, substance abuse, domestic violence
- Continue focus on “super-utilizers” in the emergency department; track impact
- Number/percent (%) of targeted population visits in outpatient clinic that received BP screening

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

- Reduce 30-day all cause readmissions = 8.73%-16.8% Jan-Sept. 2017
- Number of obesity population (Lamoille County) = 25%<sup>33</sup>  
Percent of adults with hypertension (Lamoille County) = 29% per Healthy Vermonter 2020  
Coronary heart disease death rate per 100,000 Vermonters (Lamoille County) = 99.3 per Healthy Vermonters 2020

<sup>33</sup> Percentage of adults that report a BMI of 30 or more. [www.countyhealthrankings.org](http://www.countyhealthrankings.org). 2013



- Fall-related death rate per 100,000 adults age 65+ (Lamoille County) = 161.6 per Healthy Vermonters 2020

**Copley Hospital anticipates collaborating with the following other facilities and organizations to address this Significant Need:**

Organization	Contact Name	Contact Information
Community Health Services of Lamoille County (CHSLV)	Lorrie Dupuis Community Health Team Supervisor/CHT members	<a href="https://chslv.org/">https://chslv.org/</a> 66 Morrisville Plaza, Morristown, VT 05661 (802) 851-8608
Appleseed Pediatrics		<a href="https://chslv.org/our-services/appleseedpediatrics/">https://chslv.org/our-services/appleseedpediatrics/</a> 439 Washington Hwy, Morrisville, VT 05661 (802) 888-7337
Northern Counties Health Care	Chris Towne Director of Primary Care	<a href="http://www.nchcvt.org/">www.nchcvt.org/</a> 165 Sherman Dr, St Johnsbury, VT 05819 (802) 748-9405
RISE Vermont-Lamoille	Cole Pearson Coord., Copley Hospital/RISE VT	<a href="http://risevt.org/">http://risevt.org/</a> 528 Washington Hwy, Morrisville, VT 05661 (802) 888-8249
Rural Community Transportation (RCT)	Sara Wright rctswright@gmail.com	<a href="http://www.riderct.org/">http://www.riderct.org/</a> 197 Harrel St, Suite #6, Morrisville, VT 05661 (802) 888-6200
Community Health Team (Blueprint for Health Model)	Dominique Couture LSW at Copley Hospital  Lorrie Dupuis Community Health Supervisor with CHSLV	<a href="mailto:dcouture@chsi.org">dcouture@chsi.org</a>   <a href="mailto:ldupuis@chslv.org">ldupuis@chslv.org</a>
Vermont Department of Health	Suzanne Masland Field Director	<a href="http://healthvermont.gov">healthvermont.gov</a> 63 Professional Drive, Suite #1 Morrisville, VT 05661 802-888-7447

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

Organization	Contact Name	Contact Information
Lamoille County Mental Health Services	Michael Hartman Behavioral Health Director	<a href="http://lamaille.org/">http://lamaille.org/</a> 72 Harrel St, Morrisville, VT 05661 (802) 888-5026
Lamoille Family Center	Floyd Nease Executive Director	<a href="http://www.lamoillefamilycenter.org/">http://www.lamoillefamilycenter.org/</a> 480 Cadys Falls Rd, Morristown, VT 05661 (802) 888-5229
Unified Community Collaborative (Accountable Community for Health Model)	Elise McKenna Facilitator	c/o CHSLV 66 Morrisville Plaza, Morristown, VT 05661 (802) 851-8608
Healthy Lamoille Valley	Jessica Bickford Coordinator	<a href="https://www.healthylamoillevalley.org/">https://www.healthylamoillevalley.org/</a> 480 Cadys Falls Rd, Morristown, VT 05661 (802) 730-6599

## 2. Mental Health – Local expert concern

### Local expert comments received on previously adopted implementation strategy:

*This was not a significant health need in 2015, so no comments were solicited.*

### Copley Hospital services, programs, and resources available to respond to this need include:

- Screening availability at Copley Hospital's Women Center  
[Note: Screening defined as screening for substance abuse, mental health, adverse childhood events, smoking, food insecurity, housing, BP and BMI. Note: Adverse childhood events screening is performed by the provider, with referrals made to the social worker at TWC].
- Copley Hospital partners with the Mobile Crisis Team (Lamoille County Mental Health) to assist with people presenting in the ER with a mental health crisis. The Mobile Crisis Team offers emergency and crisis services to anyone who lives in Lamoille County, 24 hours a day, 7 days a week. They also serve children in the surrounding towns including: Hardwick, Craftsbury, Greensboro, Stannard, and Woodbury.
- Training of hospital staff as patient sitters and establishment of sitter program.
- Developed mental health safe room in emergency department.

### Additionally, Copley Hospital plans to take the following steps to address this need:

- Evaluate options for increasing transportation programs (Rural Community Transportation, others) to assist with getting patients to needed mental health and behavioral health appointments.
- Place referral and resource specialist in emergency department full time.
- Partner with Lamoille County Mental Health on the Zero Suicide Program (screening, intervention, safe transition of care).
- Provide mental health awareness education for targeted staff.
- Offer de-escalation training with community organizations to build appropriate skills in the community.
- Evaluate mental health resources in the emergency department.

### Anticipated results from Copley Hospital Implementation Strategy

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

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

**The strategy to evaluate Copley Hospital intended actions is to monitor change in the following Leading Indicator:**

- Increase suicide awareness/mental health training to 100% participation for identified targeted staff
- De-escalation training - % of targeted hospital staff trained, number of trainings, number trained in the community
- Feature mental health issues and services via blog
- Ongoing evaluation of mental health resources in the emergency department
- Track number of referrals to transportation assistance for patients receiving mental/behavioral health care made by Copley Hospital
- Zero Suicide Program implemented in collaboration with Lamoille County Mental Health number of people referred by Copley Hospital as part of Zero Suicide Program

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

- Death suicide rate (Lamoille County) = 14.88/100,000<sup>34</sup>
- Poor mental health on 14 days or more last month (Lamoille County) = 9%, 2,000 adults per 2016 BRFSS County Data Profile, VDH

<sup>34</sup> Leading Causes of Death. <http://www.worldlifeexpectancy.com/usa/vermont-suicide>; 2016

**Copley Hospital anticipates collaborating with the following other facilities and organizations to address this Significant Need:**

Organization	Contact Name	Contact Information
Lamoille County Mental Health	Michael Hartman Behavioral Health Director	<a href="https://lamoille.org/">https://lamoille.org/</a> 72 Harrel St, Morrisville, VT 05661 (802) 888-5026
Community Health Services of Lamoille County (CHSLV)	Lorrie Dupuis Community Health Team Supervisor/CHT members	<a href="https://chslv.org/">https://chslv.org/</a> 66 Morrisville Plaza, Morristown, VT 05661 (802) 851-8608
North Central Vermont Recovery Center	Stefani Capizzi, Exec. Dir. Daniel Franklin, Ops Mgr.	<a href="https://www.ncvrc.com/">https://www.ncvrc.com/</a> 275 Brooklyn St, Morrisville, VT 05661 (802) 851-8120
Northern Counties Health Care	Chris Towne Director of Primary Care	<a href="http://www.nchcv.org/">http://www.nchcv.org/</a> 165 Sherman Dr, St Johnsbury, VT 05819 (802) 748-9405
RISE Vermont-Lamoille	Cole Pearson Coord., Copley Hospital/RISE VT	<a href="http://risevt.org/">http://risevt.org/</a> 528 Washington Hwy, Morrisville, VT 05661 (802) 888-8249
Healthy Lamoille Valley	Jessica Bickford Coordinator	<a href="https://www.healthylamoillevalley.org/">https://www.healthylamoillevalley.org/</a> 480 Cadys Falls Rd, Morristown, VT 05661 (802) 730-6599
Rural Community Transportation (RCT)	Sara Wright rctswright@gmail.com	<a href="http://www.riderct.org/">http://www.riderct.org/</a> 1677 Industrial Pkwy, St Johnsbury, VT 05819 (802) 748-8170

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

Organization	Contact Name	Contact Information
Lamoille Family Center	Floyd Nease Executive Director	<a href="http://www.lamoillefamilycenter.org/">http://www.lamoillefamilycenter.org/</a> 480 Cadys Falls Rd, Morristown, VT 05661 (802) 888-5229
Appleseed Pediatrics		<a href="https://chslv.org/our-services/appleseedpediatrics/">https://chslv.org/our-services/appleseedpediatrics/</a> 439 Washington Hwy, Morrisville, VT 05661 (802) 888-7337
Vermont Department of Health	Suzanne Masland Field Director	<a href="http://healthvermont.gov">healthvermont.gov</a> 63 Professional Drive, Suite #1 Morrisville, VT 05661 802-888-7447

### 3. Chronic Health Conditions – 2015 Significant Need

#### Local expert comments received on previously adopted implementation strategy:

*See Appendix B for full list of comments*

#### Copley Hospital services, programs, and resources available to respond to this need include:

- Screening availability at Copley Hospital's Women Center  
[Note: Screening defined as screening for substance abuse, mental health, adverse childhood events, smoking, food insecurity, housing, BP and BMI. Note: Adverse childhood events screening is performed by the provider, with referrals made to the social worker at TWC].
- Increasing services available via telemedicine, including Pulmonology and Nephrology as of Fall 2018. Collaboration with Central Vermont Medical Center for oncology services available at Copley Hospital.
- Workforce Wellness Program available to area businesses.
- Cardiac/Pulmonary Rehabilitation program for persons that experienced an event or has a qualifying condition.
- Prevention/Education and awareness messaging via Social Media and LiveWellLamoille.com blog.
- Discharge planning that includes scheduling Primary Care Follow-up prior to discharge.

#### Additionally, Copley Hospital plans to take the following steps to address this need:

- Evaluate options for increasing transportation assistance (Rural Community Transportation, others).
- Place referral and resource specialist in emergency department full time.
- 100% Screening of targeted patient populations in the emergency department  
[100% of targeted patient population in the emergency department will be screened by chronic health conditions and social determinants with health (SDOHS). Screening defined as screening for substance abuse, mental health, adverse childhood events, smoking, food insecurity, housing, and blood pressure (BP)].
- 100% of targeted patient population in outpatient clinics will routinely receive blood pressure screening.
- 100% of identified inpatient population will be evaluated using readmission risk assessment tool.
- Provide prevention/education awareness program through the launch of RISE VT-Lamoille due FY 2019.
- Increase Workforce Wellness service area to offer tobacco cessation and chronic disease prevention/management at worksites throughout the service area.
- 

#### Anticipated results from Copley Hospital Implementation Strategy

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

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

**The strategy to evaluate Copley Hospital intended actions is to monitor change in the following Leading Indicator:**

- Number of all cause readmissions
- Number of Workforce Wellness sessions offered/type/topic, number of participants
- Number, percent (%) of targeted inpatient population screened with readmission risk assessment tool
- Number, percent (%) of identified patient population receiving screening in the emergency department [Screening defined as screening for substance abuse, mental health, adverse childhood events, smoking, food insecurity, housing and BP]
- Number/percent (%) of targeted population visits in outpatient clinic that received BP screening
- Number of patients receiving transportation from the hospital via RCT or other arranged transportation = number, by town
- RISE VT-Lamoille – program sign-ups = number of people, number of events
- Number of targeted patient population in the emergency department receiving referrals, number of referrals, and broken out by areas; i.e. so SDOHS, PCPs, mental health, substance abuse, domestic violence

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

- Percent (%) of all cause readmissions = %
- Percent (%) of obesity population (Lamoille County) = 25%<sup>35</sup>  
Percent (%) of adults with hypertension (Lamoille County) = 29% per Healthy Vermonter 2020

<sup>35</sup> Percentage of adults that report a BMI of 30 or more. [www.countyhealthrankings.org](http://www.countyhealthrankings.org). 2013



Coronary heart disease death rate per 100,000 Vermonters (Lamoille County) = 99.3 per Health Vermonters 2020

- Leading Cause of Death for Lamoille County =

**Copley Hospital anticipates collaborating with the following other facilities and organizations to address this Significant Need:**

Organization	Contact Name	Contact Information
Community Health Services of Lamoille County (CHSLV)	Lorrie Dupuis Community Health Team Supervisor/CHT members	<a href="https://chslv.org/">https://chslv.org/</a> 66 Morrisville Plaza, Morristown, VT 05661 (802) 851-8608
Appleseed Pediatrics		<a href="https://chslv.org/our-services/appleseedpediatrics/">https://chslv.org/our-services/appleseedpediatrics/</a> 439 Washington Hwy, Morrisville, VT 05661 (802) 888-7337
Northern Counties Health Care	Chris Towne Director of Primary Care	<a href="http://www.nchcvt.org/">http://www.nchcvt.org/</a> 165 Sherman Dr, St Johnsbury, VT 05819 (802) 748-9405
RISE Vermont-Lamoille	Cole Pearson Coord., Copley Hospital/RISE VT	<a href="http://risevt.org/">http://risevt.org/</a> 528 Washington Hwy, Morrisville, VT 05661 (802) 888-8249
Rural Community Transportation (RCT)	Sara Wright rctswright@gmail.com	<a href="http://www.riderct.org/">http://www.riderct.org/</a> 197 Harrel St, Suite #6, Morrisville, VT 05661 (802) 888-6200
Community Health Team (Blueprint for Health Model)	Dominique Couture LSW at Copley Hospital	<a href="mailto:dcouture@chsi.org">dcouture@chsi.org</a>

Organization	Contact Name	Contact Information
	Lorrie Dupuis Community Health Supervisor with CHSLV	<a href="mailto:ldupuis@chslv.org">ldupuis@chslv.org</a>
Vermont Department of Health	Suzanne Masland Field Director	<a href="http://healthvermont.gov">healthvermont.gov</a> 63 Professional Drive, Suite #1 Morrisville, VT 05661 802-888-7447

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

Organization	Contact Name	Contact Information
Lamoille County Mental Health Services	Michael Hartman Behavioral Health Director	<a href="http://lamaille.org/">http://lamaille.org/</a> 72 Harrel St, Morrisville, VT 05661 (802) 888-5026
Lamoille Family Center	Floyd Nease Executive Director	<a href="http://www.lamoillefamilycenter.org/">http://www.lamoillefamilycenter.org/</a> 480 Cadys Falls Rd, Morristown, VT 05661 (802) 888-5229
Unified Community Collaborative (Accountable Community for Health Model)	Elise McKenna Facilitator	c/o 66 Morrisville Plaza, Morristown, VT 05661 (802) 851-8608
Healthy Lamoille Valley	Jessica Bickford Coordinator	<a href="https://www.healthylamoillevalley.org/">https://www.healthylamoillevalley.org/</a> 480 Cadys Falls Rd, Morristown, VT 05661 (802) 730-6599

#### 4. Substance Use/Abuse – Local expert concern

##### Local expert comments received on previously adopted implementation strategy:

*This was not a significant health need in 2015, so no comments were solicited.*

##### Copley Hospital services, programs, and resources available to respond to this need include:

- Provides SBIRT/ACES screenings at the Copley Hospital Women's Health Center.
- Referrals to Medication Assistance Treatment (MAT) program.
- Copley Hospital partners with the Mobile Crisis Team (Lamoille County Mental Health) to assist the people presenting in the ER with a mental health crisis. The Mobile Crisis Team offers emergency and crisis services to anyone who lives in Lamoille County, 24 hours a day, 7 days a week. They also serve children in the surrounding towns including: Hardwick, Craftsbury, Greensboro, Stannard, and Woodbury.

##### Additionally, Copley Hospital plans to take the following steps to address this need:

- Evaluate options for increasing transportation programs (Rural Community Transportation, others).
- Place Referral and Resource Specialist in emergency department.
- Mental health awareness education for hospital staff.
- Evaluate ability to prescribe and/or distribute Naloxone through the emergency department.
- Install a prescription drug "drop-box" for people to safely dispose of unused and/or expired prescription drugs.
- Implement collaboration with North Central Vermont Recovery Center Coaches program for targeted patient population in the emergency department.

##### Anticipated results from Copley Hospital Implementation Strategy

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

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
5. Improves ability to withstand public health emergency	X	
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

**The strategy to evaluate Copley Hospital intended actions is to monitor change in the following Leading Indicator:**

- Number, percent (%) of patients receiving referrals to North Central Vermont Recovery Center Coaches program
- Number of referrals made to Medication Assistance Treatment (MAT) program
- Number of patients receiving transportation from the hospital via RCT or other arranged transportation = Number, by county
- Number of mental health awareness education trainings held; Number of hospital staff trained
- Prescription drug drop box installed; Number of pounds of unused/expired prescription drugs disposed

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

- Number of alcohol-attributed deaths in state
  - ~58 in state (average for past 5 years)
- Number of substance/opioids abuse deaths in Lamoille County annually
  - In 2017 there were 3.
- Number of people treated for substance abuse annually in Lamoille County (state funded treatment only)
  - In 2015: 527

**Copley Hospital anticipates collaborating with the following other facilities and organizations to address this Significant Need:**

Organization	Contact Name	Contact Information
Lamoille County Mental Health Services	Michael Hartman Behavioral Health Director	<a href="http://lamoille.org/">http://lamoille.org/</a> 72 Harrel St, Morrisville, VT 05661 (802) 888-5026

Organization	Contact Name	Contact Information
Community Health Services of Lamoille County (CHSLV)	Lorrie Dupuis Community Health Team Supervisor/CHT members	<a href="https://chslv.org/">https://chslv.org/</a> 66 Morrisville Plaza, Morristown, VT 05661 (802) 851-8608
Northern Counties Health Care	Chris Towne Director of Primary Care	<a href="http://www.nchcvt.org/">www.nchcvt.org/</a> 165 Sherman Dr, St Johnsbury, VT 05819 (802) 748-9405
RISE Vermont	Cole Pearson Coord., Copley Hospital/RISE VT	<a href="http://risevt.org/">http://risevt.org/</a> 528 Washington Hwy, Morrisville, VT 05661 (802) 888-8249
Healthy Lamoille Valley	Jessica Bickford Coordinator	<a href="https://www.healthylamoillevalley.org/">https://www.healthylamoillevalley.org/</a> 480 Cadys Falls Rd, Morristown, VT 05661 (802) 730-6599
Lamoille Family Center	Floyd Nease Executive Director	<a href="http://www.lamoillefamilycenter.org/">http://www.lamoillefamilycenter.org/</a> 480 Cadys Falls Rd, Morristown, VT 05661 (802) 888-5229
Appleseed Pediatrics		<a href="https://chslv.org/ourservices/appleseedpediatrics/">https://chslv.org/ourservices/appleseedpediatrics/</a> 439 Washington Hwy, Morrisville, VT 05661 (802) 888-7337
Medically Assisted Treatment (MAT)		<a href="https://chslv.org/mat-team-outreach/">https://chslv.org/mat-team-outreach/</a>
Behavioral Health		<a href="https://chslv.org/our-services/behavioral/">https://chslv.org/our-services/behavioral/</a> 607 Washington Highway, Morrisville, VT 05661 (802) 888-8136
North Central Vermont Recovery Center	Stefani Capizzi, Exec. Dir. Daniel Franklin, Ops Mgr.	<a href="https://www.ncvrc.com/">https://www.ncvrc.com/</a> 275 Brooklyn St, Morrisville, VT 05661 (802) 851-8120

Organization	Contact Name	Contact Information
Vermont Department of Health	Suzanne Masland Field Director	<a href="http://healthvermont.gov">healthvermont.gov</a> 63 Professional Drive, Suite #1 Morrisville, VT 05661 802-888-7447

## 5. Reducing Cost of Healthcare – 2015 Significant Need

### Local expert comments received on previously adopted implementation strategy:

*See Appendix B for full list of comments*

### Copley Hospital services, programs, and resources available to respond to this need include:

- Financial assistance program offered at Copley Hospital.
- Resources to assist patients with enrolling for insurance through Vermont Health Connect.
- Continued focus on connecting “super utilizers” of the Emergency Department to needed social services.
- Continued collaboration with Community Care Management Team to refer complex patients to appropriate services.
- Ongoing implementation of inpatient readmission risk assessment tool to help reduce 30 day all cause readmissions.

### Copley Hospital does not intend to develop an implementation strategy for this Significant Need

Due to a relative lack of identified effective interventions at the hospital level other than addressing chronic conditions, preventative care and identifying people at risk to address the need, we are choosing not to develop an implementation strategy at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs as outlined.

Federal classification of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need	
1. Resource Constraints	
2. Relative lack of expertise or competency to effectively address the need	
3. A relatively low priority assigned to the need	
4. A lack of identified effective interventions to address the need	<b>X</b>
5. Need is addressed by other facilities or organizations in the community	

## 6. Housing Insecurity – Local expert concern

### Local expert comments received on previously adopted implementation strategy:

This was not a significant health need in 2015, so no comments were solicited.

### Copley Hospital services, programs, and resources available to respond to this need include:

- Provide laundry service for warming shelter.
- Provide screening for housing insecurity at the Women’s Center and with targeted population in the emergency department.

### Copley Hospital does not intend to develop an implementation strategy for this Significant Need

Due to a lack of identified effective interventions to address the need, and the availability of other organizations to address this need, we are choosing not to develop an implementation strategy at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

Federal classification of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need	
1. Resource Constraints	
2. Relative lack of expertise or competency to effectively address the need	
3. A relatively low priority assigned to the need	
4. A lack of identified effective interventions to address the need	X
5. Need is addressed by other facilities or organizations in the community	X

## Other Needs Identified During CHNA Process

7. Food Insecurity
8. Obesity
9. Alcohol Use
10. Transportation
11. Diabetes
12. Cancer
13. Heart Disease
14. Women's Health
15. Tobacco Use
16. Suicide
17. Accidents
18. Alzheimer's
19. Stroke
20. Lung Disease
21. Flu/Pneumonia
22. Kidney Disease
23. Parkinson's
24. Child Well-Being
25. Developmental Screening for Children
26. Oral Health
27. Pharmacy



## Overall Community Need Statement and Priority Ranking Score

### Significant needs where hospital has implementation responsibility<sup>36</sup>

1. Preventative Care
2. Mental Health
3. Chronic Health Conditions
4. Substance Use/Abuse

### Significant needs where hospital did not develop implementation strategy<sup>37</sup>

1. Reducing Cost of Healthcare
2. Housing Insecurity

### Other needs where hospital developed implementation strategy

1. None

### Other needs where hospital did not develop implementation strategy

1. None

---

<sup>36</sup> Responds to Schedule h (Form 990) Part V B 8

<sup>37</sup> Responds to Schedule h (Form 990) Part V Section B 8

# APPENDIX

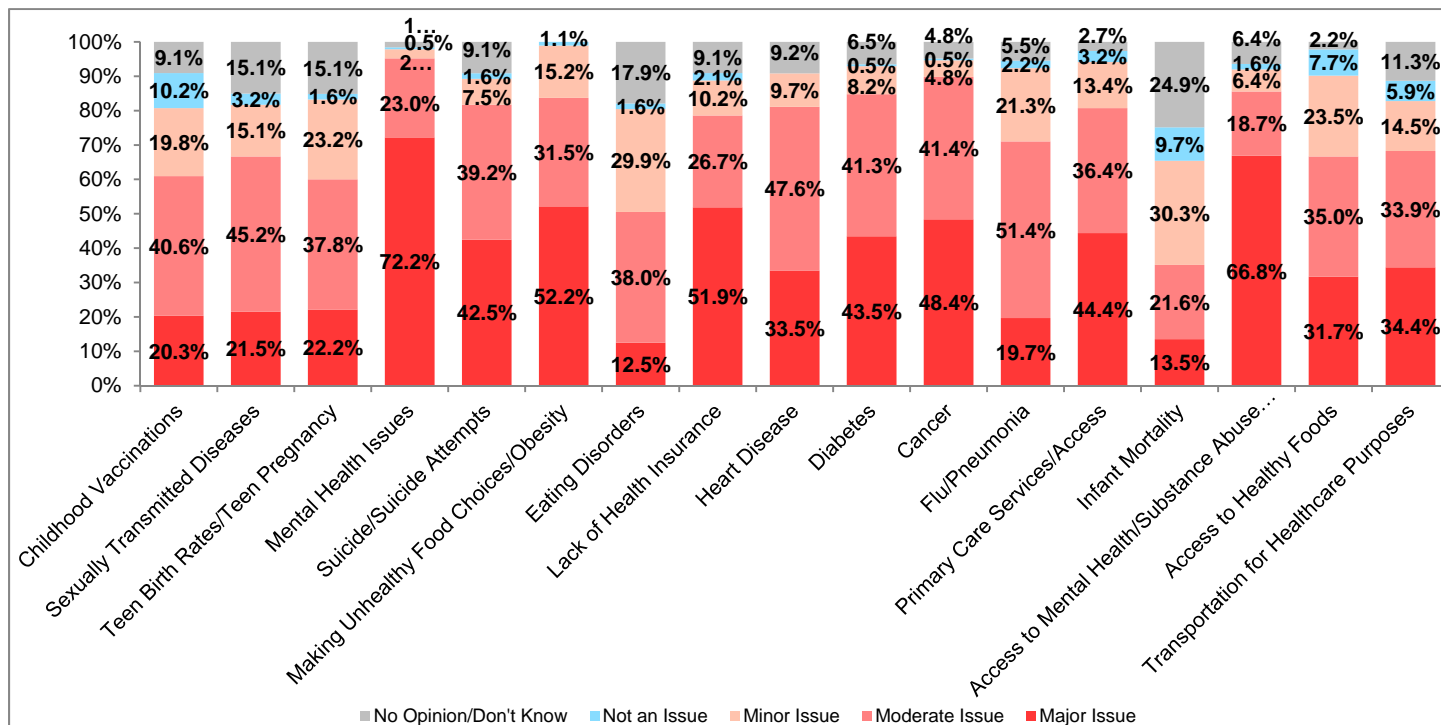
## Appendix A – Community Survey Results

Copley Hospital also solicited a survey to its service area's residents to help understand the health needs and challenges facing the local population to ensure the appropriate health needs were identified for the 2018 CHNA.

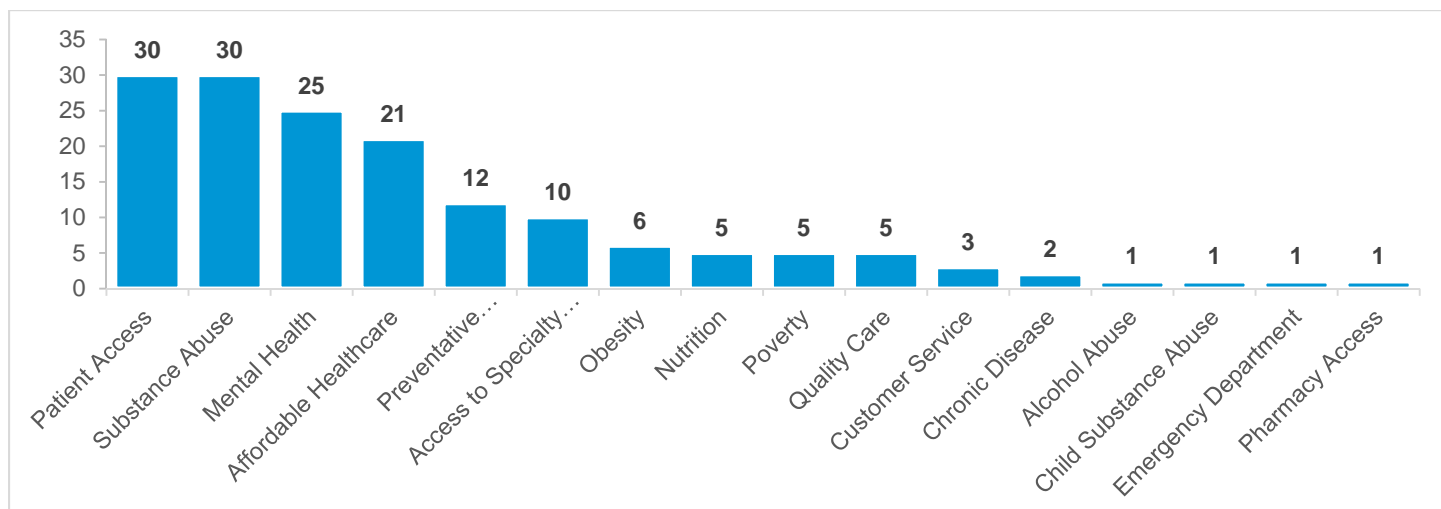
This survey was open to any area resident over 18 years of age. 172 surveys were completed.

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

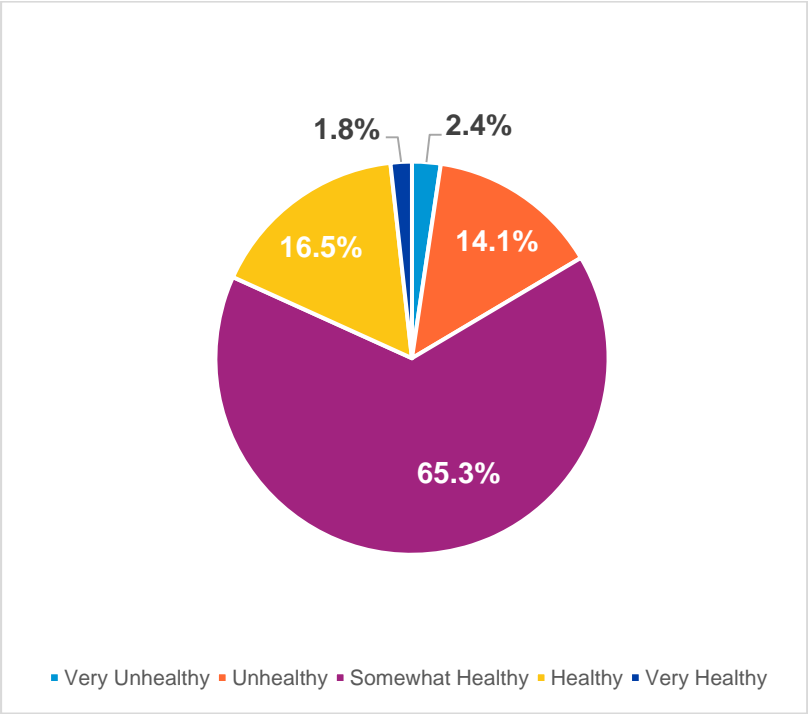
### Question: What is your opinion about the following medical and mental health issues in your community? (n=187)



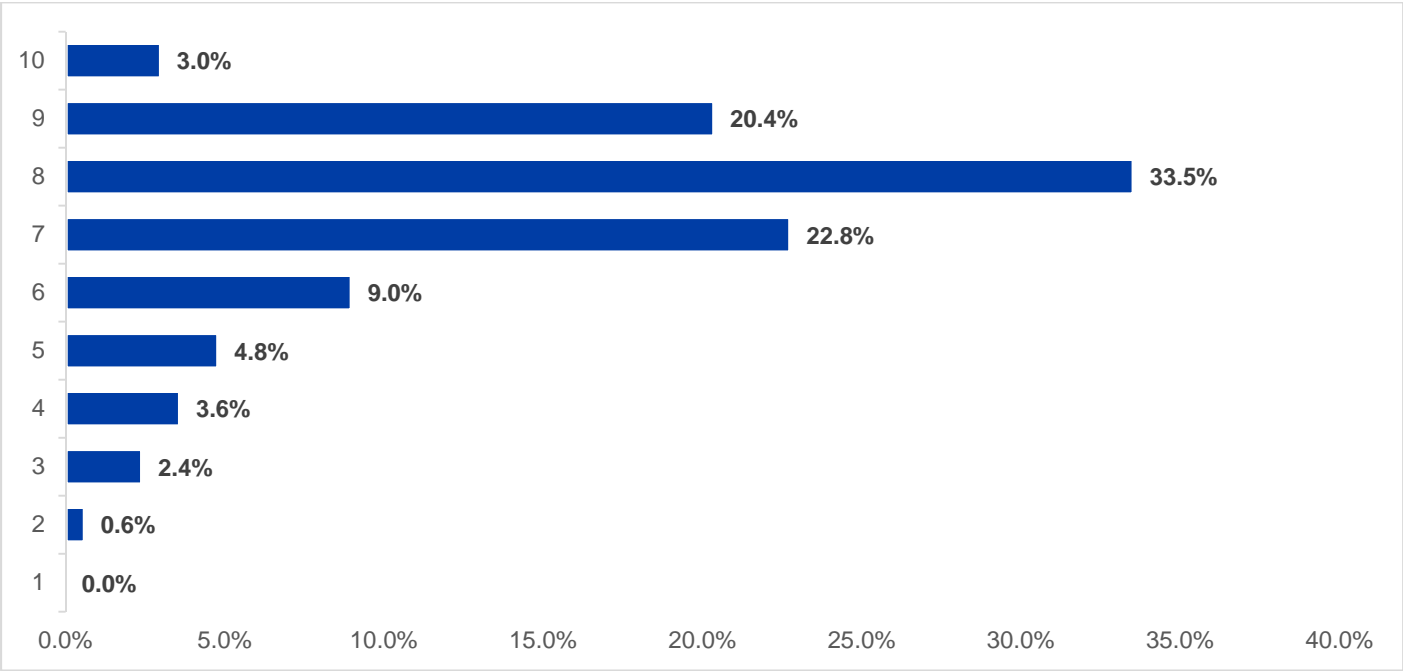
### Question: What do you believe is the most important health or medical issue facing the residents of Copley Hospital's Service Area? (n=153)



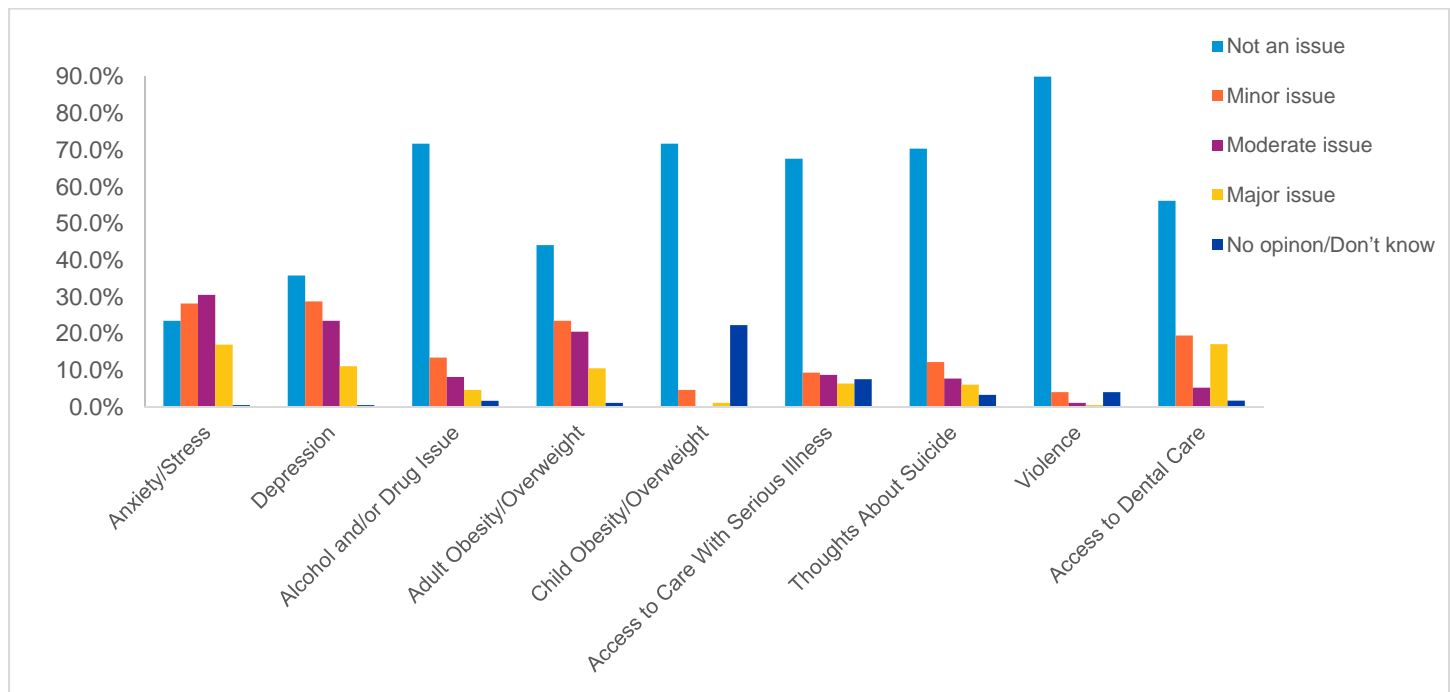
Question: How would you rate the overall health of Copley Hospital’s Service Area community? (n=185)



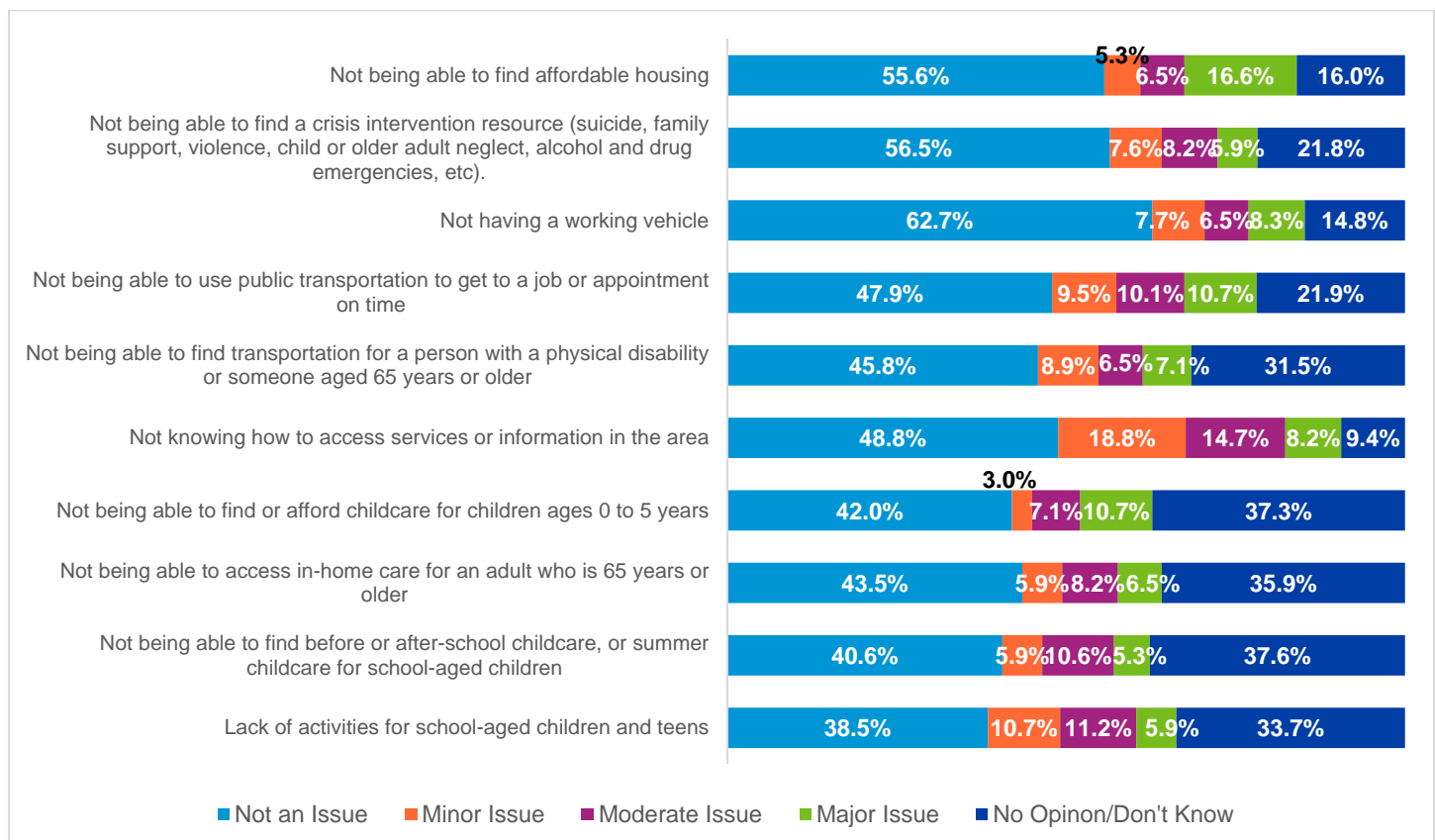
Question: From a scale of 1 (worst possible) to 10 (best possible) how do you rate your overall health at this time? (n=167)



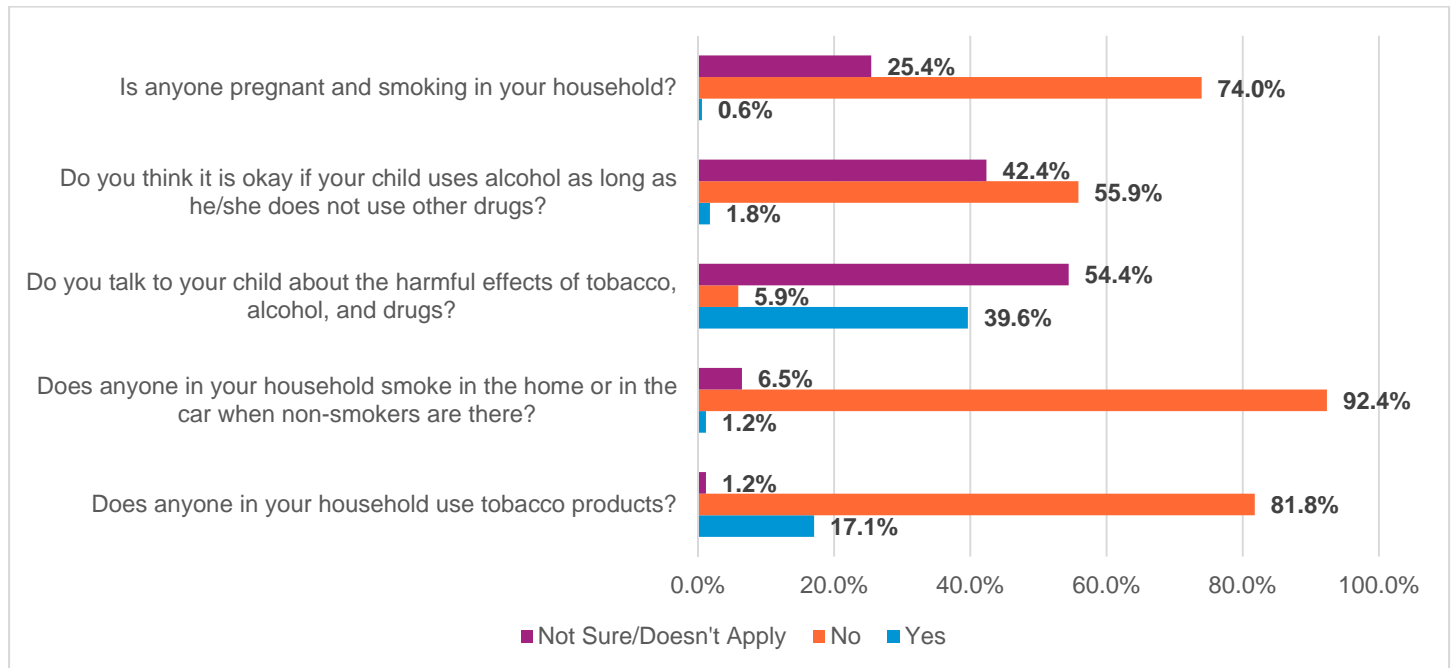
**Question: In your household, how would you describe the following health issues? (n=170)**



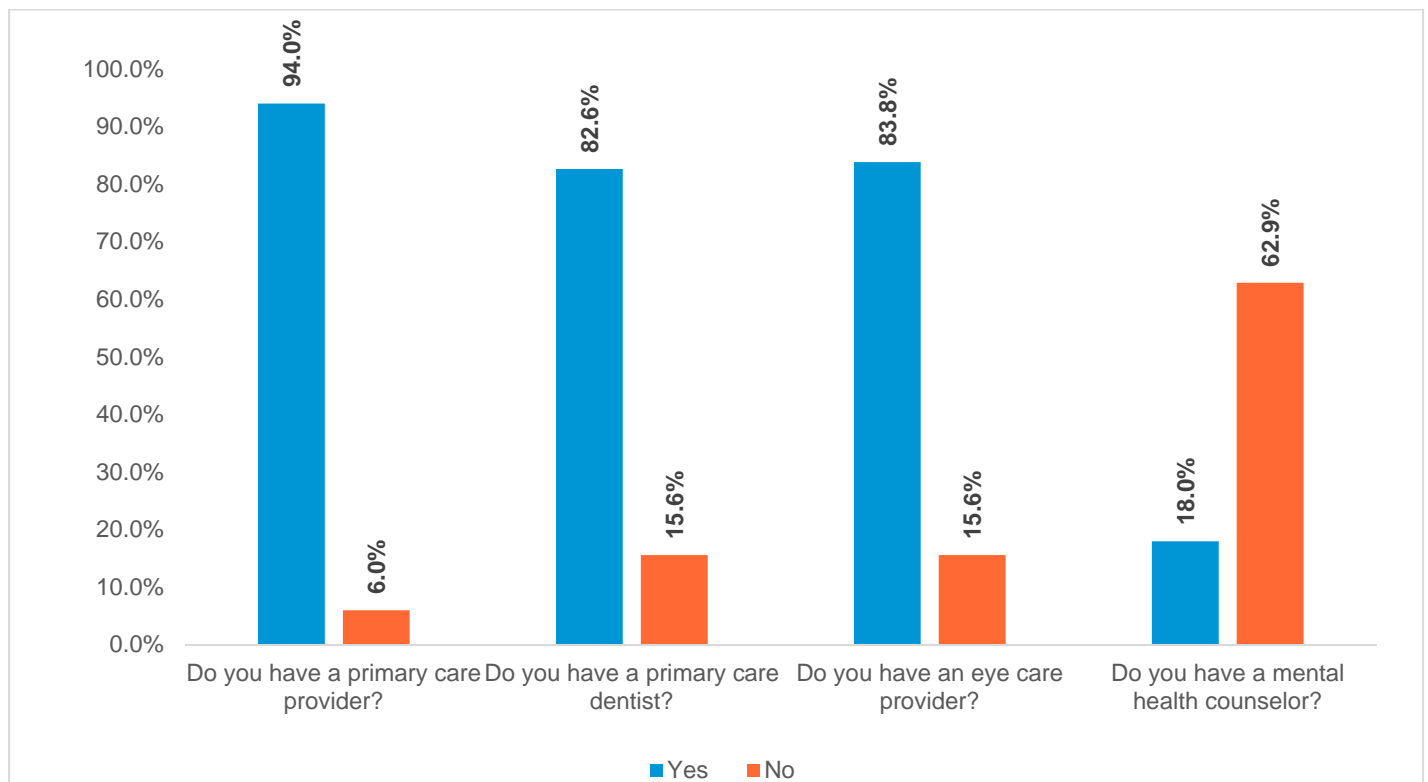
**Question: In your household, how would you rate obtaining the following support services? (n=170)**



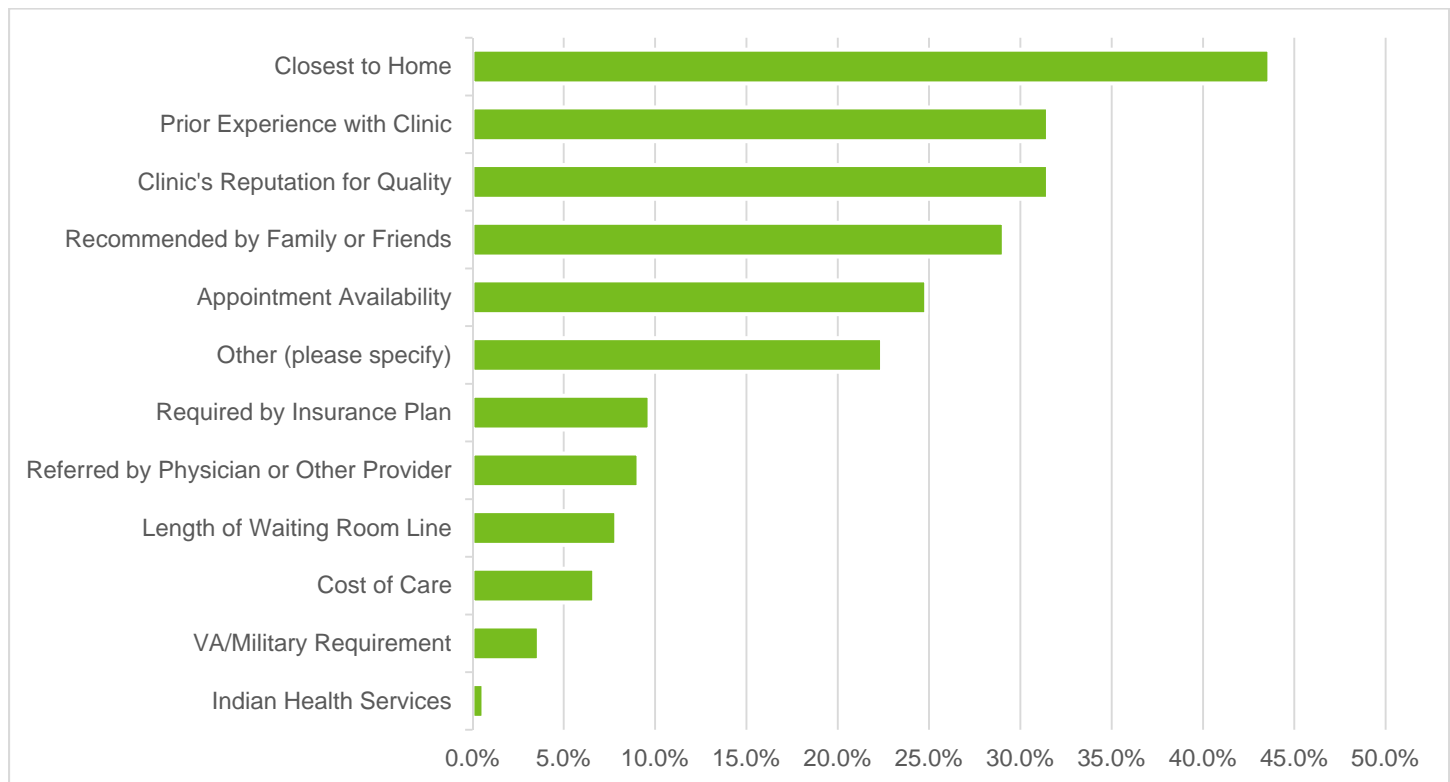
**Question: Please answer the following questions regarding tobacco products used in your household. (n=170)**



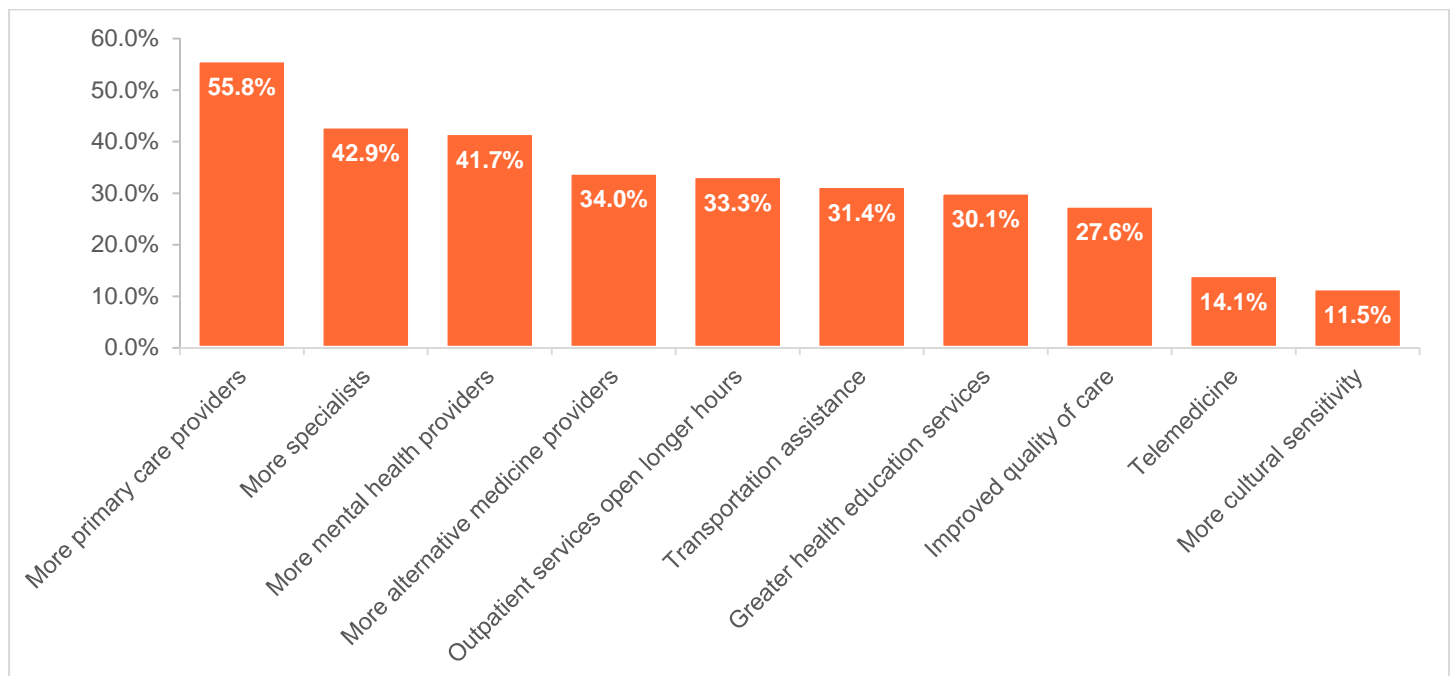
**Question: Please answer the following questions about medical services. (n=167)**



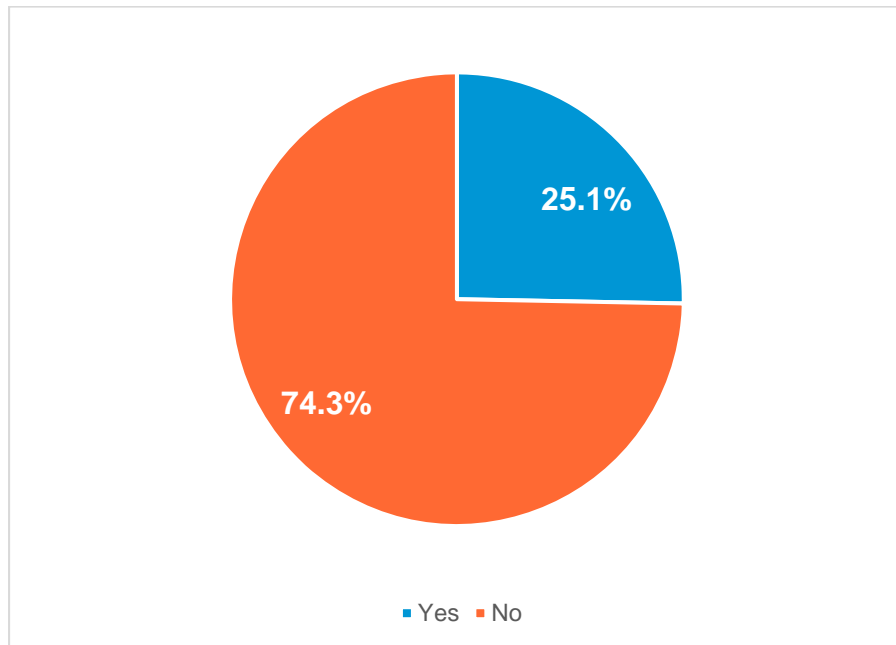
**Question: Why did you select the primary care provider you are currently seeing? (n=165)**



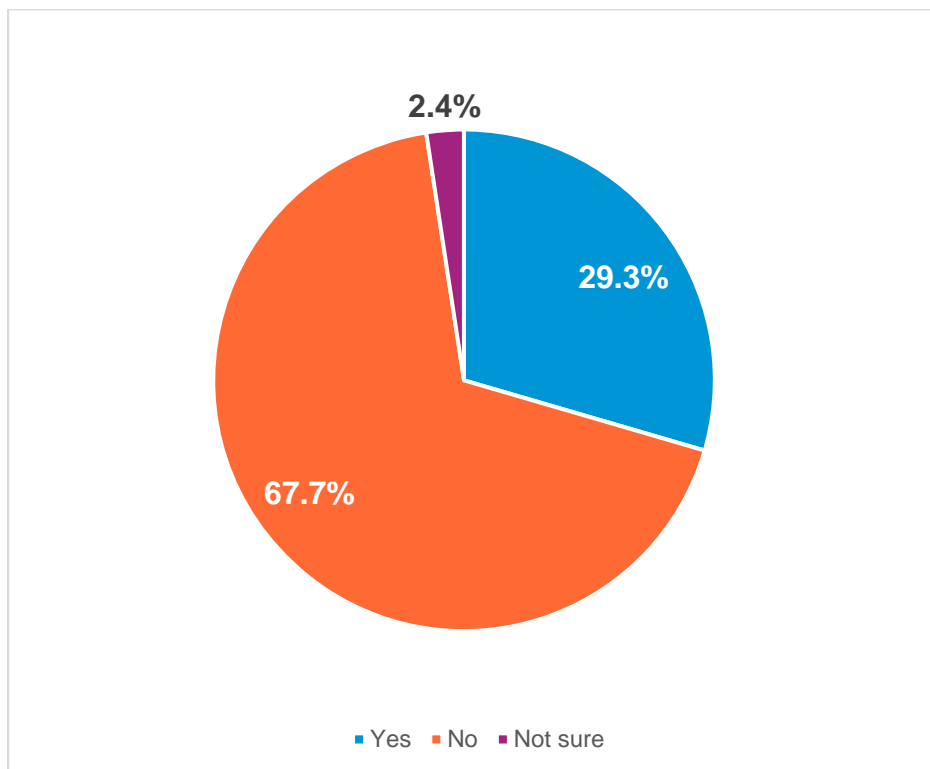
**Question: What would improve your community's access to healthcare? (n=156)**



**Question: In the past year, did you experience three (3) or more problems accessing healthcare due to cost? (n=167)**

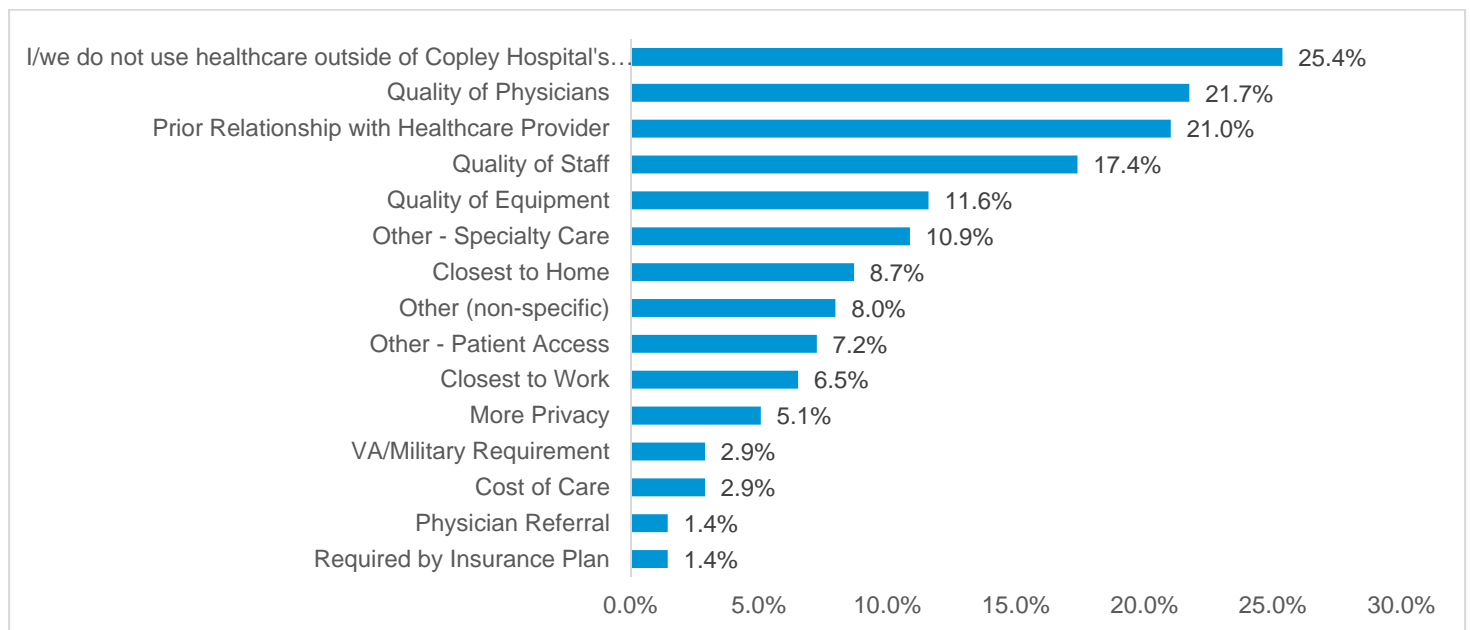


**Question: In the past two years, have you or any household member left the Copley Hospital Service Area in search of Primary Care? (n=167)**

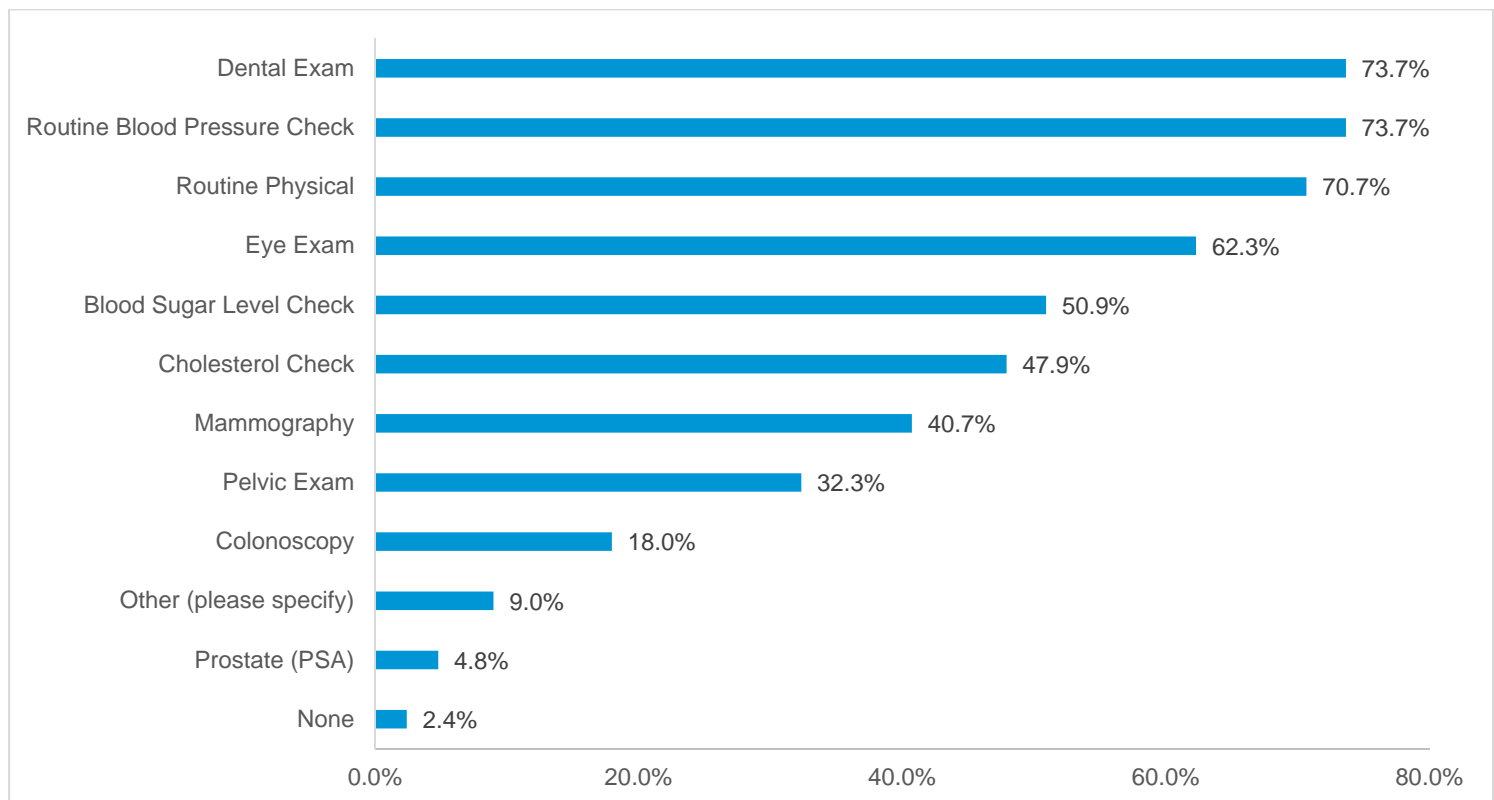




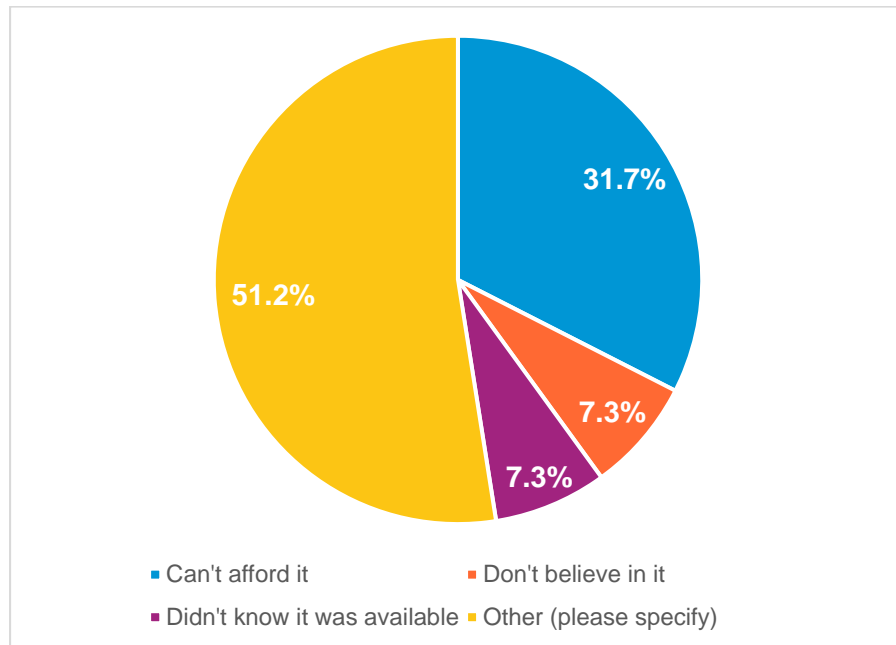
**Question: If you often seen primary healthcare outside of Copley Hospital's Service Area, what are the reasons why?  
Select all that apply (n=138)**



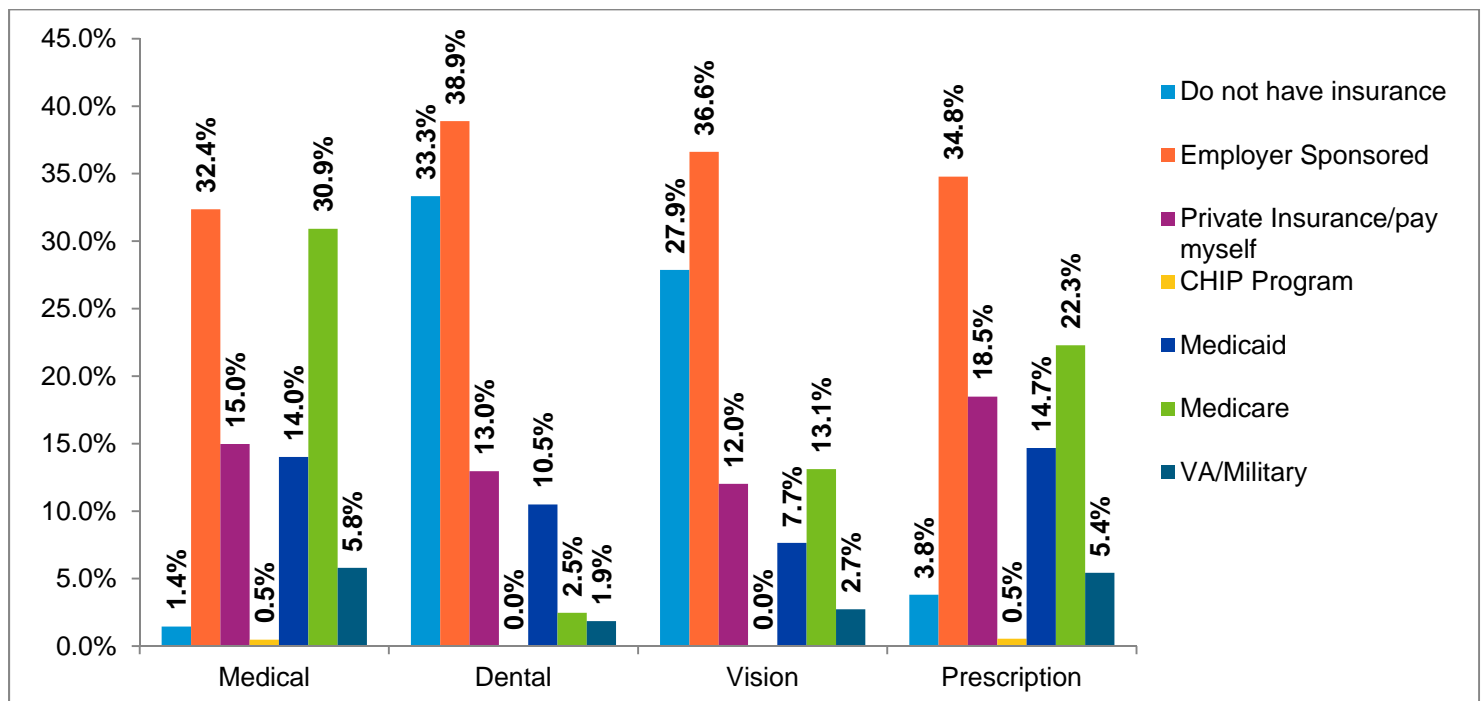
**Question: Which of following preventative services have you used in the past year? (n=167)**



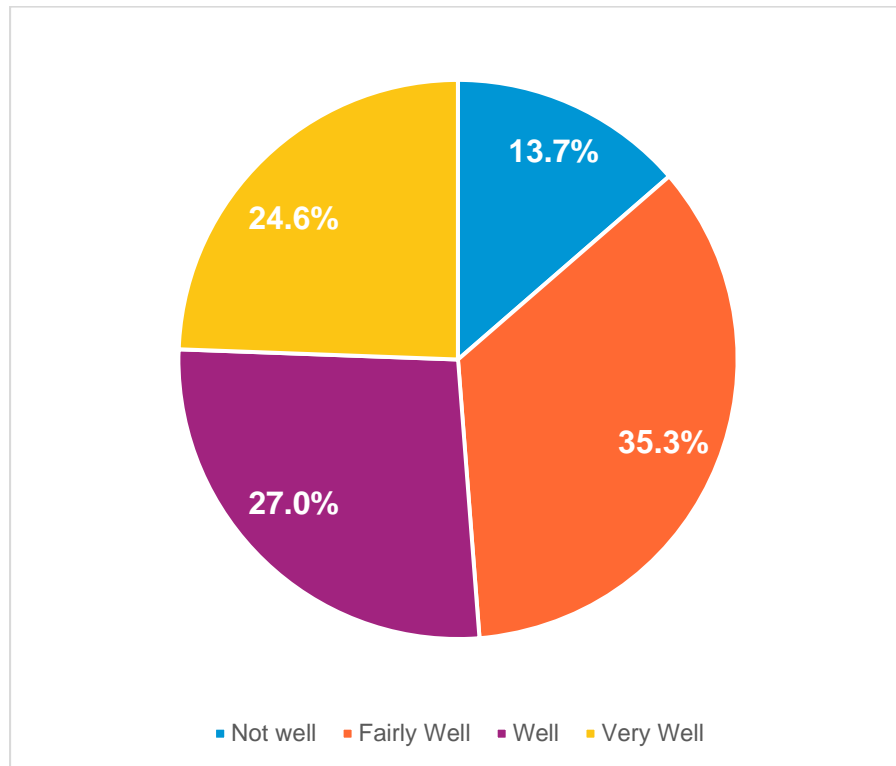
Question: If you have not used any preventative services, why not? (n=41)



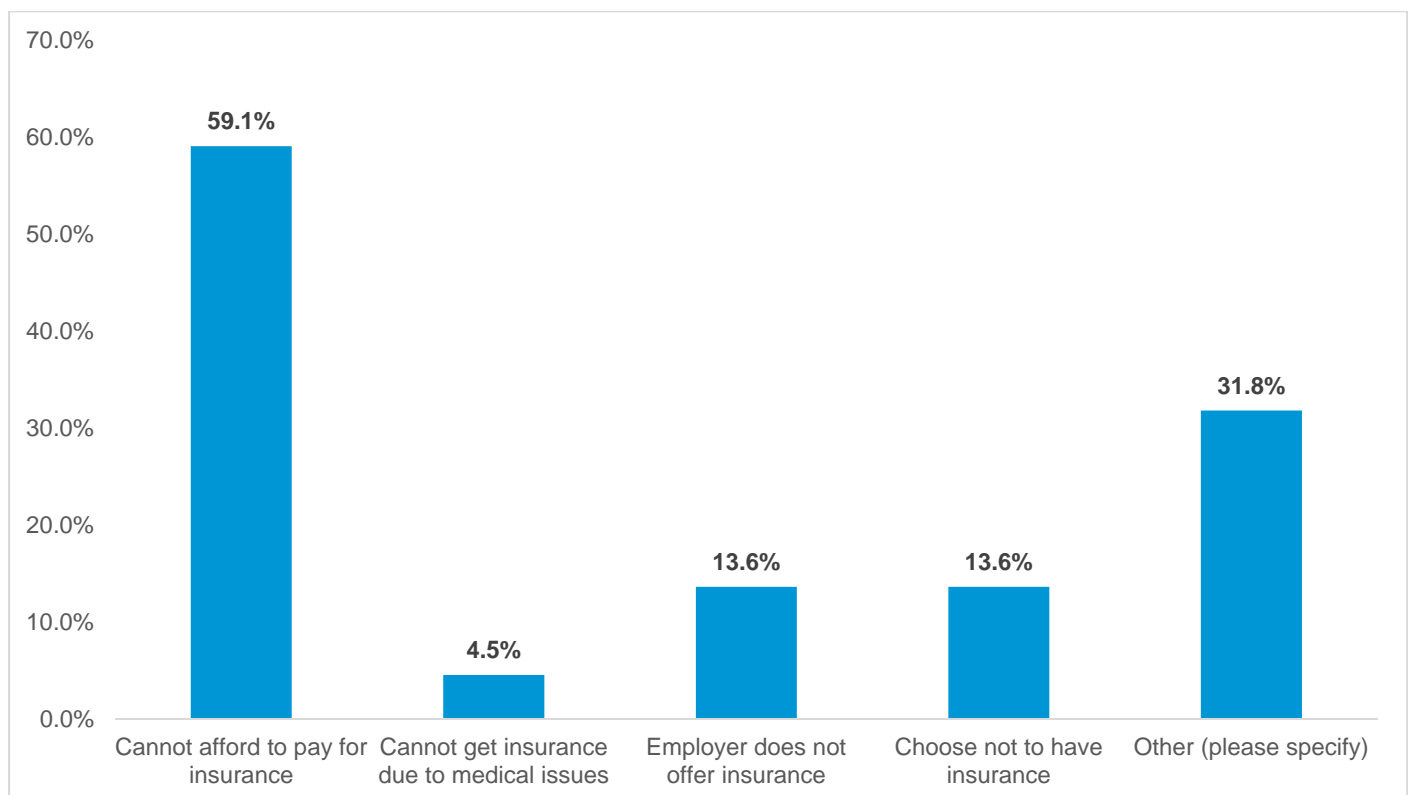
Question: What type of insurance covers the majority of your household's medical expenses? Select all that apply (n=166)



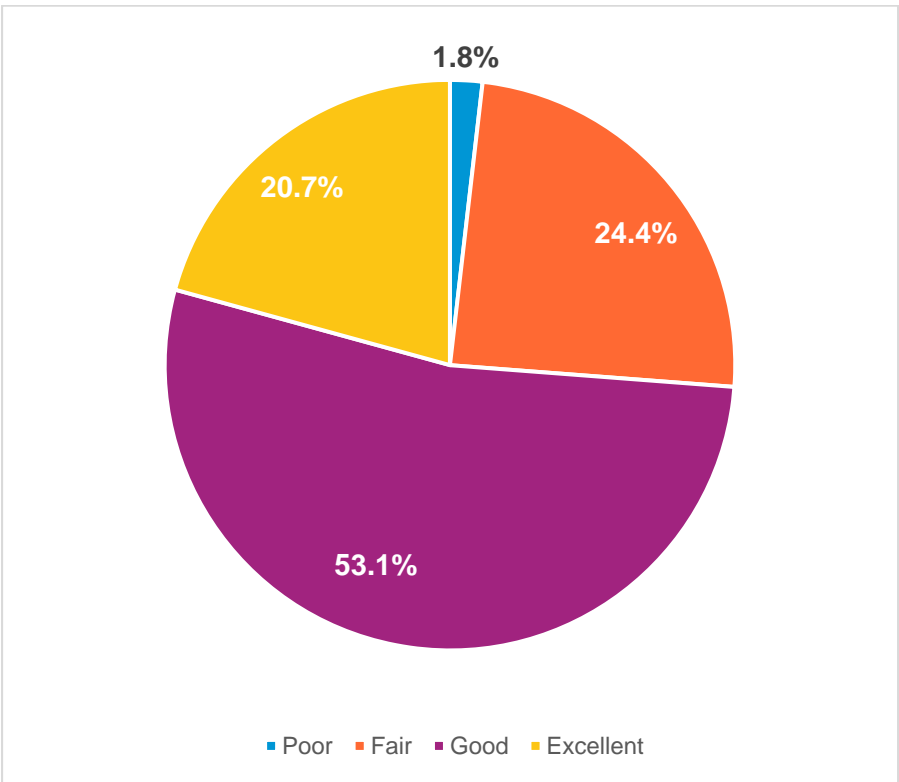
**Question: How well do you feel your health insurance covers your healthcare costs? (n=167)**



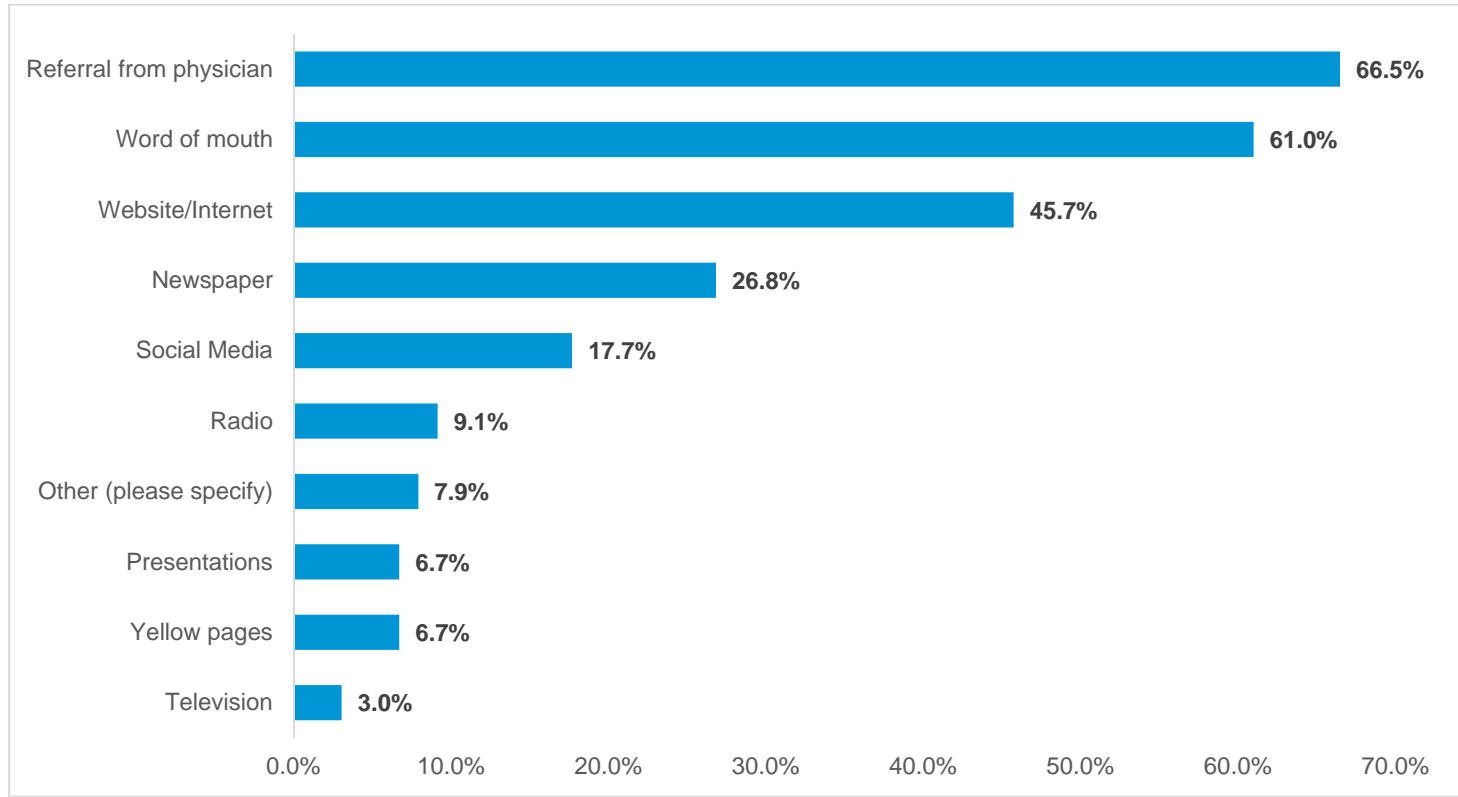
**Question: If you do NOT have medical/dental insurance, why? Select all that apply (n=44)**



**Question: How do you rate your knowledge of the health services that are available in Copley Hospital's Service Area? (n=164)**



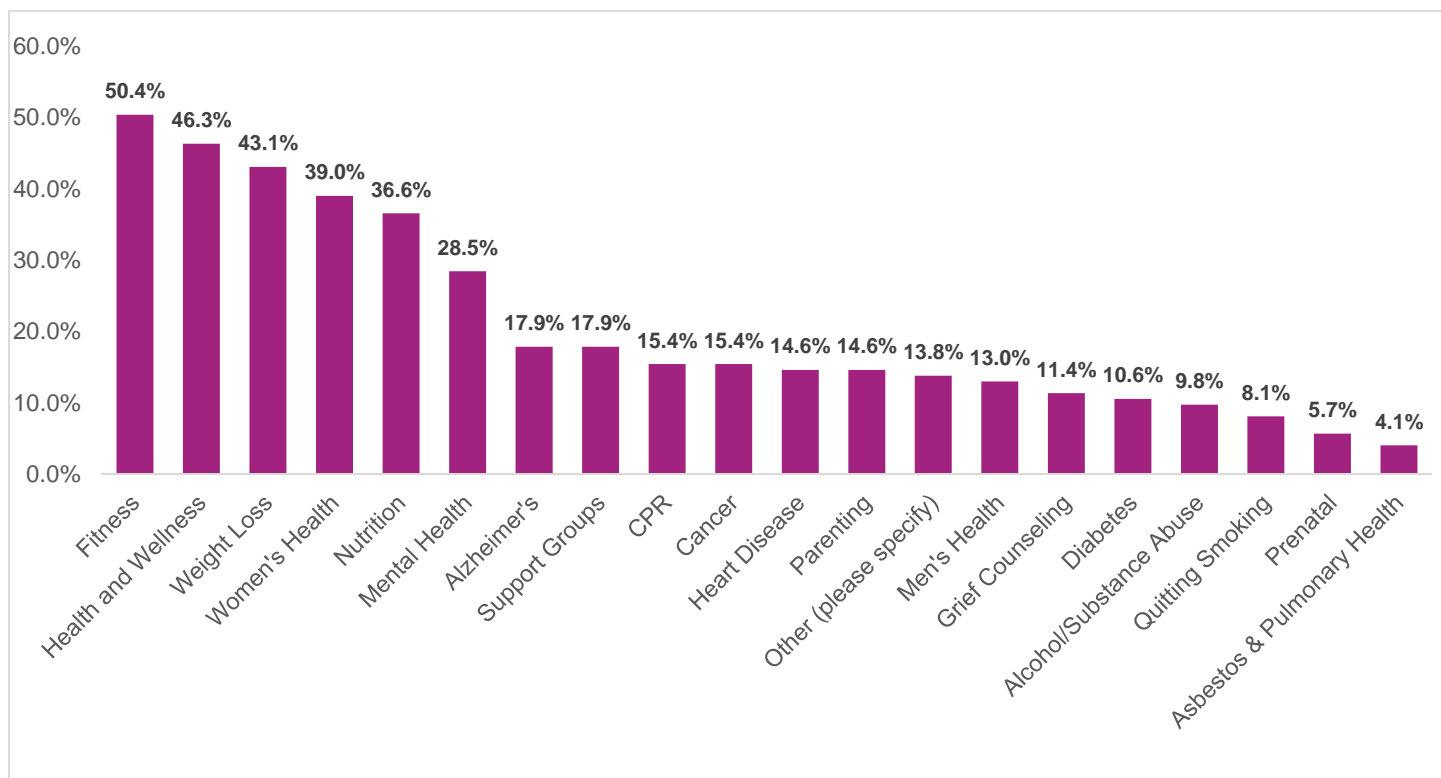
**Question: How do you learn about the health services available in your community? (n=164)**



Comments included from the question above:

- I drive by it every day
- I'm a healthcare professional
- Front Porch Forum (Copley Hospital puts in program offerings) Also, we get their newsletter
- I am a health professional in the area
- I work in human services
- Research
- Long term resident – think publications and community relations are very strong attribute of Copley Hospital

**Question: Which educational classes/programs would you be most interested in? Select all that apply (n=123)**



## Appendix B – Written Commentary on Prior CHNA (Round 1)

Hospital solicited written comments about its 2015 CHNA.<sup>38</sup> 76 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) <b>Public Health Expertise</b>	23	33	56
2) <b>Departments and Agencies</b> with relevant data/information regarding health needs of the community served by the hospital	28	29	57
3) <b>Priority Populations</b>	22	29	51
4) Representative/Member of <b>Chronic Disease Group</b> or Organization	9	38	47
5) Represents the <b>Broad Interest of the Community</b>	60	6	66
Other			6
Answered Question			76
Skipped Question			2

Congress defines “Priority Populations” to include:

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

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

- *Need for education, nurturing, care, support, financial*
- *Homelessness and transportation*
- *Insecurity around food and lack of high quality food, difficult to get to appointments, isolation,*

---

<sup>38</sup> Responds to IRS Schedule h (Form 990) Part V B 5

- *Lack of housing, lack of primary care access, lack of transportation to recovery services*
- *While racial and ethnic minority groups are not prevalent, we in the healthcare and social service community need to improve our cultural competence and health literacy through plain language. Stigma is an ongoing issue related to individuals and families accessing services for which they are eligible.*
- *People with substance abuse*
- *Concerns I have been related to persons at risk of suicide; elders with substance use and depression issues; women with depression--especially post-partum related; transportation issues*
- *I believe that the most pressing needs are for women, children, older adults, residents of rural areas and individuals with special needs who also fall into the low-income group. There are a number of people who are homeless as well as not having enough to eat. And, no doubt, some of them also lack health care.*
- *Assessment of needs beyond medical (i.e. screening for needs for "social determinants of health - housing, finance, job, alcohol /substance use Children - ensuring physical exams through 18 y.o.*
- *The individuals served by my organization have a pressing need for access to nutritious food*
- *Affordable housing is a very scarce resource and security for many young people, and can impact health status of individuals. Opiate addictions adversely affect the health of many individuals.*
- *safety, healthy food, transportation, well-paying employment, access to dental, vision, mental, and other health care*
- *Poverty is impacting the health outcomes of young children and young families. Challenges with food security, housing, and lack of access to quality child care, early developmental screening, and transportation puts young children at risk of long term adverse health outcomes. In the long term, the prevalence of chronic disease and public health investments will be crippling to public institutions without addressing these challenges.*
- *Services are not streamlined and all come with barriers.*
- *Transportation, childcare, substance abuse prevention*
- *Poverty is the great unifier of all these groups, which are all present to some degree in the Lamoille Valley. Subsequently, the greatest need is enhanced access to economic empowerment, which in turn satisfies the enhanced needs for transportation, housing, access to nutritional food, medical care, and community connection, and regular wellness activities. Barring that, access to affordable housing, transportation, and regular primary medical care is particularly needed in the region.*
- *Housing; Access to care (availability of specialists/services, and distance to services); Independence: financial, transportation, cognitive*
- *affordable housing, affordable healthcare, transportation, food security, opportunities to socialize, personal care assistance, homemaking assistance, individualized health coaching, economic security*
- *Substance use disorder; Substance abuse prevention; Treatment and Recovery needs*
- *Many people who are uninsured or under-insured. Many people with multiple co-morbidities and chronic*

diseases which could be better addressed through prevention. Health education may be lacking in some areas.

- *Affordable housing, transportation, wages, discrimination/safety (LGBT), language barriers for racial & ethnic minority groups (farm workers).*
- *Transportation for medical services; Challenges for single parent households (in particular woman) to access health services; Children with a number of ACEs (adverse childhood experiences); Older adults having adequate services to stay at home; Patients with multiple life threatening diseases/disorders*
- *There is a mixture of many groups of people.*
- *Low income groups including women, children and older adults living in rural areas such as ours have needs that should be addressed. 1. The cold winters pose problems providing heat, finding shelter, having enough nutrition, and dealing with winter ailments (flu). 2. Transportation can pose a barrier for these populations getting to and from services, including jobs. 3. The greater community needs to become aware of the issues facing this population so they be more empathetic towards their plight and offer solutions to help their neighbors and in the case of municipal leaders, their constituents. 4. There is no enough affordable housing available. The current vacancy rate for Lamoille County is 1.8% making it hard to find decent housing at an affordable price.*
- *They all need quality health care locally*
- *We have unmet housing needs in our community. Transportation continues to be an issue for many. We could use more no cost / low costs ways to get exercise, especially in bad weather. LGBT community has very limited supports.*
- *Wage disparity and benefit cliff for low income individuals and families - adverse childhood experiences impacting longer term chronic disease - acceptance and acknowledgement of LGBTQ individuals*
- *Affordable housing, employment, access to addiction/substance use disorder treatment and recovery services, transportation solutions*
- *None*
- *In general - older people with the challenge of a rural area - lack of proximate services etc. But not really sure.*
- *Affordable healthcare*
- *Low income: Need help not turning to drugs because of despair. Children: need healthy after school role models special needs: need a place to have relationships LGBT: need to feel fully welcomed*
- *Residents in rural areas have more difficulty getting to their health care professional as often as needed. Cost of health care is a burden to the other groups.*



In the 2015 CHNA, there were 3 health needs identified as “significant” or most important:

1. Reducing Cost of Healthcare
2. Chronic Health Conditions
3. Preventative Care

3. Should the hospital continue to consider the needs identified as most important in the 2015 CHNA as the most important set of health needs currently confronting residents in the county?

	Yes	No	No Opinion
Reducing Cost of Healthcare	62	7	0
Chronic Health Conditions	67	2	0
Preventative Care	69	0	0
Answered Question			70
Skipped Question			8

**Comments:**

- Substance use disorders are at the top of my list that impacts all of the above good nutrition for all folks is a key to reducing health care costs from preventing health issues to treating chronic conditions
- The cost of healthcare, while high, needs to be distributed more equitably among all sectors of healthcare. For example, prevention services, community education and incentives to initiate whole community health related environmental improvements.
- Don't forget mental health issues.
- Related to the preventative care we should include suicide and opiate addiction issues. I am hoping that the chronic condition focus includes persons with substance use and mental health conditions.
- Yes I agree but these are broad topics. The trick is targeting interventions effectively and within the scope of capability.
- These are all important - if I had to pick any to continue as a priority over another, I would select reducing the cost of healthcare and preventative care
- I also believe that there should be a focus on providing health care that is equitable to all of our populations. Our health care providers should have a basic understanding regarding inclusive of all marginalize people so that it reduces the barriers and increases access.
- No, social determinants of health must be considered as strong drivers of health outcomes and future expenditures. Addressing the cost of health care is impossible to do without expanding the availability of affordable housing, access to nutritional food, and sustainable wages. The hospital should begin to play a larger role in those areas, while concurrently pursuing preventative measures - these in tandem will drive down chronic conditions and health care costs - over time, though expenses may initially be higher for the first few years until sufficient infrastructure has been built to address the structural issues previously mentioned.
- Need to focus on integration of the healthcare system. Eliminating (not just reducing) preventable hospital visits (and improved preventative care) relies on the availability and accessibility of primary care capabilities

7 days/week.

- *I'd like to see the hospital take a stronger and more direct focus on substance abuse.*
- *Include opioid abuse with the preventative care need.*
- *There needs to be a lot of outreach to the public and support from community leaders and elected officials in order to provide focus on these goals and reach the amount of people needed to make a difference.*
- *Oral health should be added to the focus above on Preventive Care*
- *1. A primary focus should be on chronic health conditions viewed from an upstream perspective targeting the earliest years (children) and mitigating toxic stress in families and therefore adverse childhood experiences*  
*2. Reducing healthcare costs is driven these days by oversight from rom the GMCB and doesn't need the same attention as it did*  
*3. Preventative healthcare will be addressed through RISEVT efforts*
- *End of life discussion and care. Understanding palliative care as a very good option for those whose quality of life is certain not to improve. Understanding that shot in the dark attempts at staving off further decline can rob one of the quality of life owned today - cost benefit of making smart choices. This is the key to me. In the name of "a Hippocratic oath" we often do to people what we would consider cruel and unusual for an animal. There has to be real discussion of this and training for healthcare professionals - starting at the Physical level.*
- *Opioids are a bigger community problem that alcohol or tobacco at this point..*

**4. Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?**

	Yes	No	No Opinion
Reducing Cost of Healthcare	61	8	0
Chronic Health Conditions	67	2	0
Preventative Care	67	3	0
Answered Question			70
Skipped Question			8

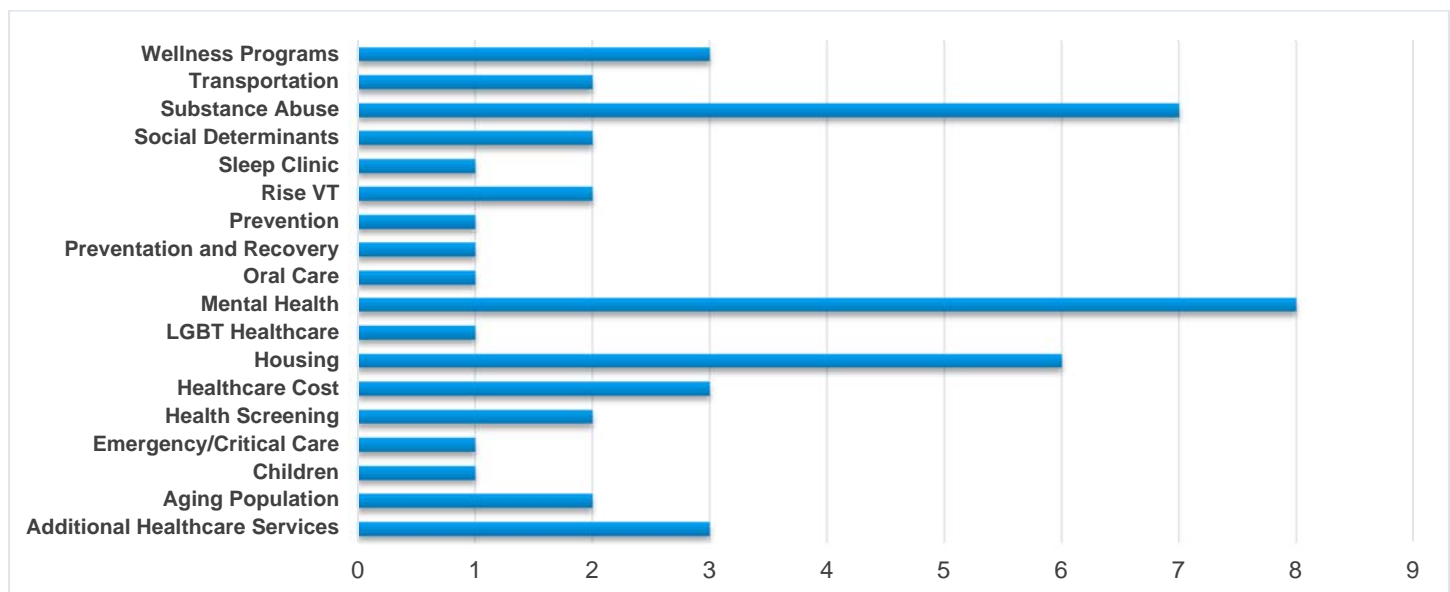
**Comments:**

- *Addictions, mental health issues*
- *Reducing cost of healthcare by redistributing funds toward prevention, education and early screening efforts*
- *Efforts in these areas are a part of the investment to change the process of care more away from reaction to poor healthcare outcomes and toward redirecting those toward better outcomes.*
- *Yes I agree, but narrowing these topics to make effective impact is key.*
- *Preventive care should shift to the primary care practices*
- *Substance abuse leads to many of the 10 Adverse Childhood Experiences, (ACEs). When an individual has 4 or more ACEs it predisposes them to a multitude of chronic lifelong health issues. A multi-generational*

approach to preventing ongoing substance abuse, including screenings, is going to be key to preventing ACEs and thereby preventing many chronic conditions in our community.

- See above. Resource allocation should be shifted towards social determinants to the highest degree possible.
- Need to support holistic / integrated care initiatives (advocacy, coordination with adjacent service organizations, etc) that provide hygiene-level factors like support systems, housing, transportation, mental health that also impact accessibility
- I'd like to see the hospital allocate much more money to the local substance abuse prevention efforts.
- I think it is critical that 'Chronic Health Conditions' encompasses substance use disorder and mental health conditions, as they are chronic diseases that affect physical, mental and societal health and wellness.
- As noted above in #4.1
- Opioids are a bigger community problem than alcohol or tobacco at this point.

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



- Achieving parity between mental and physical health - a whole-person approach to health care.
- Working with addicted patients who come to ER and resolving the problems with patients with severe mental health issues in the ER
- You are doing a great job. Keep it up!
- Our community is in need of more housing. People can't focus on their chronic health condition(s), or preventive care without having their basic needs met like shelter. We have a large amount of our population currently living in unstable housing. We also have many people unable to get to and from important supports in their lives like; AA meetings, the Recovery Center, the grocery store and the food shelf.

- *I will keep coming back to nutrition from making sure programs in the community that provide healthy meals to folks (Meals on Wheels Breakfast at the Church in Morrisville and others) have the funds they need to get good nutrition to individuals. Making sure that all the schools in our area participate in free lunch and breakfast for all kids would make a major difference in the overall health of our community and that includes supporting summer meal programs*
- *We need to also address the homelessness issue. Some of our community members that are chronically ill also have large housing issues. They can't have expected them to comply with recommendations regarding their illness if they are having to figure out how to have their basic needs met daily. Housing needs to come first.*
- *Not yet!*
- *As the Unified Community Collaborative evolves toward an Accountable Health Community, Copley needs to play a significant role in helping to form this multi-payer, multi-sector alliance and system. Copley is seen as the "Healthcare System" by the general public and Copley is a lead organization among the healthcare community. This CHNA helps set the stage for decision making and setting metrics for future action. Essentially Copley plays a significant role in addressing how the local healthcare funds are allocated.*
- *I appreciate that CHSI has become a partner in the project to reduce homelessness in our area via the support of a local shelter. I wonder if more of a mental health consultation in the ED and/or inpatient could help to identify more persons who have some co-morbid (physical/mental health) and lead to more prevention efforts.*
- *I think Copley could reduce transportation costs in the ED by working/sharing with other organizations (i.e. primary care) on transporting patients to their home through a combined fund. Copley should not pay for all of the transport needs of patients especially if the PCP recommends them going to the ED.*
- *Projects that increase preventative care and healthy lifestyles - such as healthful eating and physical activity. Veggie prescriptions or a health care share program.*
- *Social determinants of health and ACES*
- *Focus on reducing toxic stress and adversity in childhood. These factors are known to significantly increase chronic disease, including substance abuse.*
- *Housing and Hunger; Overall Prevention; Rise Vermont*
- *Social determinants of health (SDOH) are a major contributor to poor health outcomes and therefore health care costs. Copley should focus on increasing screening for SDOH as well as substance abuse and mental health disorders. In order to do this, they would need to allocate resources for screening as well as develop and implement streamlined referral protocols to appropriate community agencies.*
- *Better integration and cooperation with primary care practice - to reduce cost (e.g IT integration to cut down repeat testing and unnecessary testing, better records flow and tracking PCP, better communication to PCP office when pt are admitted and d/c). Price transparency for hospital consultations and testing. Review testing protocol to cut down on cost for unnecessary tests*
- *The care that persons receive or fail to receive as a result of a mental health crisis. The care of elderly persons*

*with dementia that causes an inability for them to be cared for at home, with resultant pressure on skilled nursing facilities.*

- *Opiate addiction*
- *While it is increasingly difficult to address the long-term health outcomes of the HSA when short-term costs are challenging, I urge the Board and Staff to begin to invest in universal developmental screening and developmental supports for the HSA's youngest residents - beginning prenatally, and heavily focused on the first three years of life. The evidence of long-term chronic disease prevention from early screening, and intervention when appropriate, is incontrovertible and should be an essential component of the HSA's focus.*
- *Health care for Trans and Non Binary individuals is essential. Trauma informed practices that affect patients and their families.*
- *Partner more closely with Prevention and Recovery... More information sharing. The hospital sees some of the treatment cases and/or refers to the MAT Team/BHW/LCMH, but the other two components are vital to a healthy community. We need to be at the table more together to support area residents and their families.*
- *Yes. See above. Investments in affordable housing in particular, yield the highest immediate savings to the hospital, in terms of ongoing medical costs, and the best outcomes, in terms of patient health.*
- *I would align the hospital's services with the needs of an aging (largely white - - CDC makes the distinction) population in our catchment area. We should be a center of excellence for the 4-5 leading causes of death among this group. Hypertension, cancers, auto accidents, stroke, etc.....whatever they are. The focus should be on emergency/critical (short term) care and then access to a broader network of healthcare capabilities. The hospital should be able to invest heavily in tele / virtual medicine capabilities*
- *Increase in prevention as it is the key to the other needs.*
- *Homelessness/affordable housing. Substance abuse - drop box for meds; direct referrals from ER to medically assisted treatment (MAT), MAT available in person's community.*
- *Screening patients/families to determine their needs that align with the social determinants of health. Providing more support in areas of gaps of social determinants of health*
- *no*
- *Copley should have more specialty resources on at the hospital, endocrine, arthritis, dermatology. cancer MDs so people don't have to travel to UVM or other further areas, we need women breast and gyn in this area.*
- *I think it is critical that 'Chronic Health Conditions' encompasses substance use disorder and mental health conditions. I think the hospital should allocate resources for supporting treatment and recovery initiatives. There are numerous medical, behavioral, and holistic approaches that are shown to lead affected individual to vastly improved life outcomes. Initiate efforts to reduce stigma around substance use disorder, such as community events, education, fundraising.*
- *Opioid use/abuse and the role the doctors there play in over prescribing- not suggesting they do, but it needs to be examined and assessed.*
- *Yes, return the Sleep Clinic so people do not need to travel.*

- *I hear they are looking into participating in Rise VT that will be great. Keeping as many health related services local that they can is helpful.*
- *Oral care is linked to chronic disease especially diabetes and heart disease. Integration of medical and dental would be welcomed. Low SES population dental seems to be addressed when a medical surgery is high priority and at times this is when infection risks are high.*
- *Including nutrition education as part of addressing all of the above as well as changing the food options at the hospital to include organic, no sugar - remove sodas and fruit drinks from the hospital.*
- *Treatment for opioid addiction*
- *I don't know if we have a comprehensive plan for regional supports for individuals and families affected by addiction. If not, perhaps Copley could help articulate the continuum of services/supports and help with identifying and filling unmet needs. This should not be a responsibility for Copley along, but given Copley's role in the community, leadership and support could be helpful.*
- *No*
- *Discussed in Question 3. Reducing the cost and measures taken in "end of life" situations.*
- *Homelessness*
- *Need for licensed professional counselors in our area*
- *Explore and increase collaborative efforts and work to support optimal mental health of community members and priority populations*
- *As stated earlier, the hospital should help in any way they can with the opioids issues in our community. I would also like to see the hospital "step-off campus" more and advocate for infrastructure that supports an active lifestyle when applicable public decisions are being made.*

**6. Please share comments or observations about keeping Reducing Cost of Healthcare among the most significant needs for the Hospital to address.**

- *Keep the utilization of a social worker in the ER needs to continue*
- *I believe you are on target*
- *This continues to be a significant need though progress is being made.*
- *I believe it is very important to continue to grow on the great work that has been done in the ED and in our community regarding care coordination. We still have a long way to go, but we need to continue to develop a strong team to help address social determinants in and around a patient's hospitalization.*
- *I don't see a single nutrition goal*
- *Copley's major investments have focused around reducing ED utilization.*
- *These two programs are winners! - Reduce the service area's rate of 30-day all-cause readmission by following-up with PCP within 7 days from discharge; All person in HSA will have a primary care provider -*

*Inpatient readmissions (Case manager doing real time reviews of hospital inpatient readmits within 30 days)*  
*- Emergency department utilization follow-up with frequent users*

- *I had not understood that the ED was yet screening for depression or suicide. If this is so, then I continue to support that effort. If not, I continue to support the effort to have this happen. A significant number of persons who die by suicide have an ED visit within 30 days of their death. Based on national statistics a depression screening for all will only result in about a 13% referral rate--i.e. that 13% will screen positively and need a referral.*
- *I think if Copley share more responsibility of these issues with other health and human service organizations throughout the health service area there would be more of an effective impact. Each health and human service organization could share a respective attributive lives contribution to an issue for a collective impact.*
- *Obesity is an addiction, focus on addictions more than biking and walk contests. We need to address why they overeat first before exercising them.*
- *The best way to reduce expensive health care and chronic disease is to reduce the prevalence of adverse childhood experiences and toxic stress. Copley should focus on supporting the development of healthy families.*
- *It's no surprise that having primary care as opposed to using the ER as the care-provider is much less costly, both monetarily and from a time-allotment standpoint. The program introduced to the ER to help patients navigate the health care and related systems (i.e., obtaining a primary care provider, scheduling and following through on appointments, securing transportation to appointments, etc.) was very effective, both from resource use and economic perspectives. This effort should continue.*
- *Must continue to keep as a priority.*
- *I do feel this is a priority concern for the hospital to address.*
- *Cost transparency - it is virtually impossible to find out how much a procedure will cost at Copley Hospital. Imaging testing protocols that raise cost (E.G: follow up imaging for pelvic cyst defaulted to imaging kidneys as well added a \$600 to the cost of the procedure - unnecessary; default Breast US for re-call of Mammogram - 2nd mammogram was normal why US?*
- *With regard to reducing obesity - education and implementation of eating well. Remove sugar drinks in schools, hospitals and places that are promoting health.*
- *Care coordination that includes home visits and concerted education are important in reducing frequent readmissions.*
- *Healthcare costs continue to be a barrier to care for many in our rural communities. Poverty seems to be the most significant social driver of health, and we all need to work together to address this challenge.*
- *ED utilization should continue to be a priority of cost for all hospitals.*
- *These are all wonderful and critical components of public health, and Copley Hospital's efforts in the HSA deserve celebration. Few of these efforts, however, address the cause of chronic disease. They all are heartfelt efforts at addressing symptoms. The sooner the Hospital turns its efforts equally to addressing causes of chronic disease: homelessness, food insecurity, and Adverse Childhood Experiences, the sooner*



*Copley will turn the curve in reducing costs by reducing expensive chronic conditions. I urge the Board and Staff of this awesome organization to consider a marked increase investment in addressing causes, rather than symptoms.*

- *I am not really familiar with how much of an impact this has had on the overall health care cost so I am unable to share about any observations.*
- *Not my area of expertise but seem logical.*
- *Investments in the above are solid and should be continued. If possible investments in the prevention and alleviation of ACES should also be considered, as they are the highest contributor to high healthcare costs over the lifespan.*
- *It's really hard to change behaviors. Copley should have expertise or access to expertise on obesity intervention options. Working with other community counseling organizations, on an integrated care approach that focuses on mental health, food stamps, housing, state/local social services, and medical obesity intervention, may be required*
- *Is the incredible increase in the cost of healthcare mainly because there is an excess of preventable visits? I am not convinced.*
- *I believe this continues to be an area of concern.*
- *I know these initiatives were implemented, and they seemed like effective strategies to help with this goal. The resulting data is what speaks to this of course, but things like connecting frequent complex patients with dedicated care coordination and medication reconciliation as part of hospital discharge were logical ideas and I have seen some of the positive results.*
- *This look fine*
- *Have incentive for people that use other equipment, treadmill use as an example have programs or incentive for them*
- *Until recently I didn't know this was a goal.*
- *This is a consummate need for a rural area and a small hospital. I support keeping it as a high priority that needs continual assessment and work.*

*Reducing the cost of healthcare is important. However, does it translate to lower cost of insurance for people that are paying for insurance? Until the cost of insurance is contained/decreased, the cost of healthcare is not decreased. Working people that do not work companies that help with insurance cannot begin to afford to provide insurance for themselves. Even the average person working with an employer that helps with insurance the cost a month is almost as much as rent.*

- *These seem reasonable and needed.*
- *Key- ED utilization being reduced. Frequent users are a challenge for sure. Partnerships with OLH have been helpful. Connecting them with a dental provider is important too. Having them understand their Medicaid dental insurance and utilizing it.*
- *As noted before, I believe statewide efforts and focus by GMCB will drive decision-making to reduce the cost*



*of healthcare*

- *This should remain a priority.*
- *With the persistent efforts of the Trump administration to undercut Obamacare, including removal of the penalty for nonparticipation, I believe this is the single most important need for the Hospital.*
- *Still think that end of life care would do more than any of these initiatives to reduce costs. Not sure that money allocated to bike share etc is the way to go. I'd like to see a focus on all hospital personnel living healthy lifestyles. I'd focus on the employees - who will then spread that to their patients, community members and families. Social media campaigns also good and cost effective. Advocacy for wellness good. Focus on the Opiate problem. It impacts so much of what ails us currently. Definitely educating the prenatal group on all. Referrals good.*
- *Yes, this is an important aspect of healthcare reform and should remain. Continue to work with CHT to reduce unnecessary ED visits and readmission.*
- *"I am in favor of each of these initiatives to continue. Certainly using the ER from PCP needs is not cost effective. Obesity can contribute to significant health problems which can be partially ameliorated with these initiatives. Unmet Mental health issues are significant precursor to poor parenting, care of children, poverty, violence; Women's issues are severely underrepresented in the current political climate*

**7. Please share comments or observations about the implementation actions the Hospital has taken to address Reducing the Cost of Healthcare.**

- *The hospital targeted an education campaign and outreach program to its highest ED utilizers. This resulted in fewer inappropriate ED visits and saved money.*
- *I think Copley is doing a great job of trying to reduce the cost of healthcare. In my role as the ED Social Worker, I have been involved in many of the above projects. Some challenges I have ran into is; lack of PCP offices able to see Pt's within 7 days of ED visit due to Patient not being established; New Pt process is long and offices requesting all past medical records prior to seeing Pt which can't usually happen within 7 days, Pt's being "terminated" from one practice and another practice being hesitant to take the Pt on as a new Pt. We did find high success rates when Social Worker helped Pt complete new Pt packet in ED and set up new Pt appt. Pt's went to most appts. No show rate very low. Over 300 people connected with PCP in 1 year.*
- *Making sure that individuals with substance use issues have a primary care doctor can make all the difference in their recovery*
- *The dedicated social worker in the ED proved to be beneficial in reducing the number and frequency of high utilizers. The number of referrals to PCPs increased, the number of follow-through to PCP is not as clear. The ED Social Worker was able to increase the number of individuals screened for MH and substance use; therefore, increasing referrals to appropriate services.*
- *Connecting patients to a primary care physician is such a value. There are still many people within the community that do not have a primary care physician and do not seek regular care. Getting repeat users of the emergency room to feel comfortable with a regular doctor that they feel is available and in touch with*

*their needs changing people's opinion about a visit. Reduce the service area's rate of 30-day all-cause readmission by following-up with PCP within 7 days from discharge; All person in HSA will have a primary care provider - Inpatient readmissions (Case manager doing real time reviews of hospital inpatient readmits within 30 days); Emergency department utilization follow-up with frequent users*

- *I appreciate the effort of the hospital to participate in the UCC and in hiring the ED social worker. I am not clear what this role is now in March of 2018 as it appears this role has now been rolled into the overall hospital social worker role. Clearly the outcome of having an ED dedicated social worker showed that to address the higher user population takes a specific focused effort. The efforts to address healthcare costs--which are related to addiction and mental health issues as co-morbid conditions--is excellent and with the health promoting activities CHSI is showing itself to have a great focus on overall health improvement in our county.*
- *It appears to me that if you are able to address all of the above issues that you will be doing well.*
- *There is not enough focus on children and young families, who are establishing health habits that will have long term implications.*
- *Reduced rates to commercial insurers by 11% over the past fiscal years.*
- *1. Emergency department referrals to Blueprint for Health Opiate Neighborhood Program (MAT) Besides very few staff in the ED, it seems that, in general, the ED is not aware of the MAT program and has very little connection with the MAT team.*
- *2. Reduce the service area's rate of 30-day all-cause readmission by following-up with PCP within 7 days from discharge*
- *If this is the goal, where are the actions that are collaborating with PCP offices to ensure this is happening? I think focusing on improved communications with community partners, including PCP offices, would improve patient outcomes, patient satisfaction, and lower health care costs.*
- *Great follow up app for discharged pt.*
- *Enhanced coordination between Copley Hospital and Lamoille Home Health and Hospice has improved.*
- *Copley has continued to make real progress in this space. Staying on-course makes the best sense.*
- *I believe the hospital's efforts to reduce ED utilization should be continued. The project they implemented with looking at 29 super users and providing case management to those patients was successful.*
- *Partner with others in the community to broaden the ways to promote dialogue about advance directives including among young and healthy people to ease end-of-life decision making and most likely to also reduce health care costs.*
- *Again, the MATT teams, the care collaboratives, and the fantastic increase in systems integration between the different, formerly separated care providers has really been profound and critical in Copley's excellent efforts to reduce costs. It cannot be overstated, however, that these efforts cannot, in the long run, create major, systemic reductions in the costs of care for the HSA. We know what can and will create these costs - again: actually addressing causes. It's not unrealistic to address these issues, as UVM Medical Center has demonstrated, but it does take courage and leadership. The Hospital can and should divert investments to*

*the efforts to counter adverse and invest in social determinants of health which are known to create long-term health resilience. You know what I mean!!*

- *The social media campaign is not working well because I have not heard nor seen anything and I am a 'plugged' in community member.*
- *Promotion of annual checkups seems to be missing. Even well-child will not turn the curve in the short term, but it helps to establish the pattern for lifelong health. I had regular well-child visits through adolescents and still continue this practice. My husband did not and he is much more likely to go only when there's a need.*
- *Invest in ACES reduction and resiliency enhancement, and social determinants.*
- *Facility utilization Pharmaceutical utilization program*
- *In the 2 years since 2015, have these actions worked? Is the annual cost of healthcare for the local population less than 2 years ago expressed as a percentage of the average income of the local population? If not, there needs to be a re-assessment of these actions.*
- *These actions appear appropriate.*
- *Significant accomplishment getting social worker in ER and The Women's Center; significant process improvement with shared care plan resulting in potential savings to health care system. Efforts toward reducing readmissions have not identified trends, new tool hopefully shows promise.*
- *I think these are good ideas and I think they have shown some positive results.*
- *They are appropriate Area*
- *they haven't given good raises, they have increased rates for health insurance, they have decrease hiring staff, putting more work on staff members who are stressed enough, we need to keep staff members happy and healthy to care for our pts, this needs a lot of work so our community can stay healthy, we need more PCP that can spend longer time with pts and address their needs fully*
- *Until recently I didn't know about the actions.*
- *These sounds like solid steps to take to control costs- especially amongst the frequent visitors to the hospital*
- *The hospital has made efforts at reducing utilization and redirecting utilization to the appropriate location i.e. back to the medical home.*
- *Keep.*
- *"I am thrilled about ED specialist who is working to have users connect to medical and dental providers. Reducing the rate of obesity actions are good. It also relates to other chronic diseases. "*
- *We should consider diverting "excess revenue" back in to community prevention efforts and not to insurance companies.*
- *I have not had direct experience with Copley in these efforts but would welcome partnerships with employers to educate employees (and their families) on efficient/effective healthcare utilization.*
- *I believe the Hospital has done as much as could be expected in this regard.*

- *ED Social Worker, working collaborative with CHT and other agencies to continue this important work.*
- *Other than what you have listed above, I cannot add*

**8. Please share comments or observations about keeping Chronic Health Conditions among the most significant needs for the Hospital to address.**

- *same as above*
- *This is an ongoing problem and should be kept as a significant need to address.*
- *to reduce costs folks must become involved in managing their chronic conditions I have no idea what the impact is of your current actions*
- *The LiveWell Lamoille Blog has gained in popularity and is assisting those of us who contribute to keep prevention at the forefront of our messaging. Healthier Living Workshops and Tobacco Cessation groups seem to be better utilized when they occur at worksites and common gathering sites, versus offering them at the hospital.*
- *Obesity is still a major issue in our community. Programs are great but the people that truly need guidance are not being addressed. People that are living below the poverty level are not looking at programs to help them physically.*
- *Above all, this is a PCP (FQHC), hospital and human services responsibility--including home health, mental health, COA and others. In the last year my agency LCMHS has developed some very positive intervention strategies related to care for persons with chronic health conditions involving the ED and IP use. Overall together we have done well in starting to improve our joint responses, but we still have a ways to go.*
- *This needs to remain a priority if we are going to reduce the portion of health care costs that chronic disease consumes.*
- *Keep as a priority*
- *I do feel this is a priority concern for the hospital to address.*
- *Chronic Obstructive Pulmonary Disease and Congestive Heart Failure patients are a very significant demographic, as well as individuals struggling with dementia*
- *the Community Health Team has done very good work in coordinating our collective efforts, and I am confident Copley will continue to support these efforts.*
- *This should be a priority area for all communities. Prevention efforts can prevent or minimize the impact of chronic health conditions.*
- *Recognize how difficult it is for people with low income to afford healthy food. Examine challenges to conventional (since 1980s?) nutrition. Sugar and not fat is a major factor in obesity.*
- *Of course, these are THE most expensive conditions to address. AND, of course, cultural and societal trends continue to impact the population's susceptibility to chronic conditions - So our efforts must continue. These efforts need to be combined with a strengthened effort to address prevention because they cannot succeed*

*on their own. Again, they address only the symptoms, and have a limited, though critical, place in the formula for the HSA.*

- What about food security? What data is being collected around obesity and the ability to purchase healthy foods when on a limited budget? Is there a relationship between those that access the food shelf due to food insecurity and obesity? Good start though.*
- It should be kept.*
- The largest driver of chronic health conditions is poverty and ACES. Investing in the social determinants and ACES amelioration will reduce chronic health conditions and their accompanying expense over time. Barring that, dollars are being spent in a reactionary way, structural changes are needed to address root causes.*
- Continued participation in integrated healthcare and social services programs (Blueprint)*
- Three important causes of the high incidence of chronic health conditions we know are smoking, lack of exercise, poor diet but if we ask the 5 "Whys" there are deeper levels of causation which need to be addressed in order to have an impact - working too hard for too little income, educational deficits, advertising and availability of products which harm health, lack of child care, lack of leisure time, lack of social support.*
- I believe this is an issue that continue to grow with our aging population.*
- Please refer to earlier comments. I think it is critical.*
- Area to keep working on*
- older pts who live by themselves and who can't afford food and meds , there is lack of trained people who could go help people who want to remain in their home vs going to nursing home, also need more open beds in our nursing home here at the manor and make it more affordable for pts.*
- I don't have a lot of knowledge about the degree of these issues in our community. I will say that these issues are always prohibitive cost drivers and addressing these will help with the cost containment goal.*
- Perhaps offer online support groups that can be accessed at any time of day. The diabetes support group is good, but moved to 1:30 in the afternoon, a time a lot of people can't get to with jobs.*
- Very needed - keep.*
- This still needs to be the priority along with intertwining prevention.*
- I believe Healthy Lamoille Valley's efforts at preventing substance use and abuse should continue to be supported and new efforts directed toward an upstream focus on preventing adverse childhood experiences, i.e., long-term impacts of obesity, substance abuse, mental health issues, etc.*
- This should remain a priority and should include strategies related to addiction to other substances in beyond alcohol and tobacco.*
- Sounds like a good idea but I have no knowledge about this matter.*
- Education in the schools might have the most impact. Help those who can be helped. Have patients talk to young people about how their habits impacted their adult lives - smokers with lung cancer, obese with*

*diabetes etc.*

- *There is a lot of DM, obesity related conditions, COPD, CHF and Mental Health that have extensive costs to the system. Continued work in this area could be enhanced by working with HH & H, MH/SA supporting agencies.*
- *Chronicity would be best served through PCPs and outside of the ER. The hospital should continue to provide support groups and other ancillary services*
- *This should be a focus of the hospital*

**9. Please share comments or observations about the implementation actions the Hospital has taken to address Chronic Health Conditions.**

- *The Live Well Lamoille blog has been well received and is being read. The hospital continues with education and programs for its employees and outside employers. Smoking cessation classes continue to be held for area businesses.*
- *I don't really know what you have done I would suggest working with several organizations and doing a series of family based events that are fun, teach about how to manage your health issues and also serve to education folks about healthy life styles we know that families are under tremendous stress so fun based, family centered events could offer help on many levels a free day at the state park with healthy foods and games and that type of thing*
- *"The environmental enhancements like the bike share take longer to see the impact. It would be good to see this support expand beyond Morristown. Fun Runs provide some visibility, not sure if they encourage new runners or walkers. Would like to see Copley further its support in offering tobacco cessation and chronic disease prevention/management at worksites. Knowing this will increase the cost of mileage and travel to offer these services in outlying areas, but that is what I see is needed in rural areas. It also supports employers to model their support for healthy environments. "*
- *I am least familiar with this aspect, but in my experience, I see that the hospital and ambulatory services have become more sensitive to recognition of a patient centered care approach. Many persons with chronic conditions have co-morbid mental health and/or substance use issues and I am not clear how regularly these are screened for and referred for treatment, but I do believe the staff have awareness of the relationship. The ED social work project seems to have focused on the persons who may be most challenged to regularly use PCP for care versus the ED which is helpful. Certainly, the hospital has be a collaborator with the efforts to track the care of patients discharged and f/u care in the community.*
- *Again, it appears to me that if you can undertake all these actions, you will be going a long way toward addressing Chronic Health Conditions.*
- *Support chronic care teams*
- *The ED social worker position is a smart investment.*
- *Continue with the yearly 5K and using the LACE tool in the acute care nursing unit.*

- *1. Targeted population(s) to receive screening for tobacco, alcohol and depression annually/as appropriate; with appropriate referrals made*
- *Is the hospital screening regularly for these conditions?*
- *The tobacco cessation groups have a low participation rate. If the hospital is screening, is there a standardized referral to these groups?"*
- *Connecting a patient in the Emergency Room with a primary care clinician is a very constructive action*
- *I don't have any real direct knowledge that would benefit here.*
- *"The Live Well blog has helped raise awareness of the importance of prevention; The hospital has worked in close partnership with the Dept. of Health in campaigns to reduce obesity. "*
- *Exercise is important for good health but doesn't do much to help one lose weight.*
- *I've been particularly impressed with Blueprints efforts at establishing connections between care teams, at their support of the MAT Team etc.*
- *I do not think that the hospital has gone far enough. Our trans community is suffering due to lack of inclusive practices and knowledge on health care practices when working with a person that is trans. What about well Men visits and well Trans visits? This is meant as authentic and not to be combative.*
- *"This could be expanded... an emphasis on well-child (maybe find a different name when youth become adolescents) through young adulthood. More marketing on the role sugars. Also, more public awareness around ACEs/toxic stress and the role they often play on obesity. The original ACEs study began around obesity. When you know the root causes, you, the individual become empowered to address the outcomes."*
- *They mostly address middle class folks who have steady employment, leisure time, social support.*
- *It appears that great progress has been made with readmission reduction.*
- *I think some great strides have been made. I'd like to see drug and alcohol screenings at all PCP appointments. I'd like to see Recovery Coaches available for the hospital for patients (and family members) with substance abuse /addiction issues.*
- *Again, they are fine*
- *not sure*
- *I wonder about some of these...while bike racks and run runs are nice and help the community...I doubt these matters to truly obese people. How do we get directly to those people and address their needs?*
- *From what I've observed, I'd say you're doing an excellent job with this and need to continue.*
- *I think the question is how do we change behavior? What other actions can we gather from our community that would help influence behavioral change?*
- *In general, the efforts are all good, but we don't do enough upstream work... it tends to be focused on adults with acute or chronic conditions.*
- *I have observed communications/activities from Copley targeted toward chronic health conditions.*



- *Haven't noticed these actions or their impact.*
- *Other than what you have listed, I have nothing to add.*
- *I do not think the hospital has done much in this regard. It should do more. A stated goal is to "advocate for town policies that support healthy lifestyle choices (sidewalks, green space, etc.) but I have not really since this in action. Copley needs to do a better job of coming of the hill and discussion these issues with the decision makers in downtown Morrisville.*

**10. Please share comments or observations about keeping Preventative Care among the most significant needs for the Hospital to address.**

- *continue to work on Blueprint for Health*
- *This continues to be a significant need.*
- *see above*
- *Preventive care must be the starting point in creating a healthy community. The healthy work to stay healthy but there is not enough partnerships and outreach to the unhealthy.*
- *As much as possible the CHSI efforts in this area need to continue. The most realistic way to reduce health care costs is to reduce unexpected need via prevention.*
- *I think that it is important to continue to focus on Preventative Care and that will also help address the other two issues.*
- *See above*
- *Prevention should receive a large portion of the hospital's community investment funds. In partnership with Health Lamoille Valley, prevention needs increased attention.*
- *Keep as a priority.*
- *Very important to offer Preventative Care*
- *May consider adding some measure for addressing opiate addiction here.*
- *It is a key area to address.*
- *It's really hard for an acute care provider to do prevention. Prevention starts way before health care.*
- *I applaud the new inclusion of prevention - but encourage more consideration of the social determinants of health and EARLY intervention. We all understand that once a child is 5 or 8.... they are nearly fully formed, and their predilection for chronic disease is already extraordinarily difficult to alter.*
- *Definitely!*
- *Prevention effort should be expanded to include homelessness and substance use disorder and mental health challenges. screenings and well patient visits can be expanded to identify these challenges before they occur, which can facilitate interventions the need for more interventions for more acute, expensive interventions.*
- *This is huge, but needs to partner more closely with primary care network. May need to develop an urgent care - outpatient capability*



- *It is a very important need to address.*
- *This issue, in my opinion, is the most important and the key to lowering health care costs.*
- *I agree that preventative care should be among the most significant needs to address.*
- *Fine*
- *not sure*
- *This ties directly into the other issues we have highlighted and remains an excellent objective to have.*
- *Preventative care is important, again people need insurance to access care. Affordable exercise options need to be available in the community also.*
- *Prevention is key to maintaining good health.*
- *It needs to be kept ...*
- *same as #9 above*
- *This should remain a priority.*
- *Obvious need.*
- *Prevention is key. Not sure what else to say except that traditional, naturopathic, dental and mental health should all be integrated into healthy preventative living. Our system of keeping everything separate just doesn't make sense.*
- *While this is important, perhaps resources could be enhanced to youth school age children that will have a larger impact for future years.*
- *Preventative care is an "upstream" method of reducing "downstream" issues that are often too late to address.*
- *early childhood - Adverse childhood experiences/trauma*

**11. Please share comments or observations about the implementation actions the Hospital has taken to address Preventative Care.**

- *I've observed outreach being done via social media.*
- *Enhance SBIRT and other validated screening tools. Expand services for healthy food options by providing Healthcare CSA Shares or Farmers*
- *See above applies generally to all three areas*
- *More needs to be done to reach young families and our youngest children. Investing in care coordination and referral to community supports is a key preventive strategy. Educating local professionals about adverse childhood experiences and toxic stress needs more attention, too.*
- *Case manager in the ER proved to be very beneficial to helping patients get the right care at the right time.*
- *more actions can be taken to address prevention specifically related to nutrition education AND taking bold steps to demonstrate leadership. i.e. remove sugar drinks and any drink with high fructose corn syrup*

- *The efforts taken are important but could be broadened to a wider audience.*
- *A number of the actions, e.g. are important elements of health care but are not prevention - more like early identification for need for care/treatment.*
- *Again, they are excellent initial forays into the clear and considerable area of impact we need to continue to address with even higher investment. Bravo. But start with Maternal Child Health!*
- *Referrals to Healthy Lamoille Valley might better be stated as collaboration with HLV. Healthy Lamoille primarily works for community, environmental, and systems level changes, only having a few direct service programs (Journey to Fatherhood, youth engagement in schools). HLV routinely works with physicians to create marketing materials that are starting to be used in key areas around Lamoille's Health Community (ie. Questions to ask your doctor when receiving a prescription, Opiate help cards, prescription drug safety and drop box information). This information is also brought to schools and area functions. Perhaps deepen the level of collaboration for deeper impact. Some of prevention's goals could easily overlap... ie - promotion of well-child visits as a tool to fight youth substance use (and many other chronic illnesses). Current prevention thought around the country is that for every dollar spent on evidenced based, research informed prevention interventions we reap \$10-\$18 in the benefits (preventable illnesses, treatment, hospitalization, loss of wages, etc.) While this investment does not see immediate results, it is vital for long-term cost reductions and better community health.*
- *See above.*
- *A good start.*
- *Copley has shown its commitment to preventative care.*
- *I think all of the above actions are effective prevention strategies.*
- *Fine*
- *hired social worker for er*
- *These are great steps to take in the right direction of preventative care*
- *Participating in the Women's Health Initiative is good. Partnering with WIC.*
- *Hospital's done well.*
- *Not familiar with how successful your screenings are for Low SES*
- *same as #9 above*
- *I have observed communications/activities from Copley in support of health lifestyles.*
- *I have seen the Hospital's widely distributed publications--look good to me.*
- *I cannot add anything to what you're already doing*

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

- *the aging population in our area will bring new challenges to Copley*

- *Keep up your good work on mental health, preventative physical activity, diabetes education, and personal, caring presence for each person!*
- *Lots of good work is being done.*
- *I want to continue to stress the issue about affordable housing in this area, the importance of keeping the local shelter running and the lack of transportation. Patients can't focus on their health when they are trying to figure out how to have their basic needs met every day. We continue to run into cuts at the State level for housing. I am fearful for the year when the housing money runs out and we see a drastic rise in homelessness in our state.*
- *working with other groups in the region think about getting services like free blood pressure checks into events at schools think about getting into parts of the community where folks who don't have easy access to health care are take information to where folks are basketball games, super markets*
- *You are doing a great job! The greatest asset to the effort you are making is the hospital's day to day approach to patients. Unbelievable gentle caring for all patients. As Chaplain, I hear the feedback, every week!!!*
- *Healthcare funding is uncertain at best. Equitable distribution of these funds with a focus on prevention needs more attention.*
- *Mental health issues should be at the forefront of conversation and not swept under the rug.*
- *I would like to see more outreach from the Copley staff. Just some thoughts- offer an hour a two of paid time a month to staff that will do community outreach, join a local board, volunteer*
- *Please continue to see healthcare as a broad brush issue. It is related to mental health, substance use, housing, child and elder abuse, and a variety of economic issues. CHSI has made some changes in understanding these related areas and I hope keep it up. Thanks*
- *No but I strongly suggest the concept of an accountable community for health (ACH) as a way to achieve support in these interventions.*
- *While I appreciate being asked to contribute to this survey - I feel as though I have not been involved in a process to fully understand the initiatives taken in the past three years and therefore don't feel comfortable assessing the actions. If time allows - I would be interested in participating in a community conversation (meeting) around these topics. I find it hard to respond thoughtfully to surveys. My apologies for not offering more substantive responses.*
- *Pay providers to do what you want instead of just processing patients through appointments.*
- *I urge Copley to look at how it can provide leadership in the region to address Adverse Childhood Experiences - to educate people about their impact, and to develop strategies and investments to reduce their prevalence.*
- *As an aging population, both in the service area and Vermont generally, we should be looking at potential needs five, ten, fifteen years from now and strategize how to meet those needs.*
- *With finite resources, Copley must focus on 2-3 key initiatives that will provide the best value for our patients and community.*

- *I think it is important for our hospital to foster advance directives discussion such as in community forums, and as well committing our resources to mental health care and palliative care.*
- *I believe all medical practitioners and the community need to understand the link between ACE (Adverse Childhood Experiences) or Toxic Stress and chronic disease.*
- *Consider how often we treat the symptoms, not the underlying root causes of disease and poor health.*
- *Overall, there are developed systems of care already in the community that need to be resourced to address long-term chronic disease prevention. I would urge the Board and Staff of Copley Hospital to look to community partners and assess their capability to be collaborators in an effort to build resilience and protective factors in the community those efforts have long been underway in sister organizations, like the Lamoille Family Center. It is only when we address the causes that require expensive interventions that we will be able to ultimately reduce their prevalence. Finally, I appreciate the opportunity to respond to this survey. Thank you!*
- *More inclusive and more involvement from those that are at the greatest risk. Opening up pan honest dialog with those that are currently going through some hardships, homelessness, substance use disorder, etc., would show a real dedication towards our community and its inhabitants. I hope that this make sense.*
- *To find new ways to include the research around ACEs/toxic stress and resilience into our daily work. Thank you!*
- *Please enhance your investments in social determinants and use your financial capacity to help patients in your Hospital Service Area obtain affordable housing and access to adequate nutrition. These investments do much to improve outcomes, and reduce costs over time.*
- *It will take a total community effort to have an impact on the root causes of chronic disease, mental health illnesses, substance abuse disorders. Everyone respects and appreciates their hospital so it is wonderful that Copley Hospital wants to take the lead.*
- *Appropriate and affordable childcare continues to be an issue in the area. It is also an excellent tool to introduce healthy habits to families.*
- *As previously mentioned, utilizing resources for prevention, treatment and recovery resources for opiate addiction and all forms of substance abuse is imperative. I believe we should be looking closely at underlying issues and adverse childhood events as an avenue for educating ALL of the service providers in this county.*
- *No*
- *NEED MORE SPECIALITY DRS AND PCP IN THIS AREA, MORE OPEN BEDS AT THE MANOR, MORE DRUG IN HOUSE TREATMENT CENTERS*
- *How does the hospital become part of the community is serves and not a building where people go to when they are sick or need medical attention. There will always be those conditions, but prevention will take a different focus. What are the desired outcomes past reduced emergency department visits? How do we measure a healthy community? How do we reach the most vulnerable and hard to reach who need the most help? How do we make is easy for those with physical and mental/emotional needs and addictions to get the on-going treatment they need to become successful in the community?*

- *The absence about anything regarding the opioid issues in our community is troubling...this is something we should all be working on. How is it not one of our top priorities?*
- *It seems as if Mansfield Orthopedics is very much favored by the hospital. Perhaps more focus on the three significant needs would yield greater results.*
- *Vaping is the next hot topic. Partnering with the housing coalition. Basic needs to be met before people can work on good health.*
- *There is a need for dermatology and it is difficult or impossible for rural, elderly to get to appointments with providers who are 50 or miles away. Copley needs to reinstate dermatology services.*
- *I believe having a dentist or a dental hygienist presence connected to the hospital would be a win-win.  
[http://pubs.royle.com/article/Dental\\_Hygienists\\_in\\_a\\_Hospital\\_Setting/2474630/300966/article.html](http://pubs.royle.com/article/Dental_Hygienists_in_a_Hospital_Setting/2474630/300966/article.html)*
- *I think the questions focused on the previous assessment priorities and actions may lead individuals completing the survey toward previously focused efforts. I tried to step out of that box to focus on upstream work with children and families to mitigate toxic stress and prevent adverse childhood experiences. Thank you!*
- *The Hospital already does an excellent job in covering health needs.*
- *continuing to look outside the box. We are lucky to have Copley Hospital in the neighborhood. Thank you for all you do.*
- *I believe there is great effort between Copley and their community partners. Brainstorming for how to do more and improve more can always work, if the resources are present to enhance initiatives.*
- *Someone asked me my opinion on how to prevent children from smoking or doing drugs. I encouraged them to begin with caring for families, especially families that are distressed, underserved, dysfunctional, or in poverty. I would suggest that targeting families is a way to help not only the adults, but even more importantly, the children in the families*
- *Let's work harder to make Copley Hospital truly a part of this community, not just a hospital organization located in Morrisville.*
- *opiate treatment*

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

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Preventative Care - 2015 Significant Need	578	40	12.04%	12.04%	Significant Needs
Mental Health	501	35	10.44%	22.48%	
Chronic Health Conditions – 2015 Significant Need	475	37	9.90%	32.38%	
Substance Use/Abuse	450	31	9.38%	41.75%	
Reducing Cost of Healthcare – 2015 Significant Need	436	33	9.08%	50.83%	
Housing Insecurity	358	32	7.46%	58.29%	
Food Insecurity	288	29	6.00%	64.29%	Other Identified Needs
Obesity	240	24	5.00%	69.29%	
Alcohol Use	205	24	4.27%	73.56%	
Transportation	178	22	3.71%	77.27%	
Diabetes	137	19	2.85%	80.13%	
Cancer	131	18	2.73%	82.85%	
Heart Disease	125	18	2.60%	85.46%	
Women's Health	121	16	2.52%	87.98%	
Tobacco Use	101	17	2.10%	90.08%	
Suicide	86	16	1.79%	91.88%	
Accidents	85	14	1.77%	93.65%	
Alzheimer's	84	13	1.75%	95.40%	
Stroke	43	12	0.90%	96.29%	
Lung Disease	39	10	0.81%	97.10%	
Flu/Pneumonia	33	10	0.69%	97.79%	
Kidney Disease	17	7	0.35%	98.15%	
Parkinson's	17	8	0.35%	98.50%	
Child Well-Being/Developmental Screening	57	3	1.19%	99.69%	
Pharmacy	10	1	0.21%	99.90%	
Oral Health	5	1	0.10%	100.00%	
Total	4800		100.00%		

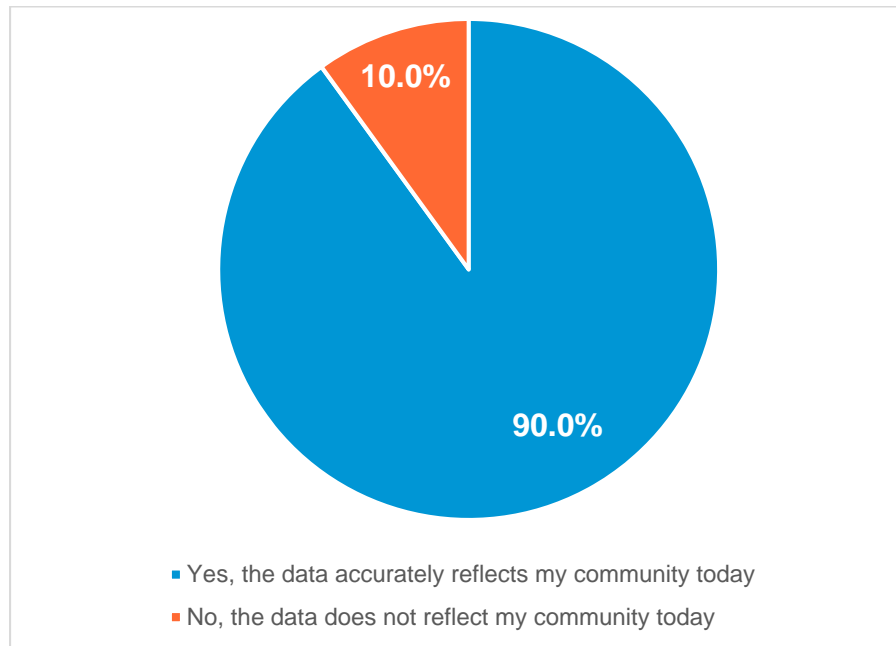
### Individuals Participating as Local Expert Advisors<sup>39</sup>

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) <b>Public Health Expertise</b>	16	21	37
2) <b>Departments and Agencies</b> with relevant data/information regarding health needs of the community served by the hospital	19	23	42
3) <b>Priority Populations</b>	23	22	45
4) Representative/Member of <b>Chronic Disease Group</b> or Organization	15	25	40
5) Represents the <b>Broad Interest of the Community</b>	42	7	9
Other			
Answered Question			58
Skipped Question			0

<sup>39</sup> Responds to IRS Schedule h (Form 990) Part V B 3 g

## Advice Received from Local Expert Advisors

Question: Do you agree with the comparison of Copley Hospital's Service Area compared to all Vermont counties?



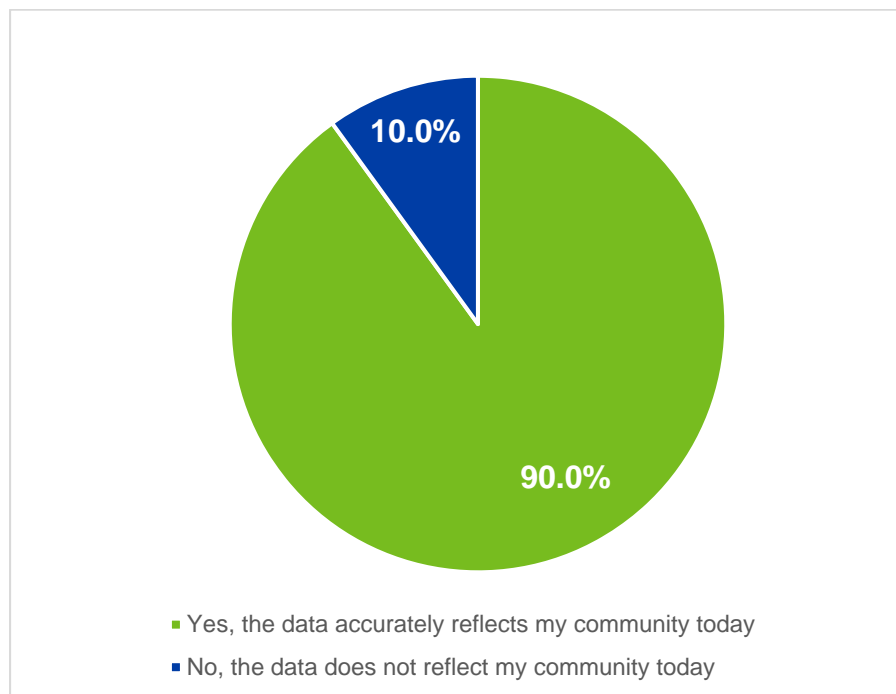
### Comments:

- *Difficult to assess quantitatively, my responses is subjective.*
- *I am shocked not to see more about substance abuse rates among youth and the 26 plus population*
- *I have no reason to believe that the Community Health rankings aren't accurate and would need a bit more information to assess and compare. That said, with the exception of a couple data points most are adult behavior. It seems that we might want to be addressing primary and secondary prevention data sources from prenatal through early childhood. Research tells us that safe and nurturing environments early on prevent chronic disease later in life.*
- *not sure*
- *not sure*
- *Lamoille county: Dentist ratio, population to mental health provider*
- *I am not surprised by the alcohol related deaths across all counties, driving alone to work, access to exercise opportunity - the things I see changing is access (especially in Lamoille County) is dentist, and mental health for acute needs and substance abuse. But, barriers still exist so that is why I checked yes. I am also surprised at the Injury deaths in all counties and teen births.*
- *Housing is becoming more of an issue in Lamoille Co. Many buildings being rehabbed then rents go up enough to exclude Section 8. A growing problem and Johnson and Morrisville*

- *I'm not sure how I would know this information.*
- *Generally accurate -- I question whether there is a problem with access to exercise opportunities in Lamoille County. We may need to educate and rethink what ""exercise"" includes. Not sure about unemployment rate...as relevant might be the type of employment (full-time vs stringing together multiple jobs) and the % with insurance (which should be 100%, but may not be)*
- *I indicated "yes" but, frankly, I am not sure what is being measured and how. Also, very unclear what the metric is that being used.*
- *I am really not sure.*
- *I'm not involved enough with a broad range of residents to be able to answer this.*
- *Need total numbers to determine if issue is statistically sound.*
- *For the most part. I do question the teen birth rates as our numbers small; therefore skewing our data.*
- *To be honest, these charts are somewhat difficult to understand, especially the first one. I am unclear exactly what information you are trying to convey with this chart.*
- *I am unsure of the accurate reflection of this data.*
- *I wonder if youth access to substances was looked at in relationship to the state? Also community perceptions as identified by the Youth Risk Behavior Survey?*
- *Without seeing the data, I can't answer with any certainty*
- *This is as best I can answer without more detail or explanation. However, trusting the expert sources, these seem appropriate.*
- *I really do not know. I do not have statistics available that would let me know how accurate the data is and the community with whom I currently interact is a very small one*
- *I do not feel I can provide an authoritative response*



**Question: Do you agree with the comparison of Copley Hospital's Service Area counties compared to its peer counties?**

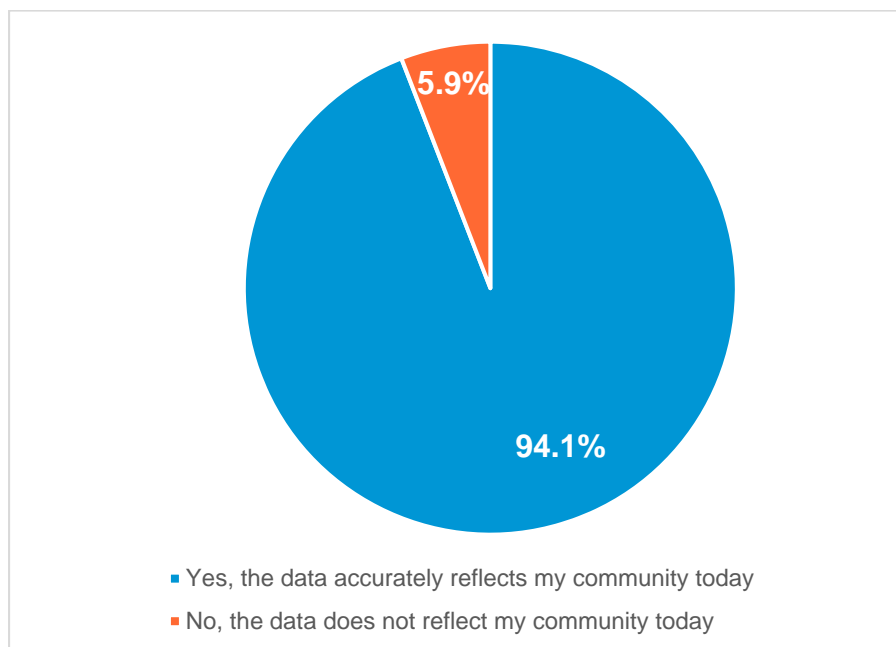


**Comments:**

- *It's interesting to see these three counties ranked to peer groups. Without knowledge of the peers though, my response doesn't have a whole lot of validity.*
- *Again, binge drinking and marijuana use missing from above as well as opioid related deaths.*
- *I have no reason not to believe the above data. That said, the data reflects primarily adult behaviors. We should be looking further upstream at child safety, primary care interventions at the earliest ages, access to timely and concrete supports for newborns and their parents, etc.*
- *no comment as I haven't seen any data*
- *not sure*
- *Lamoille County: std, uninsured*
- *I really don't know what is meant by peer groups. Population? Income? No. of Hospitals? etc. Sorry, but the above is meaningless to me without better explanation.*
- *It's ironic that Lamoille's outcomes are so good when most of our health behaviors are not.*
- *As can be seen in the data one big challenge for the area is the need to educate, prevent, and intervene in the health behavior areas.*
- *I do not live in this county and have only worked here for less than a year. This is similar to what I have been told through networking.*

- *Again, I'm not sure how I would know this information.*
- *I answered "yes" but without having access to actual studies I am not sure how I am supposed to know.*
- *Not sure*
- *Surprising.*
- *Apparently Lamoille and Caledonia tied for #1 in the Uninsured category of Clinical Care. It seems ironic that Lamoille is so highly rated in all Clinical Care areas yet falls into the bottom in all the Health Behavior assessments. Makes me wonder why our excellent Clinical Care has been unable to change health behaviors. Perhaps those with the bad health behaviors just don't seek clinical care. How does one reach them to change behavior? A major task.*
- *I do agree that our teen rates are high when you include 18 and 19 year olds. This begs the questions related to youth's outlook for higher education and employment.*
- *YES, but to a degree. Unfortunately, without any data about the peer group, you're asking us to make a determination without much data...*
- *not sure*
- *Where is the data for smoking for Lamoille and Caledonia Counties? Where is the obesity data for Lamoille and Caledonia Counties? Otherwise look appropriate with the two noted exceptions above.*
- *The data looks ok to be. The excessive drinking rating under Health Behaviors seems to high to me.*
- *Again, I really do not feel qualified to comment. I really have no idea how prevalent alcoholism is or how many alcohol related deaths there are.*

**Question: Do you agree with the population characteristics of Copley Hospital's Service Area?**

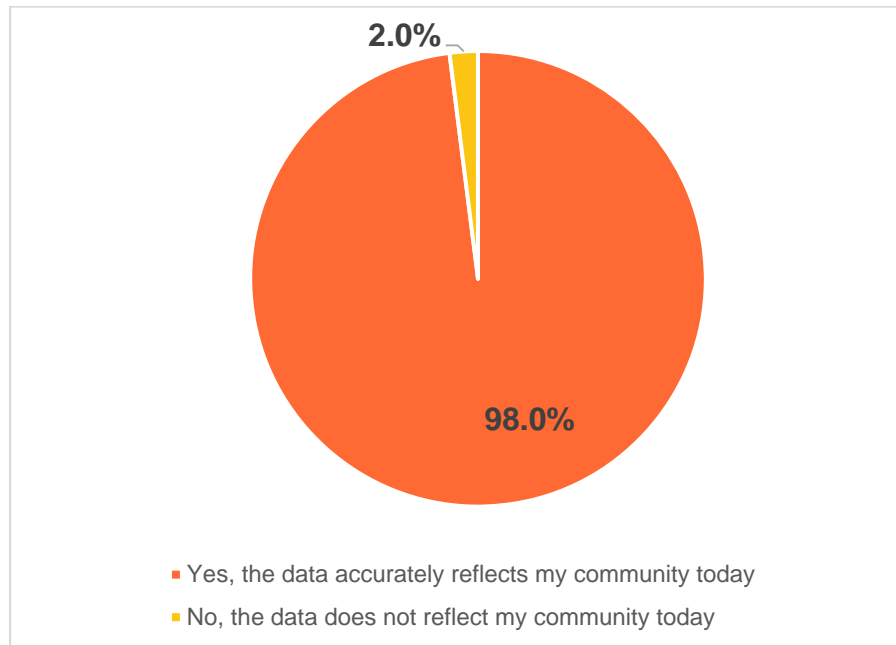


**Comments:**

- *The census chart reflects Vermont white older population. The median home value surprises me as well as the annual income.*
- *I believe that the percentages of Hispanics/whites are too low. In my experience, I meet with, speak with, and deal with, people of Hispanic background quite frequently.*
- *I have no reason to believe the data above isn't accurate. I'd like to look at early childhood data, e.g., reports and substantiations of neglect and abuse by age cohorts; food insecure households with children under 5; housing insecure households with children under 5; status of high quality child care and pre-school opportunities; etc.*
- *not sure*
- *My community is Stowe. It is filled with upper income families who are health savvy and have the means to have the best health care. If you mean Lamoille County, then I guess the data may be correct.*
- *Again, I have no actual knowledge of percentages. I am agreeing based on what I have heard about Lamoille County*
- *I suspect it is accurate based on observation and that many people do not get regular check-ups. The Urgent care in Waterbury Center is very good, but it is not convenient to many locations in the county*
- *I don't know*
- *These seem overly generous percentages for our local residents.*
- *underestimates some of the above*

- *I am not exactly sure why I was picked to complete this survey, but I don't feel qualified to comment. But, if it is true that we are # 1 out of 36 in being uninsured, then perhaps the data are fairly accurate.*

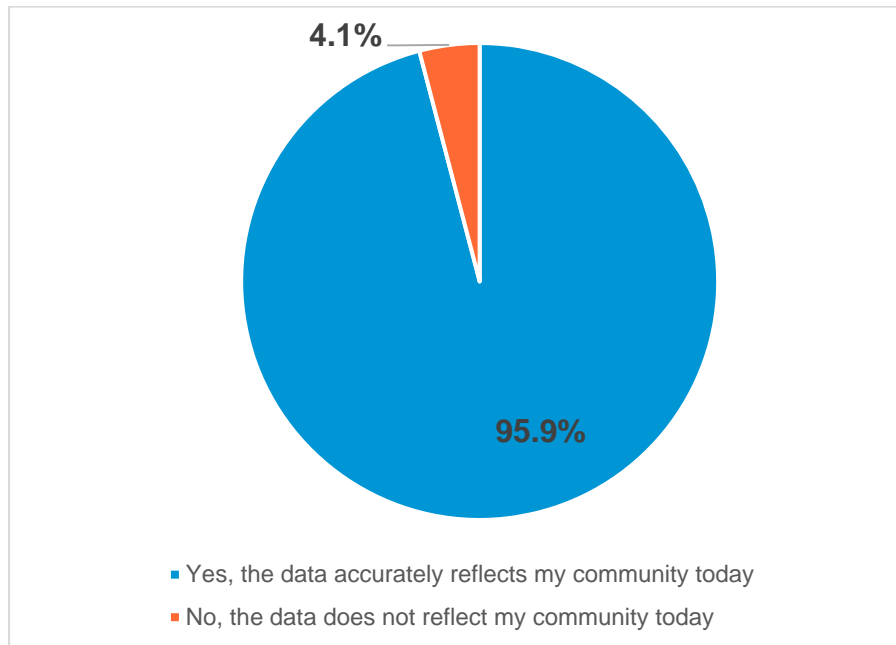
**Question: Do you agree with the national rankings and leading causes of death?**



**Comments:**

- *I can't really answer this. I'm sure there is accurate information through medical records however.*
- *Yes but, some of these diseases occur because of excessive drinking so I think we need to acknowledge that.*
- *I have no reason to believe the data isn't accurate. How do we compare to other counties for: child abuse and neglect; access to high quality child care; food security; etc.?*
- *not sure*
- *Don't know*
- *Again, I have no actual knowledge of percentages. I am agreeing based on what I have heard about Lamoille County*
- *I thought Lamoille County was higher in rates of death by suicide. I was surprised at the ranking for death by diabetes.*

Question: Do you agree with the overall social vulnerability index of Copley Hospital's Service Area?

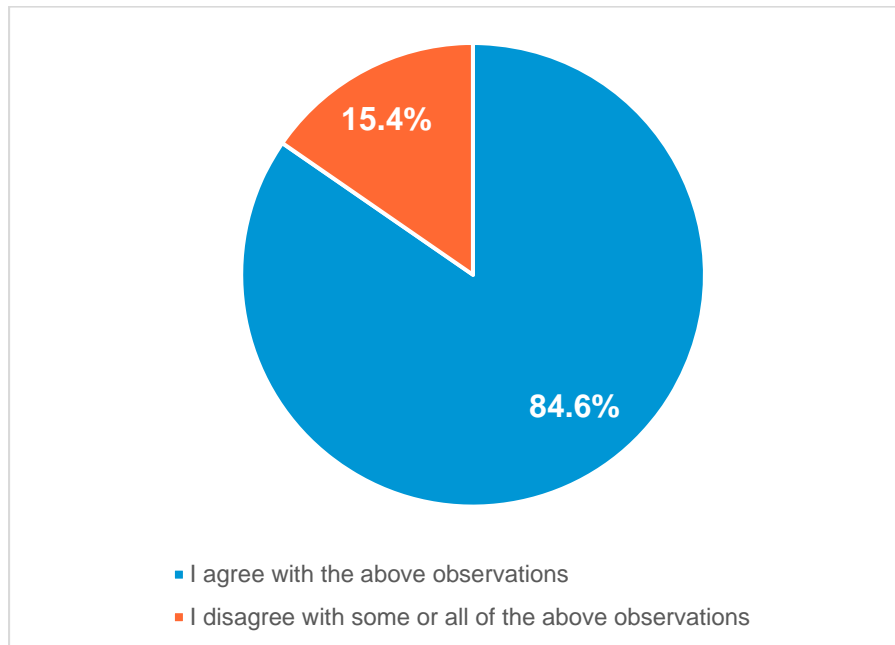


Comments:

- *The divide along Rt 15 in Lamoille County stands out in this map. I wonder if the State College in Johnson turns that region dark blue*
- *Lamoille Valley data gets skewed by pockets of wealth that throw stats off. While I agree with the darker areas as being very vulnerable I think there is much more hidden poverty and social isolation that is not represented on the map.*
- *not sure*
- *See previous answer.*
- *Again, I have no actual knowledge of percentages. I am agreeing based on what I have heard about Lamoille County*
- *This map shows Wolcott and Morristown as having 0 flags. That does not make sense to me and does not appear to be an accurate reflection of the current situation.*
- *Appears to indicate that lower income per household leads to the most problem areas (unmet needs group).*
- *Impossible for me to say without actually knowing what the SVI flags are*
- *NOT SURE*
- *Only offer a caveat if reading correctly a few towns have high vulnerability based on the themes mentioned. Only questioning validity as some state data seemed to suggest that this vulnerabilities were higher in Lamoille Country in previous years. However, if data has been validated and is credible, I am good. This just seems shocking?*

- *I do not feel I can comment on these data.*

**Question: Do you agree with the written comments received on the 2015 CHNA?**



**Comments:**

- *To me, there is an over emphasis in this assessment on housing. Copley is a Hospital employing Medical Professionals. It's not a Housing Agency.*
- *I believe that Copley should be using a validated tool to screen every person at intake for substance use issues and make referrals for follow-up. I believe that Copley should be working through the UCC to address common behavioral health issues that impact the overall health of this community like substance use disorder and ACES.*
- *I agree with the comments above, however, I want to stress the importance of increase communication between agencies. I think the ACH can help promote this. If Morrisville becomes a "risk" community, it is imperative each agency knows what the others are doing to help keep patients healthy and help each other with those initiatives. For example, the transportation comment, the primary care clinics in Morrisville have a combined fund to help with transportation to health-related visits. They may not be able to increase those funds to cover rides to and from Copley. If you want to lower transportation costs overall, perhaps the health service are could work on lowering avoidable ED visits by increasing preventative measures or improving our chronic disease management.*
- *I believe what is missing in this list is a focus on the earliest years (the first 1000 days) of a child's life.*
- *All valid! Also, Copley needs to resume sleep studies and the return of a sleep doctor to the facility. It would be nice to have an oncologist in residence as well.*
- *CHSLV is not included in the comments about how we support transportation in Lamoille County CHSLV has for years funded the GMTA route in the fair weather for Route 108 services. Also, we fund through Blueprint those that fall out of the GMTA and RCT requirements for transportation.*
- *I agree, but note that none of the comments here indicate any strong relationship to smoking, substance use, or mental health. In the data of comorbid illness those who die due to injury, cancer, COPD, and other health issues*



often have a comorbid behavioral health component. Copley does not seem to be emphasizing how to address these relationships and concerns.

- *Again, I have no actual knowledge of percentages. I am agreeing based on what I have heard about Lamoille County*
- *I question the comment about how Copley plays a significant role in addressing how the local healthcare funds are allocated. I would need to hear more about this to understand what is meant by "local healthcare funds. In this current Vermont healthcare environment, it is going to be very difficult to have specialty physicians (endocrine, arthritis, dermatology, etc.) on the Copley campus. It's difficult for UVM to recruit such specialists and even more difficult for the smaller hospitals to recruit and fund such specialists.*
- *Transportation needs to be addressed for those who live without cars.*
- *I agree that insecure housing is a problem in Lamoille, as in the rest of the state. I do not agree that spending money to integrate IT systems is the way to use scarce resources. More attention needs to be paid to children, and young families - getting them off to a good start. All newborns and their families need healthy meals and coaches to help them introduce a range of foods to their infants and young children. As a mother told me recently, there was all this help through Lamaze and other supports pre-birth. Once I gave birth there was no help for me. This is the most important time in a child and family's life. We need to do more to assure infants and their parents get what they need at this critical juncture.*
- *for the most part although there are too many observations to ask this question for an overall agreement*
- *This is an EXCELLENT list*
- *Today I think Copley is well positioned to assist in promoting preventive measures such as access to healthy food and meaningful physical activity in multiple environments such as the workplace, in schools and childcares and in communities.*
- *Working in closer cooperation with other healthcare providers to stem the loss of staffing would be a huge win for the region. While there is no statistical evidence (yet) of a loss of services or quality of those services, I believe it is only a matter of time before Lamoille County sees a loss in both range and quality of services due to the strained workforce.*
- *Copley is seen as the "Healthcare System" by the general public and Copley is a lead organization among the healthcare community. I agree strongly with this comment*
- *These are really great observations and comments. while I do not completely agree, I believe that are a start to addressing some barriers or inequities.*

## Appendix D – National Healthcare Quality and Disparities Report<sup>40</sup>

The national health disparities highlighted in this report help inform areas in which there are significant challenges throughout the country and where resources are being allocated in order to address them. The National Healthcare Quality and Disparities Reports (QDR) (annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

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

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

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

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

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

### Trends

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

---

<sup>40</sup> <http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/index.html> Responds to IRS Schedule h (Form 990) Part V B 3 i

insurance continued to decrease through the end of 2014,<sup>41</sup> consistent with these trends.

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

#### **Trends**

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

#### **Disparities**

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

#### **Trends**

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

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

#### **Trends**

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.<sup>42</sup>

#### **Disparities**

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.<sup>43</sup>

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

#### **Disparities**

---

<sup>41</sup> Levy J. In U.S., Uninsured Rate Sinks to 12.9%. <http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx>.

<sup>42</sup> In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

<sup>43</sup> Long SK, Karpman M, Shartz A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. <http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.html>

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

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

#### **Disparity Trends**

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

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

#### **Trends**

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

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

#### **Trends**

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

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

#### **Achieved Success**

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

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

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

### **Improving Quickly**

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

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

admissions

- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at time of surgery

## **Worsening**

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

- Maternal deaths per 100,000 live births
- Children ages 19-35 months who received 3 or more doses of Haemophilus influenzae type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- *Admissions with diabetes with short-term complications per 100,000 population, age 18+*
- *Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year*
- Women ages 50-74 who received a mammogram in the last 2 years
- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- *People with current asthma who are now taking preventive medicine daily or almost daily*
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

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

## **Disparities**

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

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

## **Disparity Trends**

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

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

### Disparities Trends

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

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

### Geographic Disparities

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

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

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all

Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

### **Trends**

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and \$12 billion savings in health care costs.<sup>44</sup>
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

### **Disparities Trends**

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

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

### **Trends**

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

### **Disparities**

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

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

### **Disparities Trends**

---

<sup>44</sup> Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. <http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html>



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

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

#### **Trends**

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

#### **Disparities**

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

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

#### **Trends**

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.
- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.
- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

#### **Disparities**

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

#### **Disparities Trends**

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

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

#### **Trends**

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

## Disparities

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

## Disparities Trends

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

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

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

## Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.<sup>45</sup>
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.

---

<sup>45</sup> Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1800\\_collins\\_biennial\\_survey\\_brief.pdf?la=en](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en)

- There are few measures to assess trends in Care Affordability.

## **Disparities**

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

## **CONCLUSION**

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

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

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

### Illustrative IRS Schedule h Part V Section B (Form 990)<sup>46</sup>

#### Community Health Need Assessment Illustrative Answers

1. Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?  
*No*
2. Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If “Yes,” provide details of the acquisition in Section C  
*No*
3. During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If “No,” skip to line 12. If “Yes,” indicate what the CHNA report describes (check all that apply)
  - a. A definition of the community served by the hospital facility  
*See footnotes 18 and 20 on page 12*
  - b. Demographics of the community  
*See footnote 21 on page 13*
  - c. Existing health care facilities and resources within the community that are available to respond to the health needs of the community  
*See footnote 32 on page 36*
  - d. How data was obtained  
*See footnote 11 on page 8*
  - e. The significant health needs of the community  
*See footnote 31 on page 34*
  - f. Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups  
*See footnote 12 page 9*
  - g. The process for identifying and prioritizing community health needs and services to meet the community health needs  
*See footnote 39 page 91*
  - h. The process for consulting with persons representing the community's interests

---

<sup>46</sup> Questions are drawn from 2014 Federal 990 schedule h.pdf and may change when the hospital is to make its 990 h filing

*Footnote 8 and 9 page 7*

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

*See footnote 10 on page 8, footnotes 13 and 14 on page 9, and footnote 26 on page 21*

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

*N/A*

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

*2015*

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

*Yes, see footnote 15 on page 9 and footnote 38 on page 67*

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

*No*

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

*See footnote 4 on page 4 and footnote 7 on page 7*

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

*Yes*

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

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

*<https://www.copleyvt.org/>*

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

*No other website*

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

*Yes*

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

*No other effort*

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

*Yes*

9. Indicate the tax year the hospital facility last adopted an implementation strategy: 20\_\_  
2015

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

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

*[https://www.copleyvt.org/wp-content/uploads/2015/09/Copley\\_CHNA\\_2015.pdf](https://www.copleyvt.org/wp-content/uploads/2015/09/Copley_CHNA_2015.pdf)*

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

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

*See footnote 32 on page 36*

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

*None incurred*

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

*Nothing to report*

c. If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities?

*Nothing to report*