North Country Hospital

Community Health Needs Assessment

2018 Report

NCH 2018 Community Health Needs Assessment Report

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Introduction

As part of its strategic initiative, and in compliance with the Patient Protection and Affordable Care Act (ACA 501(r) (3), North Country Hospital (NCH) has conducted a Community Health Needs Assessment (CHNA). The most recent previous assessment was completed in 2015, and prior to that in 2012. As in the past, the 2018 CHNA is comprised of a number of processes and data elements as described in the following pages. Following analyses of the various data elements, NCH, along with a team of priority community stakeholders has identified five Priority Health Concerns that its communities are encountering and on which it anticipates a positive impact can be made through the implementation of strategies to help meet those needs. This report includes a description of the decision making process regarding how priorities were identified and are or are not addressed in the accompanying Implementation Strategy document.

Availability of the CHNA and Implementation Strategy

Upon completion of the entire CHNA process, the documents comprising the NCH CHNA Report and Implementation Strategy will be made widely available in an easily downloadable format on the NCH website at www.northcountryhospital.org. A hard copy will also be available by calling NCH Administration at 334-3203 and requesting a copy. This information will be available to community members without the need to have special hardware or software, without payment or fee, or without the requirement of creating an account or being required to provide personally identifiable information. NCH's previous CHNA documents, completed in 2012 and 2015, as well as the related Implementation Strategy documents will continue to be available on the NCH website or at no charge to interested community members who are encouraged to contact NCH administration at the above telephone number to request a copy.

NCH Core CHNA Team

A core team of NCH staff began a series of planning meetings in February 2018 to develop the CHN assessment process. The leader of this core team is Julie Anne Riffon, LICSW, PCMH CCE, Executive Director Primary Care and Quality and Blueprint for Health Project Manager, NCH Medical Group Operations.

Other core team members included the following NCH staff:

- Mary Hoadley, Director of NCH Wellness Center and NCH Employee Wellness
- Joanne Fedele, RN, MSN, CHC, Community Health Planner
- Bobby Jo Rivard, Executive Assistant, Medical Group Operations

Initial plans for the assessment process and a timeline were developed by J. Riffon with overall guidance from NCH Senior Leadership. The plans, processes, and timeline were discussed and reviewed by the Core CHNA Team, with only slight modifications, in order to present it to the CHNA Advisory Team and to begin its implementation accordingly.

Development of the CHNA Advisory Team

In keeping with the guidelines for a comprehensive CHNA, a number of priority community stakeholders who represent the broad interest of the NCH Service Area (also referred to as the Newport Service Area), including leaders and representatives of organizations that serve various segments of the population in the NCH service area were invited to participate on the CHNA Advisory Team. With the NCH Core Team as a subgroup of the CHNA Advisory Team, the Advisory Team was lead and discussion was facilitated by J. Riffon.

In addition to members of the NCH Core Team, the CHNA Advisory Team membership includes:

- Avril Cochran, RN, VP of Patient Care Services, NCH
- Carol Boucher, BA, Interim Executive Director, Northeast Kingdom Human Services (NKHS), a mental health agency serving the three counties of VT's Northeast Kingdom
- Marcia Stricker, Chief of Adult Division of Services, Northeast Kingdom Human Services (NKHS)
- Justin Barton-Caplin, District Director, Newport Office of VT Dept. of Health (VDH), serving VT's Orleans and northern Essex Counties.
- Kathy Griffin, Director of Parent Child Center, Outreach & Youth Services for Northeast Kingdom Community Action (NEKCA), the anti-poverty agency serving the three counties in VT's Northeast Kingdom
- Lyne Limoges, RN, MSN, Executive Director, Orleans Essex Visiting Nurse Association & Hospice, Inc. (OEVNA&H), providing homecare and hospice services in Orleans and northern Essex Counties.
- Meg Burmeister, Executive Director, Northeast Kingdom Council on Aging (NEKCOA), a local agency providing services and resources to older Vermonters, serving the three counties of VT's Northeast Kingdom.
- Michelle Tarryk, MS, Executive Director, Northeast Kingdom Learning Services (NEKLS), the local agency providing educational services to adults of all ages with the goal of their completing a high school education, serving the three counties of the VT's Northeast Kingdom

Advisory Team Process

From early March through August 2018, the Advisory Team met a number of times for the following purposes:

- To gain an understanding of the overall NCH CHNA process
- To review and discuss several pages of community health data formatted and compared to state and national data. These data tables are included in this CHNA in Appendix A.
- To assist in developing the questions that comprise the community-wide survey, available in both hard copy and electronically.
- To assist in developing the questions to be asked at various community focus groups.
- To assist in establishing priority sites for these community focus groups with the goal of reaching subgroups of the population such as senior citizens, young parents, low socioeconomic groups, and/or individuals affected by substance use.
- To plan a series of meetings following the completion of the survey and forums with the goal of setting criteria for priority health needs, identifying such needs from all the data that was compiled from all the above sources, and for discussion of how these issues are or are not being addressed in the community.
- To determine the Implementation Strategy for each of the Priority Health Concerns, including identifying the current strategies, partners/collaborators, potential plan/upcoming development of resources to address each Priority Health Concern, and measures to assess progress and/or success.

Quantitative Data Collection: Sources and Process

NCH's CHNA process includes review of quantitative data detailed in a separate document, Appendix A, attached to this report. Data were collected describing a diverse range of health indicators and risk factors. As noted previously, these data for Orleans County (OC) and Essex County (EC) are compared to VT and US rates, as well as VT 2020 Goals, when available. The sources for all data elements are identified in the document and include the VT Department of Health, the VT Department of Labor, US Census Bureau, VT Cancer Registry, and the University of Wisconsin 2018 County Health Rankings, among other sources. Data are included for all the following categories:

- General Population Data / Demographics / Socioeconomic / Education Level / Insurance Status / Health Care Access
- Maternal /Child Health Indicators
- Immunization & Infectious Disease
- Youth Health or Risk Behaviors – Tobacco Use/ Alcohol Use/ Marijuana and Prescription Drug Use /Obesity/ Physical Activity
- Adult Health or Risk Behaviors - Tobacco Use/ Alcohol Use /Obesity / Physical Activity / Fruit & Vegetable Servings / Marijuana Use / Non-medical Use of Pain Relievers
- Arthritis
- Asthma
- Cancer Screening – Breast, Cervical, Colon
- Cancer Diagnosis
    - Advanced Stage
    - Cancer Incidence
    - Cancer Mortality
- Diabetes Mellitus
- Heart Disease & Stroke
- Mental Health – Suicide Rate / Teen Suicide Plan Rate/ Depression Screening in Medicaid Beneficiaries
- 10 Leading Causes of Death-

Data Comparison of Some Indicators in NCH 2015 CHNA with NCH 2018 CHNA and Some VT Rates as Available
(It should be noted that for some measures, wording is changed from one year to another. Therefore, some measures are not comparable to previous years. Also, data described under Comments (right-hand column) that show some improvement from 2015 to 2018 are likely not statistically relevant, but rather show an improved trend for this time period.)

Indicator/ Measure to Assess Progress As Per 2018 Implementation Strategy	Data in 2015 CHNA	Data in 2018 CHNA	VT Rate	Notes/ Comments
By 2021, reduce % of adults who smoke cigarettes to VT goal of 12% from 22%	25% OC 18% EC (BRFSS 2012-2014)	22% OC 27% EC (BRFSS 2015-2016)	17% (BRFSS 2015-2016)	**Improvement noted for OC: decrease from 25% to 22% of adults who smoke cigarettes**
By 2021, increase % of adults who made a quit attempt to VT goal of 80% from 62%	49% Statewide rate (2014 VT Adult Tobacco Survey)	62% NCH Service area (BRFSS 2015-2016)	43% (2016 VT Adult Tobacco Survey)	**Rate in NCH's service area (62%) is better than statewide rate (43%).**
By 2021, reduce % of youth in grades 9-12 who smoke cigarettes to VT goal of 10% from 12 %.	19% OC 14% EC (YRBS 2013)	12% OC 20% EC (YRBS 2015)	11% (YRBS 2015)	**Improvement noted for OC: decrease from 19% to 12% of youth who smoke cigarettes**
By 2021, increase the % of pregnant women who do not smoke during pregnancy to VT goal of 90% from 76%	79.5% (NCH births for FY 2014)	76% (NCH births for FY 2017)	84% Rates vary widely by HSA in VT, range of 81% at UVMMC to 66% Springfield for same time frame)	NOTE: % of women who smoked but quit before 4th month for NCH births is 32% for FY 2017; VT rate is 26% for same time period. For FY 2014 NCH rate was 29% and VT rate was 27%. **Some improvement as noted above**
By 2021, reduce % of youth ages 12-17 yrs. who binge drink (5 or more drinks in a row past 30 days) to VT goal of 10% from OC rate of 18%	24% (2013 YRBS)	18% for OC (2015 YRBS)	16% (2015 YRBS)	**Some improvement noted for OC: decrease from 24% to 18% of youth who binge drink**

Indicator/ Measure to Assess Progress As Per 2018 Implementation Strategy	Data in 2015 CHNA	Data in 2018 CHNA	VT Rate	Notes/ Comments
By 2021, reduce the % of adults who binge drink to 10% from 15%	17% (BRFSS 2014)	15% (BRFSS 2015-2016)	18% (BRFSS 2015-2016)	**Slight improvement noted: decrease from 17% to 15% of adults who binge drink**
By 2021, reduce % of adult prescription drug misuse to 2% from current rate of 6%.	Please see comments	6% (YRBS 2015)	Please see comments	Unable to find data specific to NCH HSA prior to 2015 data noted in 2018 column. 2014 VT Rates: Age 26+ yrs: 2.5% Age 18-25: 7.6% (BRFSS, 2015)
By 2021, increase % of pregnant women who do not use illicit drugs to VT goal of 100% from VT rate of 95%.	Not previously reported in CHNA	95% (VT rate; county rate not available)	95% (YRBS -2015)	
BY 2021, increase % of pregnant women who drink no alcohol to VT goal of 100% from VT (2012) rate of 88%. (County rates not available.)	Please see comments	Please see comments	Please see comments	VT rates of alcohol use: 3 mos. before pregnancy / in last 3 mos. of pregnancy 2012 69.8% 13.7% 2013 68.0% 12.8% 2014 70.0% 15.0% 2015 68.9% 15.8% (cdc.gov; PRAMS)
By 2021, reduce % of people age 12+ yrs. who need and do not receive treatment of alcohol use to VT goal of 5% from 7%	Not previously reported in CHNA	7%		Cannot find this. Can only find number and % of VT adults and VT youth that use alcohol and drugs and receive treatment.
Reduce the % of people age 12+ yrs. who need and do not receive treatment of illicit drug use treatment from 3% to 2%.	As above	3%		As above.

Indicator/ Measure to Assess Progress As Per 2018 Implementation Strategy	Data in 2015 CHNA	Data in 2018 CHNA	VT Rate	Notes/ Comments
Continue to reduce the rate of suicide deaths among adults to maintain a level below the VT goal of 11.7 / 100,000. OC rate is 9.9 and EC rate is 10.4/ 100,000.	OC: 20.9/100,000 EC: N/A (VT Vital Statistics, 2007-2009)	OC: 9.9 EC: 10.4 (VT Vital Statistics, 2012-2014)	14.3 (2015)	**Rate for OC is lower than previously reported in 2015 (20.9/ 100,000) and both OC (9.9) and EC (10.4) are below statewide rate (14.3) and goal (11.7).**
By 2021, reduce the % of youth in grades 9 – 12 with BMI ≥95 percentile (obese).	OC: 15% EC: 19% (YRBS 2013)	OC: 16% EC: 19% (YRBS 2015)	12% (YRBS 2015)	
By 2021, reduce the % of adults age 20+ who are obese (BMI 30+) to 20% from 30% for OC & 22% for EC	OC: 26% EC: 27% (BRFSS 2012-13)	OC: 30% EC: 22% (BRFSS 2015-16)	28% (BRFSS 2015-16)	**Improvement in EC from previous rate of 27% to recent rate of 22%, and both below statewide rate.**
By 2021, increase % of women delivering a live birth who had a healthy weight before pregnancy (BMI≤ 25) to VT goal of 65% from 41.6%.	58.4% (NCH FY 2014, VDH, Div of Health Surveillance, Public Health Statistics)	58% (NCH FY 2017, VDH, Div of Health Surveillance, Public Health Statistics)	53% (FY 2017, VDH, Div of Health Surveillance, Public Health Statistics)	Rate varies by hospital service area throughout VT, with a range of 42% at Copley to 63% at CVMC and Northwestern for same time period. **NCH service area is mid-range when compared to statewide range as above. Improvement still needed.**
By 2021, decrease % of people who report food insecurity in OC and EC to VT goal of 10% from 14.5% in OC and 14.6% in EC.	Not reported in 2015 CHNA	Not reported in 2018 CHNA data document	Not found	Data found and goal added after discussion by CHNA Advisory Team. Data now listed in the Implementation Strategy document. Source unknown.

Indicator/ Measure to Assess Progress As Per 2018 Implementation Strategy	Data in 2015 CHNA	Data in 2018 CHNA	VT Rate	Notes/ Comments
By 2021, increase % of children ages 6-9 who use the dental care system to VT goal of 100% from 95% for all VT children.	Not reported in 2015 CHNA	Not reported in 2018 CHNA data document	Please see comments.	As above. Also, VT measure written as: % children in grades K-6 using yearly dental care: 2016 VT rate was 77%. VT goal was 80%. (VT Oral Health Scorecard, 2018) County data not available.
By 2021, increase the % of adults who use the dental care system to VT goal of 85% from 68% in NCH service area.	Not reported in 2015 CHNA	Not reported in 2018 CHNA data document	Please see comments	As above. Also, VT measure written as: % adults using yearly dental care: 2016 VT rate was 71%. (VT Oral Health Scorecard, 2018) County data not available.
By 2019 increase the % of people who have a usual primary care provider to VT goal of 100% from 91% for NCH service area.	Measurement not worded this way for 2015 CHNA. Measure was for % Adults 18+ w/ health insurance.	91% NCH service area (BRFSS, 2015-16)	94% (BRFSS, 2015-16)	Note: % adults age 18- 64 w/ health insurance: NCH service area: 92% VT rate: 94% VT goal: 100% (BRFSS 2015-16)
Additional measure related to above reported both in 2015 and 2018 CHNAs. % adults who did not visit a doctor due to cost in past year	10% in NCH service area. 9% VT rate. (BRFSS 2012-13)	8% in NCH service area. (BRFSS 2015-16)	8% (BRFSS 2015-16)	**Improvement in this measure from 2015 data to 2018 data.** **Decrease from 10% to 8% in NCH service area and same as VT rate.**

Indicator/ Measure to Assess Progress As Per 2018 Implementation Strategy	Data in 2015 CHNA	Data in 2018 CHNA	VT Rate	Notes/ Comments
Continue to reduce the fall related death rate and to maintain a level below the VT goal of 118.7/ 100,000 for adults age 65+.	Not reported in 2015 CHNA. But research shows previous NCH service area rate: 118.3 VT rate: 125.1 (VT Vital Statistics 2011-2013)	Not reported in 2018 NCH CHNA data document. Added with Advisory Team discussion. NCH service area: 105.6 (VT Vital Statistics 2012-2014)	118.7 (VT Vital Statistics 2012-2014)	**Research in VT data shows that improvement shown in this measure, from previous fall related death rate for NCH service area of 118.3 (2011-2013 Vital Statistics) to more recent rate of 105.6 (2012-2014 Vital Statistics).** **Both rates for NCH service area were below VT rate. Range within other hospital service areas is 68.6 (Brattleboro) to 196. 5 (Morrisville).**
Increase % of adults age 65+ who receive annual influenza immunizations to VT goal of 90% from 64% in NCH service area.	OC: 62% EC: 71% VT: 65% VT Goal: 90% (Adult BRFSS, 2012-2013)	NCH service area: 64% VT Goal: 90% (Adult BRFSS, 2014)	VT rate: 62% (Adult BRFSS, 2014)	**Slight improvement of 62% to 64% when OC compared to NCH service area, from 2015 to 2018 data. Most recent data show rate in NCH service area (64%) is slightly better than statewide rate (62%).**
Increase % of adults age 65 + who receive the pneumococcal vaccine to VT goal of 90% from 64 % in NCH service area.	OC: 68% EC: 75% VT: 73% (Adult BRFSS, 2012-2013)	NCH service area: 64% VT Goal 90% (Adult BRFSS 2014)	VT rate: 72% (Adult BRFSS 2014)	

Qualitative Data Collection: Sources and Process

The CHNA process also included a review of qualitative data, including:

- A summary of the previous CHNA Implementation Strategy, updated in 2017, to assess the impact of actions taken since the preceding CHNA
- Findings from a community survey that was developed and distributed to a wide range of community members
- Findings from questions that were developed and discussed with those attending the 6 in-person focus groups

Samples of the survey and focus group questions, with a summary of findings, are included within this report. As of August 2018, there have been no written comments received on NCH's most recent CHNA and/or adopted Implementation Strategy for the CHNA Advisory Team to review.

The **Community Survey**, titled like the 2015 CHNA - *"Tell us what you think!"*- was distributed widely. Respondents were asked to indicate their perception of how important each of a number of health issues is to the health of people living in Orleans and Northern Essex Counties. The survey also asked respondents about their perceptions of the availability/ adequacy or lack of availability/adequacy of a broad spectrum of services and resources. The survey was easily electronically accessible via a survey monkey link which was widely circulated through e-distribution lists reaching clients served by numerous agencies, organizations and employers in the NCH service area. NCH also informed community members regarding its availability and accessibility via NCH website and Facebook and encouraged community members to complete it. All responses were confidential and anonymous.

Paper copies of the survey were distributed and then collected by some members of the Advisory Team for their patients / clients/ employees to complete. Some paper copies were also available at the NCH Wellness Center.

Focus Groups: The second method of qualitative data collection in the NCH CHNA process was provided by holding a series of community focus groups during the month of April and May to solicit information from individuals who are elderly, with low incomes and/or parents of young children and individuals impacted by substance use. As mentioned previously, a set of questions to be presented to group participants was developed by the Advisory Team with guidance from NCH Senior Leadership. A script was also developed for the facilitator to be used with each group so that the process in each group would be as similar as possible. The goal was to elicit responses to the same set of questions from subgroups of the population in the hospital service area that might not otherwise have easy access to the survey or might not be able to easily communicate their comments and concerns. Participants of these groups were eligible for a random drawing of a small gift certificate to local markets upon conclusion of the group discussion. The community focus groups were held at the following sites:

- Journey to Recovery Community Center, Newport,
- United Church of Newport
- Barton Area Senior Services, Inc. (BASSI; previously known as the Barton Meal Site)
- Sunrise Manor Senior Housing, Island Pond
- Westfield Meal Site
- Forever Young Club, Senior Citizens Club, Newport

Community Survey Results: Demographic information about respondents

A total of 276 surveys were completed, including 199 done online and 77 done with paper and pen.
Demographic data describing survey respondents are as follows. ***Please note that not all respondents responded to all questions.***

Total number of survey respondents was 276.
Of the 276:

- 15% were male
- 83% were female

- 67% were between the age of 19-64
- 33% were 65 or older

- 16% have a household income less than $25,000
- 25% have a household income between $26,000-$50,000
- 36% have a household income greater than $50,000
- 22% did not want to say

Of the 276 survey respondents:

- 26% were retired
- 66% were employed FT or PT
- 2% were unemployed, looking for work
- 5% were unemployed not looking for work or disabled, not able to work
- 1% was working more than one job

- 7% had less than 12th grade education (no diploma or GED)
- 18% had a high school diploma or GED
- 31% had some college or Associate Degree or Technical Degree
- 44% had a four year degree or graduate school degree

Regarding access of health care services by the 276 survey respondents, the following data was gathered.

Within the past 18 months:
70% had seen an eye doctor
24% had not
5% did not feel it was necessary

79% had seen a dentist
18% had not
3% did not feel it was necessary

96% had seen a doctor/ medical provider
3% had not

11% had seen a mental health provider
41% had not
48% did not feel it was necessary

2% had seen a substance use provider
39% had not
59% did not feel it was necessary

Regarding town of residence, the survey respondents were from the following communities:

Albany- 1%	Charleston – 3%	Glover - 2%	Jay – 1%	Newport Town – 8%
Barton - 5%	Coventry -3%	Holland – 4%	Lowell – 2%	North Troy – 1%
Brownington - 5%	Derby – 16%	Irasburg -3%	Morgan – 2%	Orleans – 3%
Canaan - 1%	Derby Line -2%	Island Pond – 7%	Newport City – 21%	Troy - 4%
				Westfield – 3%

Focus Groups: Demographic information about participants

The total number of participants in the 6 focus groups was 62. ***Please note that not all participants responded to all questions.***

Total number of participants in the focus groups was 62.
Of the 62:

- 25% were male
- 74% were female
- 1% was transgender

- 19% were between the age of 19-64
- 81% were 65 or older

- 40% have a household income less than $25,000
- 22% have a household income between $26,000-$50,000
- 6% have a household income greater than $50,000
- 32% did not want to say

Of the 62 focus group participants:

- 58% were retired
- 13% were employed FT or PT
- 6% were unemployed, looking for work
- 10% were unemployed not looking for work or disabled, not able to work

- 21% had less than 12th grade education (no diploma or GED)
- 29% had a high school diploma or GED
- 18% had some college or Associate Degree or Technical Degree
- 16% had a four year degree or graduate school degree

Regarding access of health care services by the 62 focus group participants, the following data was gathered.

Within the past 18 months:
58% had seen an eye doctor
24% had not
2% did not feel it was necessary

42% had seen a dentist
39% had not

81% had seen a doctor/ medical provider
3% had not

10% had seen a mental health provider
52% had not
19% did not feel it was necessary

6% had seen a substance use provider
53% had not
22% did not feel it was necessary

Regarding town of residence, the focus group participants were from the following communities:

Barton – 3%
Brownington – 2%
Derby – 10%
Island Pond – 18%
Lowell – 5%
Montgomery – 2%
Newport City – 18%
Newport Town – 11%
W. Charleston – 2%

Results from Community Survey Respondents and Focus Group Participants

Analyses from the results of the survey process, found that respondents considered the issues listed on the table below to be "important" and "very important" to the health of people living in Orleans County and Northern Essex County. The following were found to be the eleven top issues of concern to respondents. Comments and responses from focus group participants also supported these findings.

Health issues most often identified as important or most important- 2018
Child abuse or neglect
Dental needs
Use of street drugs such as heroin, cocaine, etc. among youth
Healthy eating habits such as eating fruits and vegetables daily
Mental health problems such as anxiety and depression
Use of street drugs such as heroin, cocaine, etc., among adults
Being overweight – youth
Safety/ Crime
Violence in the home
Tobacco use among youth
Rape and/or sexual assault

Regarding healthcare services or community resources, the following were identified most often by survey respondents to be "available but not enough" or "not available." Again, comments and responses from focus group participants supported these findings.

Healthcare services and/or community resources identified as "available but not enough" or "not available"
Mental health care when you need it
Dental care/ medical care when you need it without going to ED
Older Vermonters: housing
Services for people of any age to remain in their home
Older Vermonters: home care
Dental care
Addiction support services
Drug treatment / alcohol treatment when you need it
Older Vermonters: Nursing Home / Adult day care
Services that encourage healthy eating, such as farmers' markets
Affordable exercise/ fitness programs

Prioritization Process for Priority Health Concerns

In reviewing all of the above findings, the Advisory Team identified similarities and decided that some of these findings could be categorized together. Additionally, the Advisory Team utilized a set of criteria in reviewing the findings from the community surveys and focus groups as well as the data in Appendix A to determine the leading community health issues pertinent to the NCH service area. These criteria were utilized to first identify the health needs of the community, next to prioritize them and lastly to identify which needs would be recognized as Priority Health Concerns and be addressed by an Implementation Strategy for improvement.

The magnitude and severity of each of the health concerns were assessed as high or moderately high, with consideration of vulnerable populations and opportunity to affect change throughout the process. The criteria which were utilized are aligned with those recommended by the Catholic Health Association (CHA) to prioritize community health needs as documented in Assessing & Addressing Community Health Needs (CHA, 2015) and also meet 501 (r) (3) regulations. The criteria utilized for prioritization include:

- Magnitude of problem (i.e., % of population affected) and/or significance based on circumstances present in our community
- Severity (i.e., rate of mortality or morbidity, if applicable), and/or scope or urgency of the health need
- Vulnerable population impacted/ identified (examples include low income individuals, children and/or elderly all which are significant for the NCH Service Area)
- Opportunity to affect change which includes consideration of estimated feasibility and effectiveness of possible interventions, associated health disparities or importance to the community

Priority Health Concerns Identified for Development of Implementation Strategy

After review of the combination of data and the results of the community survey and focus group processes, the Advisory Team prioritized the following as priority health concerns and recommended these as the focus of the Implementation Strategy for the 2018 NCH CHNA. The Advisory Team further decided to phrase the Priority Health Concerns in a positive format as seen in the table below. The U.S. Centers for Disease Control and Prevention defines aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level."

2018 Priority Health Concerns	Magnitude	Severity	Vulnerable Population	Opportunity to affect change
Supporting substance free life style and mental wellness	✓	✓	✓	✓
Supporting older Vermonters aging in place	✓	✓	✓	✓
Supporting tobacco free life styles	✓	✓	✓	✓
Supporting healthy eating and physical activity	✓	✓	✓	✓
Supporting access to medical and oral health resources	✓	✓	✓	✓

Related Concerns that Affect the Health of the Community

The Advisory Team acknowledges that there are related concerns that were identified through the assessment process that impact the health of the NCH service area but which NCH's Implementation Strategy does not intend to directly address with specific measures or activities to assess progress. This is primarily due to the realization that these concerns do not entirely meet the above criteria, specifically in the area of "opportunity to affect change." These related priority concerns include:

- Higher rates of unemployment and poverty
- Lower rate of high school education among adults
- Transportation challenges
- Reduced access to post high school education for some community members due to financial barriers

Overview of Implementation Strategy

NCH's Advisory Team developed an Implementation Strategy to describe how the anticipated plans will address each of the five Priority Health Concerns identified as priorities. The Implementation Strategy is a separate CHNA document and describes how NCH plans to work with community partners to address these health concerns. It includes a brief overview of current strategies within the community, identifies collaborating resources, describes anticipated developments/plans for the next three years and identifies resources NCH plans to commit to address each Priority Health Concern. It also includes process or outcome measures with goals to be utilized to monitor results of the strategies implemented. Whenever possible these measures are linked to goals in the Healthy Vermonter 2020 initiative, Vermont's Health Improvement Plan and Vermont's All-Payer ACO model goals.

Development of the Implementation Strategy

In order to develop the CHNA Implementation Strategy the Advisory Team completed a series of action steps which consisted of:

- Identification of which local agencies/ partners currently provide resources to address each need in some manner
- Held a series of meetings with representatives from these agencies / partners to assess the current status of their specific resources
- In collaboration with these partners, assessed how these resources meet current or future needs
- As appropriate, assessed any changes since the last NCH CHNA of 2015
- As appropriate, established outcome measures to assess progress over the next three years aligning with Healthy Vermonters 2020 goals, VT's Blueprint for Health and/or OneCare Vermont All-Payer ACO model initiatives

To carry out the above action steps, representatives from the following local agencies /partners were invited to participate in forums with the Advisory Team, with each forum specifically addressing one of the Priority Health Concerns. Collaborating partners invited to a meeting for each of the five health concerns are outlined below. It is important to note that various members of the Advisory Team also represent areas of expertise regarding each of health concerns and participated in the implementation strategy work groups.

Supporting Substance Free Lifestyles and Mental Wellness

- Northeast Kingdom Learning Services– Regional Prevention Partnerships
- Northeast Kingdom Human Services including Addiction Services Standing Committee
- Orleans Essex VNA & Hospice
- Northeast Kingdom Community Action
- District Director of Newport Probation Parole
- NCH Primary Care Services – Social Services, Newport and Barton
- Vermont Department of Health

Supporting Older Vermonters Aging in Place

- SASH – Support and Services at Home, under Rural Edge Senior Housing Units
- Specific members of the Advisory Team:
    - Northeast Kingdom Council on Aging
    - Orleans Essex Visiting Nurses Association and Hospice
    - Northeast Kingdom Community Action
    - Northeast Kingdom Human Services

Supporting Tobacco Free Life Styles

- NEKLS – Tobacco Prevention Services
- Manager, NC OB/GYN Practice, focusing on prevention/ cessation in women of child-bearing age
- NCH – Tobacco Treatment Specialist / Community Health Planner (already a member of NCH CHNA Core Team)
- Vermont Department of Health

Supporting Healthy Eating and Physical Activity

- Green Mountain Farm to School and its Lunch Box Program
- NEKCA /HeadStart Nutrition Program
- Upper Kingdom Food Access
- Siskin Ecological Adventures / Coutts-Moriarty Camp
- Pediatrician, Border Pediatrics
- Vermont Department of Health
- The Wellness Center

Supporting Access to Medical and Oral Health Resources

- NCH Core CHNA Team
- With input from NCH CHNA Advisory Team

NCH Resources Available to Address Identified Needs:

NCH plans to commit resources to improve the health of the community as identified and prioritized through the CHNA process. Some resources are specific for each Priority Health Concern and details are contained in the Implementation Strategy document in the column titled "Anticipated Plan/Upcoming Development (1/1/19-12/31/21)". Examples include:

- Staff time dedicated to activities which directly link to NCH's Implementation Strategy for each of the Priority Health Concerns, including the Director of Wellness Center, Dietician, Community Health Planner, Director of Development and Community Relations, and Executive Director of Primary Care and Quality
- Commitment to designate a NCH staff person as lead person for each of the Priority Health Concerns who will partner with community resources and will monitor progress in meeting CHNA Implementation goals related to each of these health concerns.
- Expansion of the NCH website to provide increased information to the community about resources and activities available for each of the Priority Health Concerns identified.
- Provide a report of implementation strategy activities at least annually to the NCH Board of Directors and to the Upper Northeast Kingdom Community Council and the NCH Board of Directors

Plan for Communication of Results of the CHNA Report and Implementation Strategy:

NCH plans to make both the CHNA Report and the Implementation Strategy document widely available to the public. This will include:

- Easily downloadable format on the NCH's website at www.northcountryhospital.org (No special hardware or software, fee, or need to create an account will be required to read and/or download the CHNA documents.)
- Availability of hard copy by calling NCH administrative office at 802-334-3203.
- Presentation at the Newport Area Community Health Team composed of representatives of thirty or more local organizations.
- Presentation at Newport area UNEKCC.
- NCH's Office of Development and Community Relations will coordinate publicity efforts to notify the community of the availability of the NCH CHNA Report and Implementation Strategy Plan.
- In addition, a summary of the 2012 and 2015 CNHA Report and Implementation Strategy document, updated in 2017, will also continue to be available utilizing the same access points as above.

Supporting documents for the 2018 CHNA Report include:

Appendix A: Quantitative Data reviewed for 2018 CHNA
2018 CHNA Implementation Strategy
2015 CHNA Implementation Strategy, updated in 2017