PENOBSCOT VALLEY HOSPITAL
LINCOLN, ME

2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

ADOPTED BY BOARD RESOLUTION NOVEMBER 25, 2013[1]

QHR | Consulting Services

[1] Response to Schedule H (Form 990) Part V B 2 and section 501(r)1

QHR | Consulting Services

Dear Community Resident:

Penobscot Valley Hospital (PVH) welcomes you to review this document as we strive to meet the health and medical needs in our community. All not-for-profit hospitals are required to develop this report in compliance with the Affordable Care Act.

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

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

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

The report is a response to a federal requirement of not-for-profit hospitals to identify the community benefit it provides in responding to documented community need. Footnotes are provided to answer specific tax form questions. For most purposes, they may be ignored. Of greater importance, however, is the potential for this report to guide our actions and the efforts of others to make needed health and medical improvements.

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

Thank You

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EXECUTIVE SUMMARY

Executive Summary

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

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

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

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

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

Project Objectives

PVH partnered with Quorum Health Resources, LLC (QHR) for the following[4]:

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

Brief Overview of Community Health Needs Assessment

Typically, 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 to

[2] Part 3 Treasury/IRS – 2011 – 52 Notice … Community Health Needs Assessment Requirements…and https://www.federalregister.gov/articles/2013/04/05/2013-07959/community-health-needs-assessments-for-charitable-hospitals
[3] As of the date of this report Notice of proposed rulemaking was published 6/26/2012 and available at http://federalregister.gov/a/2012-15537
[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

the less fortunate without means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

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

- Emergency room open to all, regardless of ability to pay;
- Surplus funds used to improve patient care, expand facilities, train employees and prpvide community education.
- Controlled by independent civic leaders;
- All available and qualified physicians are privileged;
- Specifically, the IRS requires:
    - Effective on tax years beginning after March 23, 2012, each 501(c) (3) hospital facility is required to conduct a CHNA at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment;
    - The assessment may be based on current information collected by a public health agency or 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); and
    - Each hospital facility is required to make the assessment widely available and ideally downloadable from the hospital web site.
- Failure to complete a CHNA in any applicable three-year period results in a penalty to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four);

- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties[5]; and
- This report was developed under the guidance of IRS/Treasury 2011-52 as modified by the Draft Federal Regulations published in the April 5, 2013 Federal Register.

[5] Section 6652

APPROACH

Approach

To complete a CHNA, the hospital must:

- Describe the processes and methods used to conduct the assessment;
    - Sources of data and dates retrieved;
    - Analytical methods applied;
    - Information gaps impacting ability to assess the needs; and
    - Identification of with whom the hospital collaborated.
- The proposed regulations provide that a hospital facility's CHNA report will be considered to describe how the hospital facility took into account input if the CHNA report:
    - Summarizes, in general terms, the input provided and how and over what time period such input was provided;
    - Provides the names of organizations providing input and summarizes the nature and extent of the organization's input; and
    - Describes the medically underserved, low income, or minority populations being represented by organizations or individuals providing input.
- Describe the process and criteria used in prioritizing health needs;
- Describe existing resources available to meet the community health needs; and
- Identify the programs and resources the hospital facility plans to commit to meeting each identified need, and the anticipated impact of those programs and resources on the health need.

QHR takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with local survey data, and resolve any data inconsistency or discrepancies from the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources to exist in their portion of the county[6].

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

Most data used in the analysis is available from public internet sources. Critical data needed to address specific regulations or developed by the individuals cooperating with us in this study is displayed in the report of the appendix. Data sources include[7]:

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Penobscot County compared to all ME counties	June 27, 2013	2002 to 2010
www.communityhealth.hhs.gov	Assessment of health needs of Penobscot County compared to its national set of "peer counties"	June 27, 2013	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the contribution each group makes to the entire area; and, to access population size, trends, and socio-economic characteristics	June 27, 2013	2012
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	June 27, 2013	2012
www.caringinfo.org and www.iweb.nhpco.org	To identify the availability of hospice programs in the county	June 27, 2013	2012
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	June 27, 2013	1989 through 2009
www.dataplace.org	To determine availability of specific health resources	June 27, 2013	2005
www.cdc.gov	To examine area trends for heart disease and stroke	June 27, 2013	2008 to 2010

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

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.CHNA.org	To identify potential needs among a variety of resource and health need metrics	June 27, 2013	2003 to 2010
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	June 27, 2013	2013
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	June 27, 2013	2010 published 11/29/12

- In addition, we deployed a CHNA "Round 1" survey to our local expert advisors to gain local input as to local health needs and the needs of priority populations. Local expert advisors were local individuals selected to conform to the input required by the Federal guidelines and regulations[8];
- We received community input from 11 local expert advisors. Survey responses started September 13, 2013 and ended with the last response on October 4, 2013; and
- Information analysis augmented by local opinions showed how Penobscot County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on if they believe certain population groups (or people with certain situations) need help to improve their condition, and if so, who needs to do what[9].

When the analysis was complete, we put the information and summary conclusions before our local group of experts[10], who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional statements of need, and new needs did emerge from this exchange[11]. Consultation with local experts occurred again via an internet-based survey (explained below) during the period beginning October 4, 2013, and ending October 10, 2013.

With the prior steps identifying potential community needs, the local experts participated in a structured communication technique called a Delphi method, originally developed as a systematic, interactive forecasting method that relies on a panel of experts. Experts answer questionnaires in a series of rounds. We contemplated and implemented one round as referenced during the above dates. After each round, we provided an anonymous summary of the experts' forecasts from the previous round, as well as reasons provided for their judgments. The process encouraged experts to revise their earlier answers in light of the replies of other members of their panel. Typically, this

[8] Response to Schedule H (Form 990) Part V B 1 h; complies with 501(r)(3)(B)(i)
[9] Response to Schedule H (Form 990) Part V B 1 f
[10] Part response to Schedule H (Form 990) Part V B 3
[11] Response to Schedule H (Form 990) Part V B 1 e

process decreases the range of answers and moves the expert opinions toward a consensus "correct" answer. The process stops when we identify the most pressing, highest priority, community needs.

In the PVH process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and challenge conclusions developed from the data analysis. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

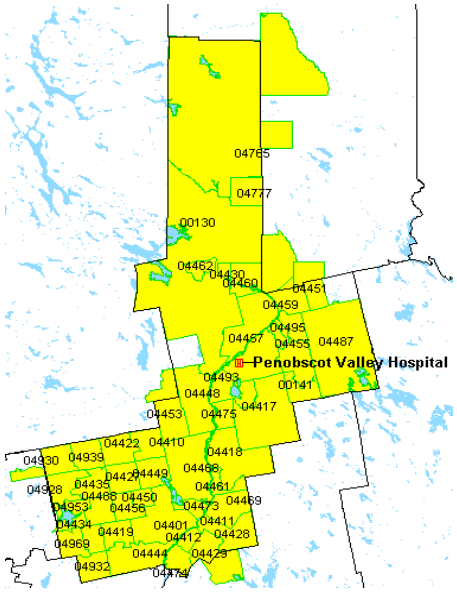
The proposed regulations clarify a CHNA need only identify significant health needs, and need only prioritize, and otherwise assess, those significant identified health needs. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. The determination of the break point, Significant Need as opposed to Other Need, was a qualitative interpretation by QHR and the PVH executive team where a reasonable break point in the descending rank order of votes occurred, indicated by the weight amount of points each potential need received and the number of local experts allocating any points to the need. Our criteria included the Significant Needs had to represent a majority of all cast votes. The Significant Needs also needed a plurality of Local Expert participation. When presented to the PVH executive team, the dichotomized need rank order (Significant vs. Other) identified which needs the hospital needed to focus upon in determining where and how it was to develop an implementation response.[12]

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

FINDINGS

Findings

Definition of Area Served by the Hospital Facility[13]



PVH, in conjunction with QHR, defines its service area as Penobscot County in ME, which includes the following ZIP codes:

00130	Outarea	00141	Outarea	04401	Bangor
04410	Bradford	04411	Bradley	04412	Brewer
04417	Burlington	04418	Greenbush	04419	Carmel
04422	Charleston	04427	Corinth	04428	Eddington
04429	Holden	04430	East Millinocket	04434	Etna
04435	Exeter	04444	Hampden	04448	Howland
04449	Hudson	04450	Kenduskeag	04451	Kingman
04453	LaGrange	04455	Lee	04456	Levant
04457	Lincoln	04459	Mattawamkeag	04460	Medway
04461	Milford	04462	Millinocket	04468	Old Town
04469	Orono	04473	Orono	04474	Orrington
04475	Passadumkeag	04487	Springfield	04488	Stetson
04493	West Enfield	04495	Winn	04765	Patten
04777	Stacyville	04928	Corinna	04930	Dexter
04932	Dixmont	04939	Garland	04953	Newport
04969	Plymouth				

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

In 2011, the Hospital received 94% of its patients from this area[14].

[14] Truven MEDPAR patient origin data for the hospital; Responds to IRS Form 990 (h) Part V B 1 a

Demographic of the Community[15]

The 2013 population for Penobscot County is estimated to be 155,919[16] and expected to decrease at a rate of 0.4%. This is lower than the 0.3% projected ME decrease and 3.3% national growth. Penobscot County anticipates a population of 155,229 by 2018.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2013 median age for the county is 40.3 years, which is younger than the State median age (43.3 years), but older than the national median age (37.5 years). The 2013 Median Household Income for the area is $44,649 which is lower than the State median income of $46,288 and the national median income of $49,233. Median Household Wealth value is below the State value, but above the National value. The Median Home Values for the area is $137,394 which is lower than the State and National values. Penobscot County's unemployment rate as of April, 2013 was 7.3%[17], which is worse than the 6.9% statewide, but better than 7.6% national civilian unemployment rates.

The portion of the population in the county over 65 is 15.6%, below the State average. The portion of the population of women of childbearing age is 19.5% above the State average of 17.8% but below the national average of 19.8%. 0.8% of the population is Black non-Hispanic and 94.3% is White non-Hispanic. The Hispanic population comprises 1.2% of the total.

Demographics Expert 2.7
2013 Demographic Snapshot
Area: Penobscot County, ME 6.2013
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA		2013	2018	% Change
2010 Total Population	156,220	308,745,538	Total Male Population	76,863	76,408	-0.6%
2013 Total Population	155,919	314,861,807	Total Female Population	79,056	78,821	-0.3%
2018 Total Population	155,229	325,322,277	Females, Child Bearing Age (15-44)	30,441	29,374	-3.5%
% Change 2013 - 2018	-0.4%	3.3%				
Average Household Income	$56,799	$69,637				

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2013	% of Total	2018	% of Total	USA 2013 % of Total
0-14	24,777	15.9%	24,427	15.7%	19.6%
15-17	5,437	3.5%	5,168	3.3%	4.1%
18-24	18,771	12.0%	16,728	10.8%	10.0%
25-34	19,588	12.6%	20,939	13.5%	13.1%
35-54	41,171	26.4%	37,326	24.0%	26.9%
55-64	21,841	14.0%	22,848	14.7%	12.4%
65+	24,334	15.6%	27,793	17.9%	13.9%
Total	155,919	100.0%	155,229	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2013 Household Income	HH Count	% of Total	USA % of Total
<$15K	0	#DIV/0!	#DIV/0!
$15-25K	0	#DIV/0!	#DIV/0!
$25-50K	0	#DIV/0!	#DIV/0!
$50-75K	0	#DIV/0!	#DIV/0!
$75-100K	0	#DIV/0!	#DIV/0!
Over $100K	0	#DIV/0!	#DIV/0!
Total	0	#DIV/0!	#DIV/0!

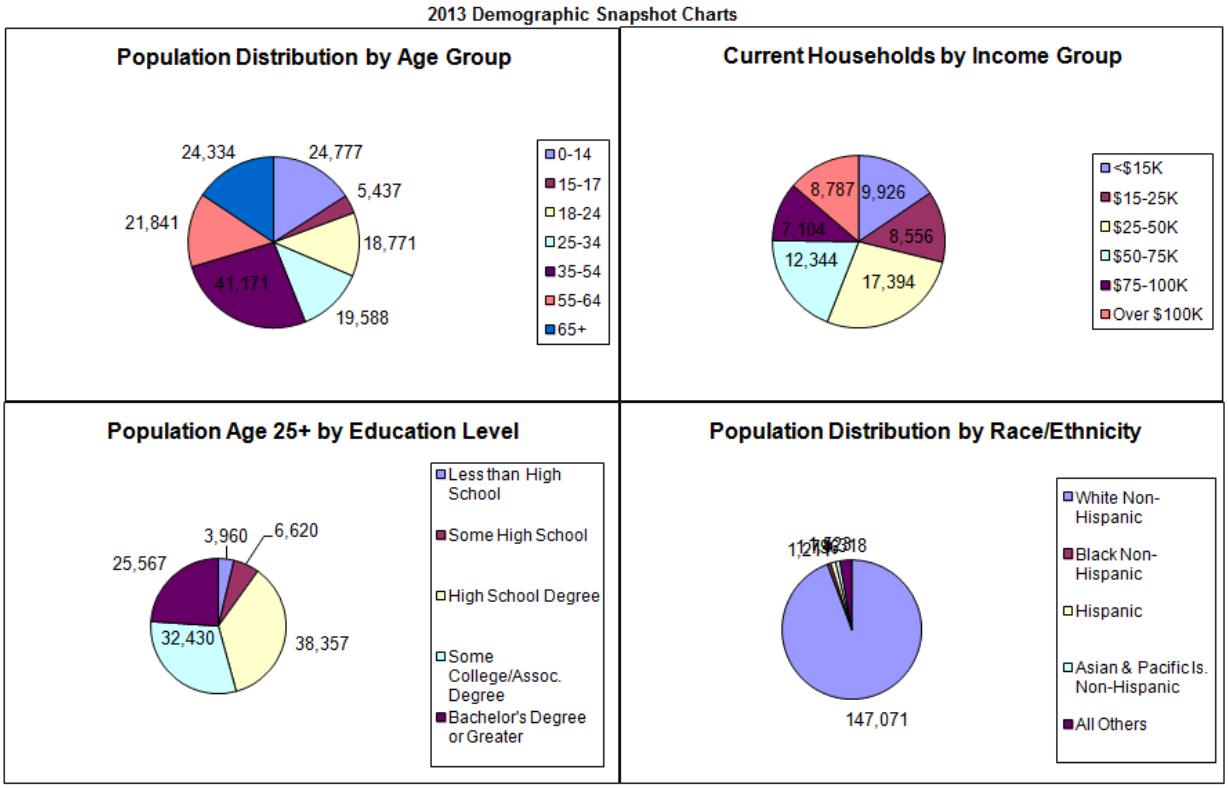
EDUCATION LEVEL

	Education Level Distribution		
2013 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	3,960	3.7%	6.2%
Some High School	6,620	6.2%	8.4%
High School Degree	38,357	35.9%	28.4%
Some College/Assoc. Degree	32,430	30.3%	28.9%
Bachelor's Degree or Greater	25,567	23.9%	28.1%
Total	106,934	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2013 Pop	% of Total	USA % of Total
White Non-Hispanic	147,071	94.3%	62.3%
Black Non-Hispanic	1,211	0.8%	12.3%
Hispanic	1,796	1.2%	17.3%
Asian & Pacific Is. Non-Hispanic	1,523	1.0%	5.1%
All Others	4,318	2.8%	2.9%
Total	155,919	100.0%	100.0%

[15] Responds to IRS Form 990 (h) Part V B 1 b
[16] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[17] http://research.stlouisfed.org/fred2/graph/?g=jO1



2013 Benchmarks
Area: Penobscot County, ME 6.2013
Level of Geography: ZIP Code

Area	2013-2018 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2013-2018	Females 15-44 % of Total Population	Females 15-44 % Change 2013-2018	Median Household Income	Median Household Wealth	Median Home Value
USA	3.3%	37.5	13.9%	16.3%	19.8%	-0.1%	$49,233	$54,682	$169,011
Maine	-0.3%	43.3	17.1%	13.8%	17.8%	-3.5%	$46,288	$68,040	$169,407
Selected Area	-0.4%	40.3	15.6%	14.2%	19.5%	-3.5%	$44,649	$57,938	$137,394

Demographics Expert 2.7
DEMO0003.SQP

The population also was examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to discern the following table of probable lifestyle and medical conditions present in the population. Items with red text are viewed as statistically important, potentially adverse findings. Items with blue text are viewed as statistically important, potential beneficial findings. Items with black text are viewed as either not statistically different from the national normal situation, or not considered either favorable or unfavorable in our use of the information.

Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle		
BMI: Morbid/Obese	106.9%	27.3%
Vigorous Exercise	97.6%	49.6%
Chronic Diabetes	115.0%	12.0%
Healthy Eating Habits	92.3%	27.3%
Very Unhealthy Eating Habits	119.0%	4.6%
Behavior		
I Will Travel to Obtain Medical Care	99.5%	29.7%
I Follow Treatment Recommendations	88.6%	35.8%
I am Responsible for My Health	94.8%	61.0%
Pulmonary		
Chronic COPD	120.1%	8.4%
Tobacco Use: Cigarettes	118.2%	30.6%
Chronic Allergies	107.4%	20.8%
Cancer		
Mammography in Past Yr	96.3%	43.7%
Cancer Screen: Colorectal 2 yr	94.7%	23.4%
Cancer Screen: Pap/Cerv Test 2 yr	91.0%	54.8%
Routine Screen: Prostate 2 yr	93.3%	29.7%
Orthopedic		
Chronic Lower Back Pain	113.8%	25.7%
Chronic Osteoporosis	115.5%	11.2%

Health Service Topic	Demand as % of National	% of Population Affected
Heart		
Routine Screen: Cardiac Stress 2yr	91.5%	14.3%
Chronic High Cholesterol	99.0%	22.1%
Routine Cholesterol Screening	93.8%	47.5%
Chronic High Blood Pressure	110.3%	29.0%
Chronic Heart Disease	119.3%	10.0%
Routine Services		
FP/GP: 1+ Visit	102.7%	90.6%
Used Midlevel in last 6 Months	104.0%	43.5%
OB/Gyn 1+ Visit	90.8%	41.9%
Ambulatory Surgery last 12 Months	102.5%	19.7%
Internet Usage		
Use Internet to Talk to MD	76.9%	11.2%
Facebook Opinions	89.5%	9.2%
Looked for Provider Rating	84.7%	12.2%
Misc		
Charitable Contrib: Hosp/Hosp Sys	91.5%	21.9%
Charitable Contrib: Other Health Org	87.9%	34.3%
HSA/FSA: Employer Offers	96.1%	49.8%
Emergency Service		
Emergency Room Use	104.5%	35.5%
Urgent Care Use	97.8%	23.1%

Leading Causes of Death

Cause of Death			Rank among all counties in ME	Rate of Death per 100,000 age adjusted		
ME Rank	Penobscot Co. Rank	Condition	(#1 rank = worst in state)	ME	Penobscot Co.	Observation
1	1	Heart Disease	3 of 16	157.4	218.9	As expected
2,8,11,13,17, 25,26,28,29, 32,33	2	Cancer	5 of 16	187.0	206.7	Higher than expected
4	3	Stroke	2 of 16	38.2	55.2	As expected
3	4	Lung	11 of 16	49.0	48.9	As expected
20, 23, 30	5	Accidents	13 of 16	41.1	37.7	Lower than expected
6	6	Alzheimer's	8 of 16	27.0	27.3	As expected
7	7	Diabetes	7 of 16	20.9	24.8	As expected
10	8	Flu - Pneumonia	5 of 16	14.7	20.0	As expected
9	9	Kidney	7 of 16	16.4	17.9	Higher than expected
21	10	Blood Poisoning	2 of 16	7.9	12.0	As expected
15	11	Suicide	10 of 16	14.1	10.9	As expected
16	12	Liver	6 of 16	8.9	10.3	As expected
19	13	Parkinson's	7 of 16	7.6	7.5	As expected
18	14	Hypertension	7 of 16	4.9	5.1	Lower than expected
Not Ranked	15	Homicide	14 of 15	2.2	0.9	Lower than expected

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

Some information is available to describe the size and composition of various uninsured persons, low income persons, minority groups, and other vulnerable population segments. Specific studies identifying needs of such groups, distinct from the general population at a county unit of analysis, are not readily available from secondary sources.

The National Healthcare Disparities Report results from a Congressional directive to the Agency for Healthcare Research and Quality (AHRQ). This production is an annual report to track disparities related to "racial factors and socioeconomic factors in priority populations." The emphasis is on disparities related to race, ethnicity, and socioeconomic status. The directive includes a charge to examine disparities in "priority populations," which are groups with unique healthcare needs or issues that require special attention[18].

Nationally, this report observes the following trends:

- Measures for which African Americans were worse than Whites and are getting better:
    - Diabetes – Hospital admissions for short-term complications of diabetes per 100,000 population;
    - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over; and
    - Functional Status Preservation and Rehabilitation. Female Medicare beneficiaries age 65 and over, who reported ever being screened for osteoporosis with a bone mass or bone density measurement.
- Measures for which Blacks were worse than Whites and staying the same:
    - Cancer – Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over; breast cancer deaths per 100,000 female population per year; adults age 50 and over who ever received colorectal cancer screening; colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over; colorectal cancer deaths per 100,000 population per year;
    - Diabetes – Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes;
    - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year; Children ages 19-35 months who received all recommended vaccines;

[18] http://www.ahrq.gov/qual/nhdr10/Chap10.htm 2010

  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months; people age 12 and over treated for substance abuse who completed treatment course;
  - Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
  - Supportive and Palliative Care – High-risk long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
  - Timeliness – Adults who needed immediate care for an illness, injury, or condition in the last 12 months, who received care as soon as they wanted; emergency department visits where patients left without being seen; and
  - Access – People with a usual primary care provider; people with a specific source of ongoing care.

- Measures for which Asians were worse than Whites and getting better:
  - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  - Patient Safety – Adult surgery patients who received appropriate timing of antibiotics.

- Measures for which Asians were worse than Whites and staying the same:
  - Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and
  - Access – People with a usual primary care provider.

- Measures for which American Indians and Alaska Natives were worse than Whites for the most recent year and staying the same:
  - Heart Disease – Hospital patients with heart failure who received recommended hospital care;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  - Respiratory Diseases – Hospital patients with pneumonia who received recommended hospital care;
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement;

  - Supportive and Palliative Care – Hospice patients who received the right amount of medicine for pain; high-risk, long-stay nursing home residents with pressure sores; adult home healthcare patients who were admitted to the hospital; and
  - Access – People under age 65 with health insurance.

- Measures for which American Indians and Alaska Natives were worse than Whites for the most recent year and getting worse:
  - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  - Patient safety – Adult surgery patients who received appropriate timing of antibiotics.

- Measures for which Hispanics were worse than non-Hispanic Whites for the most recent year and getting better:
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;
  - Lifestyle Modification – Adult current smokers with a checkup in the last 12 months who received advice to quit smoking; adults with obesity who ever received advice from a health provider about healthy eating; and
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.

- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and staying the same:
  - Cancer – Women age 40 and over who received a mammogram in the last two years; adults age 50 and over who ever received colorectal cancer screening;
  - Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
  - Heart Disease – Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge; hospital patients with heart failure who received recommended hospital care;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months;

  - Respiratory Disease – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
  - Lifestyle Modification – Adults with obesity who ever received advice from a health provider to exercise more;
  - Supportive and Palliative Care – Long-stay nursing home residents with physical restraints; high-risk, long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
  - Patient Safety – Adult surgery patients who received appropriate timing of antibiotics;
  - Timeliness – Adults who needed care right away for an illness, injury, or condition in the last 12 months and got care as soon as wanted;
  - Patient Centeredness – Adults with ambulatory visits who reported poor communication with health providers; children with ambulatory visits who reported poor communication with health providers; and
  - Access – People under age 65 with health insurance; people under age 65 who were uninsured all year; people with a specific source of ongoing care; people with a usual primary care provider; people unable to get or delayed in getting needed care due to financial or insurance reasons.

- Measures for which Hispanics were worse than non-Hispanic Whites for the most recent year and getting worse:
  - Maternal and Child Health – Children ages 3-6 who ever had their vision checked by a health provider.

We asked a specific question to our local expert advisors about unique needs of priority populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received to identify unique population needs to which we should respond. Specific opinions from the local expert advisors are summarized as follows[19]:

- I consider basic preventive care a central unmet need. Too many still do not have a primary care provider for medical and/or dental care. This is often related to poverty, leaving people very limited options for maintaining optimal health.

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

- Our rural, poor and disadvantaged patients have significant issues with a very poor general, over-all health status.
- Obstetrical patients with positive drug tests are a special population needing attention. We see a high number of individuals who need access to dialysis treatment and don't have the resources (i.e. money, family, car etc) to make it to their appointments.
- This area is a low income area therefore people can't and or don't want buy healthy food which can lead to diabetes, heart attack and more chronic health issues and diseases. Think there needs to be more education with healthier eating and smarter choices on a budget.

Statistical information about special populations follows:

Access to Care: Penobscot County, ME

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

Uninsured individuals (age under 65)[1]	**16,144**
Medicare beneficiaries[2]	
Elderly (Age 65+)	**20,616**
Disabled	**7,060**
Medicaid beneficiaries[2]	**39,351**
Primary care physicians per 100,000 pop[2]	**100.2**
Dentists per 100,000 pop[2]	**57.9**
Community/Migrant Health Centers[3]	**Yes**
Health Professional Shortage Area[3]	**No**

nda No data available.

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

Vulnerable Populations: Penobscot County, ME

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

Vulnerable Populations Include People Who[1]	
Have no high school diploma (among adults age 25 and older)	**14,487**
Are unemployed	**4,443**
Are severely work disabled	**3,974**
Have major depression	**10,625**
Are recent drug users (within past month)	**13,141**

nda No data available.

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

Findings

Upon completion of the CHNA, QHR identified several issues within the Penobscot Valley community:

Conclusions from Public Input to Community Health Needs Assessment

Eleven area experts participated in a survey asking opinions about their perception of local healthcare needs. In descending order of opinion, nine of them identified topics as being of "Major Concern" or "Most Important Issue to Resolve":

1. Obesity – 100% listed as a major concern;
2. Smoking/Tobacco Use – 89% listed as a major concern;
3. Alcohol and Drug Abuse – 67% listed as a major concern;
4. Mental Health/Suicide – 78% listed as a major concern; and
5. Diabetes – 56% listed as a major concern.

Summary of Observations from Penobscot County Compared to All Other State Counties, in Terms of Community Health Needs

- In general, Penobscot County residents are about average health for State;
- In a health status classification termed "Health Outcomes," County ranks 9th among 16 counties (best being #1). On measures of morbidity and mortality, Penobscot County performs at State average, but worse than the National benchmark for poor mental health days. On measures of premature death (death prior to the age of 75), poor or fair health, poor physical health days, and low birth weight, Penobscot County performs below State averages and does not meet National benchmarks; and
- In another health status classification "Health Factors," Penobscot County fares slightly worse, ranking 8th among the 16 counties. The clinical measure for supply of primary care physicians and dentists, diabetic screening, and mammography screening are better than State average, but do not meet National benchmarks. Uninsured values are at State average, but do not meet National benchmarks. Conditions where improvement remains to achieving state average rates and then national goals include:
    - Adult smoking;
    - Adult obesity;
    - Physical inactivity;
    - Preventable hospital stays;

- Drinking water safety; and
- Limited access to healthy foods.

Summary of Observations from Penobscot County Peer Comparisons

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

UNFAVORABLE – observations occurring at rates worse than national AND worse than among peers:

- White non Hispanic Infant Mortality;
- Breast Cancer (female);
- Colon Cancer; and
- Stroke.

SOMEWHAT A CONCERN – observations because occurrence is EITHER above national average or above peer group average:

- Neonatal Infant Mortality;
- Lung Cancer;
- Births to Women age 40-54; and
- Unintentional Injury.

BETTER PERFORMANCE – better than peers and national rates:

- Low Birth Weight (<2500 g);
- Very Low Birthweight (<1500 g);
- Premature Births (<37 weeks);
- Births to Women Under 18;
- Births to Unmarried Women;
- No Care in First Trimester;
- Infant Mortality;
- Post-neonatal Infant Mortality;

- Coronary Heart Disease;
- Motor Vehicle Injuries; and
- Suicide.

Conclusions From the Demographic Analysis Comparing Penobscot County to National Averages

Penobscot County in 2013 comprises 155,919 residents. During the next five years, it is expected to see a population decrease of 0.4% to achieve 155,229 residents. This is lower than the anticipated state (4.2%) and national growth (3.3%). The population is younger and has a lower median income than state and national comparisons. 15.6% of the population is age 65 or older, lower than ME. 1% are non-Hispanic White, Asian, and Pacific Island origin; Hispanics constitute 1.2% of the population; Blacks comprise 0.8% of the population; Whites 94.3%. Females ages 15 to 44 comprise 19.5% of the population, greater than the percentage in ME (17.8%), but less than the nation (19.8%).

The following areas were identified comparing the county to national averages. Metrics impacting more than 30% of the population and that are statistically significantly different from the national average:

- Personal Responsibility for Health was 5.2% below average, impacting 61% – an adverse finding;
- Pap/Cervix Screening was 9% below average, impacting 54.8% – an adverse finding;
- Routine Cholesterol Screening was 6.2% below average, impacting 47.5% – an adverse finding;
- OB/GYN 1+ Visit was 9.2% below average, impacting 41.9% – an adverse finding;
- Compliance with Treatment Recommendations was 11.4% below average, impacting 35.8% – an adverse finding;
- Charitable Contributions to Other Health Organizations was 12.1% below average, impacting 34.3% – neither a beneficial or adverse finding; and
- Tobacco Use: Cigarettes was 18.2% above average, impacting 30.6% – an adverse finding.

Situations and conditions statistically significantly different from the national average, but impacting less than 30% of the population include:

- Routine Screen: Prostate 2 years was 6.7% below average, impacting 29.7% – an adverse finding;

- Chronic High Blood Pressure was 10.3% above average, impacting 29% – an adverse finding;
- Healthy Eating Habits was 7.7% below average, impacting 27.3% – an adverse finding;
- BMI: Morbid/Obese was 6.9% above average, impacting 27.3% – an adverse finding;
- Chronic Lower Back Pain was 13.8% above average, impacting 25.7% – an adverse finding;
- Cancer Screen: Colorectal 2 years was 5.3% below average, impacting 23.4% – an adverse finding;
- Charitable Contributions to Hospitals/Hospital Systems was 8.5% below average, impacting 21.9% – neither a beneficial or adverse finding;
- Chronic Allergies was 7.4% above average, impacting 20.8% – an adverse finding;
- Looked for Provider Rating was 15.3% below average, impacting 12.2% – neither a beneficial or adverse finding;
- Chronic Diabetes was 15% above average, impacting 12% – an adverse finding;
- Chronic Osteoporosis was 15.5% above average, impacting 11.2% – an adverse finding;
- Use Internet to Talk to MD was 23.1% below average, impacting 11.2% – neither a beneficial or adverse finding;
- Chronic Heart Disease was 19.3% above average, impacting 10% – an adverse finding;
- Face book Opinions was 10.5% below average, impacting 9.2% – neither a beneficial or adverse finding;
- Chronic COPD was 20.1% above average, impacting 8.4% – an adverse finding; and
- Very Unhealthy Eating Habits was 19% above average, impacting 4.6% – an adverse finding.

Key Conclusions from Consideration of the Other Statistical Data Examinations

Additional observations of Penobscot County found:

- Palliative Care programs (programs focused not on curative actions but designed to relieve disease symptoms pain and stress arising from serious illness) do not exist in the county; and
- Hospice: Six programs exist in the county.

Ranking the causes of death in County finds the leading causes to be the following (in descending order of occurrence):

- Heart Disease #1 cause of death statewide and in County – 218.9/100,000 ranking #3 among 16 ME Counties;

- Cancer # 2 cause of death statewide and in County – 206.7/100,000 ranking #5 ME County – significantly higher than expected;
- Stroke #3 cause of death in County, statewide #4 – 55.2/100,000 ranking #2 ME County;
- Lung Disease #4 cause of death in County, statewide #3 – 48.9/100,000 ranking #11 ME County;
- Accidents #5 cause of death in County, statewide #20 – 37.7/100,000 ranking #13 ME County - significantly lower than expected;
- Alzheimer's #6 cause of death statewide and in County – 27.3/100,000 ranking #8 ME County;
- Diabetes #7 cause of death statewide and in County – 24.8/100,000 ranking #7 ME County;
- Flu-Pneumonia #8 cause of death in County, statewide #10 – 20/100,000 ranking #5 ME County;
- Kidney Disease #9 cause of death statewide and in County – 17.9/100,000 ranking #7 ME County – significantly higher than expected
- Blood Poisoning #10 cause of death in County, statewide #21 – 12/100,000 ranking #2 ME County; and
- Among other leading causes of death, Hypertension and Homicide are significantly lower than expected.

The overall, all race incident of Heart Disease death is above state average, but below national averages. There is insufficient data for the incident of Heart Disease death for Blacks in Penobscot County. The overall, all race incidence of Stroke deaths is above state and national average. There is also insufficient data to account for the incident of Stroke deaths among Blacks. Diabetes is above state average.

Life expectancy for Penobscot County males in 1989 was 72 years, 1.3 years behind the top counties, improving in 2009 to 75.3 years, 2.2 years behind the top counties.

Life expectancy for Penobscot County females in 1989 was 79.2 years, 0.7 years behind the top counties, improving in 2009 to 80.7 years, 1.3 years behind the top counties.

EXISTING HEALTH CARE FACILITIES, RESOURCES AND IMPLEMENTATION PLAN

Significant Health Needs

We used the priority ranking of area health needs by the local expert advisors to organize the search for locally available resources as well as the response to the needs by PVH[20]. The following list includes:

- 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 PVH's current efforts responding to the need;
- Establishes the Implementation Plan programs and resources PVH will devote to attempt to achieve improvements;
- Documents the Leading Indicators PVH will use to measure progress;
- Presents the Lagging Indicators PVH 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, PVH is the major hospital in the service area. PVH is a 25 bed, critical access hospital located in Lincoln. ME. The next closest facilities are outside the service area and include:

- Millinocket Regional Hospital – 25 bed critical access hospital in Millinocket, ME; 35 miles away from Lincoln (45 minutes);
- St. Joseph Hospital – 105 bed acute care medical facility in Bangor, Me; 47.5 miles away from Lincoln (49 minutes); and
- Eastern Maine Medical Center – 246 bed acute care medical facility in Bangor, ME; 48.9 miles away from Lincoln (50 minutes).

All data items analyzed to determine whether 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 PVH Implementation Plan utilizes Leading Indicators, which anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of

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

desired change in the Lagging Indicator. In the QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

Significant Needs

1. Obesity – County Health Rankings 2013 Summary for Penobscot County produced by the Robert Wood Johnson Foundation and the University of Wisconsin for Maine Health reports 31% of the population of Penobscot County is obese compared to 28% for the State of Maine and the National Benchmark of 25%.

Problem Statement: The percent of the population that is obese should be decreased.

PVH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- PVH registered dietitian visited students involved in the Carleton Project at Northern Penobscot Tech Region III and taught a session on Cooking Matters;
- PVH supports grant-funded community health coalition in collaboration with Millinocket Regional Hospital and the River Coalition in Old Town. SPINT for Life is part of a statewide system of public health organizations called Healthy Maine Partnerships that bring people and resources together to improve the health of Maine residents;
- PVH staff works with Health Access Network to develop a process to disseminate 5-2-1-0 Let's Go materials to families. As a result, 5-2-1-0 bookmarks on healthy eating and active lifestyles are being given to all children with the books they receive through the "Raising Readers" program at well child visits;
- PVH provides healthy meals for patients and staff – Flash frozen meals are prepared for families for people unable to get healthy meals; and
- PVH Provides information at Health Fairs about the medically based Gym program for the community at the downtown Rehabilitation center.

PVH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:[21]

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how PVH services can benefit their initiatives. PVH will initiate efforts by contacting each organization to establish a forum for effort collaboration; and
- Developing a program directed to obesity education for schools.

ANTICIPATED RESULTS FROM PVH IMPLEMENTATION PLAN:

- The focus of the implementation plan is education to influence life style and nutrition and healthy eating to reduce Obesity.

[21] This section in each need for which the hospital plans an implementation strategy responds to Schedule H (form 990) Part V Section B 6. a. and 6. b.

LEADING INDICATOR PVH WILL USE TO MEASURE PROGRESS:

- The number of presentations will increase. The hospital goal is to conduct at least 10 presentations. Current value is 0.

LAGGING INDICATOR PVH WILL USE TO IDENTIFY IMPROVEMENT:

- Percent of adults with Obesity > 30 BMI.

Other local resources identified during the CHNA process which are believed available to respond to this need include the following:
PVH Medical Staff Address and Telephone #s listed on the Hospital Web Site: http://www.pvhme.org
Health Access Network, FQHC, 175 W. Broadway, Lincoln, Maine, 04457 Ph: 207- 794-6700
Sprint For Life, c/o PVH Administration, Ph: 207-794-3321
Lincoln Maine Parks and Recreation, 65 Main St., Lincoln, Maine, 04457 Ph: 207-794-6548

2. Smoking – 22% of Penobscot County residents are smokers according to Penobscot County Health Rankings produced by the Robert Wood Johnson Foundation and University of Wisconsin Maine Health Report

PVH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- PVH Pulmonary Function testing;
- Education of inpatients : A packet of information regarding smoking cessation counseling is provided; and
- The PVH campus is 100% non smoking.

PVH DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED:

- The Sprint For life/River Coalition and the Healthy Maine Partnership is addressing this problem; and
- Physician Practices and Health Access Network address this problem.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
PVH Medical Staff Address and Telephone #s listed on the Hospital Web Site: http://www.pvhme.org
Health Access Network, FQHC, 175 W. Broadway, Lincoln, Maine, 04457 Ph: 207- 794-6700
Sprint for Life / River Coalition, Contact: PVH Administration Ph: 207-794-3321

3. Alcohol/Drug Abuse – Percentage of adults reporting Excessive Drinking in the past 30 days is 15% compared to the Best Maine County 13% and the National Benchmark of 7%. Motor Vehicle Crash rate is 10 per 100,000 population compared to the best County in Maine 9% and the National Benchmark of 10 according to the RWJ and University of Wisconsin Summary for Penobscot County 2013. Statistics on Drug abuse are not available.

Problem Statement: The percent of the population with excessive alcohol and drug abuse should be decreased. Currently excessive drinking occurs with 15% of the population.

PVH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- PVH treats and refers emergency department patients;
- Patients are admitted as inpatients for detoxification;
- PVH provides space for ALANON and AA at no cost for meetings;
- PVH promoted the national and statewide Prescription Drug Take Back event with the Lincoln Police Department; and
- PVH worked with SAD #30 to help them host an underage drinking/substance abuse town hall forum.
- PVH works with Sprint for Life / River Coalition to increase awareness of alcohol and drug abuse.

PVH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how PVH services can benefit their initiatives. PVH will initiate efforts by contacting each organization to establish a forum for effort collaboration; and
- PVH will expand the Town Forum to include Alcohol and Drug Abuse information and education materials and access to treatment and support services.

ANTICIPATED RESULTS FROM PVH IMPLEMENTATION PLAN:

- The focus of the implementation plan is education to influence and reduce the number of individuals who abuse alcohol and drugs.

LEADING INDICATOR PVH WILL USE TO MEASURE PROGRESS:

- The implementation of a Town Forum for Alcohol and Drug Abuse. Measure of Progress is the number of people attending the Town Forum.

LAGGING INDICATOR PVH WILL USE TO IDENTIFY IMPROVEMENT

- Percent of adults with excessive drinking (Currently 15%).

Other local resources identified during the CHNA process which are believed available to respond to this need include the following:
PVH Medical Staff Address and Telephone #s listed on the Hospital Web Site: http://www.pvhme.org
Health Access Network, FQHC, 175 W. Broadway, Lincoln Maine 04457 Ph: 207-794-6700
Mattanawcook Academy, RSU No. 67, 33 Reed Dr., Lincoln, Maine 04457 Ph: 207-794-6711
Northern Penobscot Tech Region 3, 35 West Broadway, Lincoln, Maine 04457 Ph: 207-794-3004
Sprint for Life / River Coalition, Contact: PVH Administration Ph: 207-794-3321
Lincoln Schools, RSU No. 67, 33 Reed Dr., Lincoln, Maine 04457 Ph: 207-794-6711
Lincoln Police Department, 1 Adam St., Lincoln, Maine 04457 Ph: 207-794-8455
Wellspring, 98 Cumberland Place, Bangor, Maine 04401 Ph: 888-590-2879
Acadia Hospital, 268 Stillwater Avenue, Bangor Maine 04402 Ph: 207-973-6100
Whitehouse Counseling, 189 Exchange St., Bangor, Maine 04401 Ph: 207-262-0055

4. Mental Health/Suicide – Suicide is the #11 cause of death in Penobscot County. The county is ranked #10 in Maine. Inadequate social support is worse than the national average. This need was ranked significant by the expert panel.

Problem Statement: Access to Mental Health Services needs to be improved

PVH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- PVH treats and refers emergency department patients for Psychiatric care.

PVH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how PVH services can benefit their initiatives. PVH will initiate efforts by contacting each organization to establish a forum for effort collaboration; and
- PVH will expand access to Mental Health Services by initiating a Psychiatric Telemedicine program from the ED.

ANTICIPATED RESULTS FROM PVH IMPLEMENTATION PLAN

- Increased access to Mental Health Services through a telepsychiatry program to diagnose patients who need inpatient and outpatient services.

LEADING INDICATOR PVH WILL USE TO MEASURE PROGRESS:

- The number of Psychiatric Telemedicine Sessions in the ED. Currently 0.

LAGGING INDICATOR PVH WILL USE TO IDENTIFY IMPROVEMENT

- A decrease in the Suicide Rate. (Current suicide rate is 14.1/100,000)

Other local resources identified during the CHNA process which are believed available to respond to this need include the following:
Penobscot Valley Medical Staff Address and Telephone #s listed on the Hospital Web Site: http://www.pvhme.org
Health Access Network, FQHC, 175 W. Broadway, Lincoln, Maine 04457 Ph: 207-794-6700
Wellspring, 98 Cumberland Place, Bangor, Maine 04401 Ph: 888-590-2879
Dorothea Dix Psychiatric Center, 656 State Street, Bangor Maine 04401, Ph: 207-941-4000
Acadia Hospital, 268 Stillwater Avenue, Bangor Maine 04402 Ph: 207-973-6100
Whitehouse Counseling, 189 Exchange St., Bangor, Maine 04401 Ph: 207-262-0055

5. Diabetes – County Health Rankings for Penobscot County Diabetes is 7th ranked County in Maine and the 7th leading cause of death in Penobscot County. Penobscot County is 15% above the national average for the nation.

Problem Statement: The incidence of Diabetes should be decreased and the death rate decreased.

PVH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- PVH diagnoses and treats patients with Diabetes
- The registered dietitian acts as a resource for education for diabetics

PVH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how PVH services can benefit their initiatives. PVH will initiate efforts by contacting each organization to establish a forum for effort collaboration; and
- PVH will initiate a diabetic screening program.

ANTICIPATED RESULTS FROM PVH IMPLEMENTATION PLAN:

- The focus of the implementation plan is earlier diagnosis thereby providing the opportunity for earlier treatment to manage the disease.

LEADING INDICATOR PVH WILL USE TO MEASURE PROGRESS:

- The number of patients screened. Current starting value is 0.

LAGGING INDICATOR PVH WILL USE TO IDENTIFY IMPROVEMENT:

- A decrease in the number of deaths from Diabetes, currently 20.9/100,000. Available Maine State Health Comparisons.

Other local resources identified during the CHNA process which are believed available to respond to this need include the following:
PVH Medical Staff Address and Telephone #s listed on the Hospital Web Site: http://www.pvhme.org
Health Access Network, FQHC, 175 W. Broadway, Lincoln, Maine, 04457 Ph: 207- 794-6700

Other Needs Identified During the CHNA Process

Overall Community Need Statement and Priority Ranking Score:

Significant Needs Where Hospital Has Implementation Responsibility

1. Obesity;
3. Alcohol and Drug Abuse;
4. Mental Health/Suicide; and
5. Diabetes.

Significant Needs Where Hospital Did Not Develop Implementation Plan

2. Smoking/Tobacco Use.

Other Needs Where Hospital Developed Implementation Plan

None

Other Identified Needs Where Hospital Did Not Develop Implementation Plan

6. Affordability;
7. Physicians;
8. Chronic COPD, Pulmonary Disease;
9. Alzheimer's;
10. Dental;
11. Priority Populations;
12. High Cholesterol;

13. Transportation;
14. Coronary Heart Disease;
15. Physical Environment;
16. Cancer;
17. Stroke;
18. Accidents;
19. High Blood Pressure;
20. Predisposing Conditions;
21. Flu/Pneumonia;
22. Life expectancy/Premature death;
23. Chronic Osteoporosis;
24. Kidney Disease;
25. Maternal and Infant Measures;
26. Sexually Transmitted Disease;
27. Blood Poisoning; and
28. Low Back Pain.

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APPENDICES

Appendix A – Local Expert Advisor Opinion About Significant Needs

Our local expert advisors participated in an online survey offering opinions regarding their perceptions of community health needs. The following is an analysis of their responses:

The first question was open-ended. "What do you believe to be the most important health or medical issue confronting the residents of your County?" Answers were placed in a "Word Cloud" format for analysis and generated the following image:

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

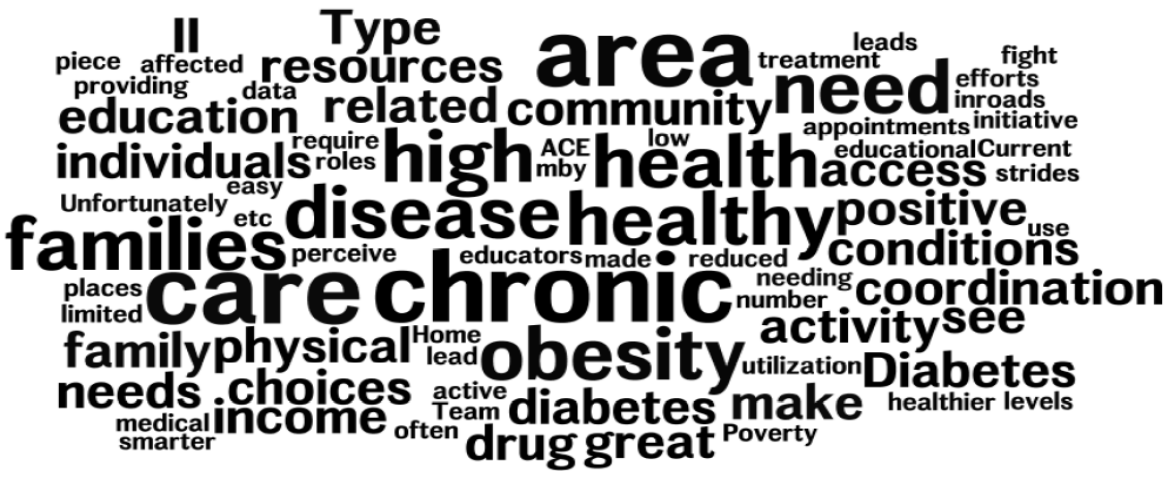
Specific verbatim comments received were as follows:

- Basic preventive care is a central unmet need. Too many still do not have a primary care provider for medical and/or dental care. This is often related to poverty, leaving people very limited options for maintaining optimal health.
- Obesity Mental Health Drug addiction.
- Access to healthy food and physical activity as an important health and medical issue confronting residents in Penobscot County. Basic access to fresh, healthy foods as well as opportunities for physical activity present a huge barrier for the health and wellness of residents.
- Lack of physical activity, nutrition, & poverty.

- Our rural, poor and disadvantaged patients have significant issues with a very poor general, over-all health status. Primary Care Providers provide adequate access for patients but their compliance is very poor.
- The lack of volume in obstetrical care creates a loss leader for inpatient and outpatient care.
- Dental health care is available at our FQHC so access is assured but again patient and parental compliance is very poor. Children and adolescents present with advanced dental disease, referred to by the clinicians as Mountain Dew Mouth.
- The co-location of behavioral health with primary care services is essential.
- Access to primary care providers is essential. Recruitment and retention of primary care providers will assure that access. Provider student loan debt forgiveness is absolutely critical but is currently lacking directly effecting recruitment and retention and thus access.
- Adequate transportation to medical appointments and a comprehensive understanding of what their health care options are, such as preventive health, dental, mental health services, substance abuse etc. Also, education about necessary and unnecessary testing and how to advocate for themselves with their PCP.

Our second question to the local experts was, "Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e., people with certain situations), which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what."

The responses generated the following image:



Specific verbatim comments received were as follows:

- There are few family who are not negatively affected by alcohol and/or drug use. The impact

on families is often catastrophic.

- Poverty in and of itself places individuals and families at risk for chronic health conditions such as cardiac problems; diabetes and obesity. Some inroads in helping those on limited income prepare healthy meals for their families has recently occurred and is a small step in a positive direction.
- I believe the needs of the uninsured or low-income are being met and do not need any further assistance.
- There does need to be an educational piece on obesity and parents, educators, health care and the community take active roles in the fight against obesity.
- I perceive there to be a high incidence of Type II Diabetes in the area which is directly related to nutrition and physical activity. The formation of the Lincoln ACE Team is a great addition to see where improvements in the outdoor physical activity environment can be made.
- Unfortunately there is no one-step solution to reducing the rate of Type II Diabetes and other chronic disease in the area, by working together and providing education as well as making access to healthy choices as easy as possible, we could make great strides.
- Current data demonstrates high levels of chronic and co-morbid disease conditions exist in our county. The Patient Centered Medical Home initiative and other related efforts require community based disease management and care coordination. Clinical care coordination leads to improved medical care and reduced utilization. This is where resources should be targeted.
- Obstetrical patients with positive drug tests are a special population needing attention.
- We see a high number of individuals who need access to dialysis treatment and don't have the resources (i.e., money, family, car etc) to make it to their appointments.
- This area is a low income area therefore people can't and or don't want buy healthy food which can lead to diabetes, heart attack and more chronic health issues and diseases. There needs to be more education with healthier eating and smarter choices on a budget.

Appendix B – Process to Identify and Prioritize Community Need[22]

Need Candidate	Total Points Allocated	Cumulative Percentage of Response	Number of Local Experts Voting for Need	Point Break from Higher need	Need Determination
1. OBESITY/OVERWEIGHT	168	18.7%	9		Signficant Needs
2. SMOKING / TOBACCO USE	107	30.6%	8	61	
3. ALCOHOL AND DRUG ABUSE	72	38.6%	6	35	
4. MENTAL HEALTH / SUICIDE	65	45.8%	7	7	
5. DIABETES	60	52.4%	5	5	
6. AFFORDABILITY	55	58.6%	5	5	Other Identified Needs
7. PHYSICIANS	40	63.0%	2	15	
8. CHRONIC COPD / (LUNG DISEASE) / PULMONARY	37	67.1%	5	3	
9. ALZHEIMER'S	33	70.8%	3	4	
10.DENTAL	29	74.0%	4	4	
11.PRIORITY POPULATIONS	28	77.1%	2	1	
12. CHOLESTEROL (HIGH)	24	79.8%	4	4	
13.TRANSPORTATION	23	82.3%	3	1	
14. CORONARY HEART DISEASE	20	84.6%	3	3	
15. PHYSICAL ENVIRONMENT	20	86.8%	1	0	
16. CANCER	19	88.9%	3	1	
17. STROKE	18	90.9%	3	1	
18. ACCIDENTS	17	92.8%	3	1	
19. BLOOD PRESSURE (High)	13	94.2%	3	4	
20.PREDISPOSING CONDITIONS	11	95.4%	3	2	
21. FLU/PNEUMONIA	9	96.4%	2	2	
22. LIFE EXPECTANCY / PREMATURE DEATH	9	97.4%	3	0	
23. CHRONIC OSTEOPOROSIS (bone disease)	8	98.3%	2	1	
24.KIDNEY	6	99.0%	2	2	
25. MATERNAL AND INFANT MEASURES	5	99.6%	1	1	
26. SEXUALLY TRANSMITTED DISEASE	2	99.8%	1	3	
27.BLOOD POISONING	1	99.9%	1	1	
28. LOW BACK PAIN (Chronic)	1	100.0%	1	0	
Total	900		9		

- I am not adding points to this because if people would lose weight and exercise it would eliminate many of the points I have allocated for. Many people today are lazy and will do just about anything to have the working people support them that includes risking their health. We all know how bad drugs, smoking, etc is for our bodies but that does not stop people from doing it. I feel we need to have made ourselves accountable for our actions, especially those who choose to live an unhealthy lifestyle.
- I also feel doctors need to stop "ruling out" things instead of treating what they feel is wrong. I realize healthcare is no more than a big business but it is very hard on our pocketbooks!!!

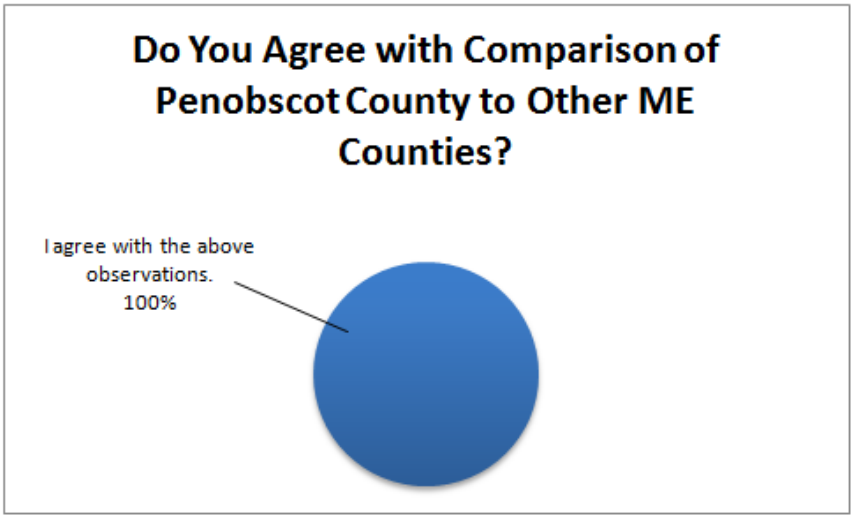
[22] Responds to IRS Schedule H (990) Part V B 1. g. and V B 1. h.

Individuals Participating as Local Expert Advisors

Organization	Position	Area of Expertise
Partnership for Healthy Northern Penobscot	Community Health Educator	Public Health
Select Designs	Owner	long term resident
Community Health and Counseling Services	Manager of Clinical Operations	Home Care and Hospice
PVH	CEO	Administration
Eastern Area Agency on Aging	Director of Community Services	aging services
SAU 31	School Nurse	School Nurse in this area for 26 years. Was Community Health Nurse for 12 years. Served on PVH board and HAN board. Served on TBOC committee
Penobscot Valley Hopsital	Penquis District Public Health Liaison	Public Health
Clinical Consultation & Counseling, PA	Vice President/Clinician	psychotherapy
Health Access Network	FNP	patient education
Partnership for Healthy Northern Penobscot	SNAP-Ed Nutrition Education Coordinator	Dietitian/public health nutritionist, serving low-income population, new to area
Health Access Network	CEO	Medical Practice management, Registered Nurse, local and national experience.
Town of Lincoln	Town Manager	Public Personnel Director
Health Access Network	CEO	RN

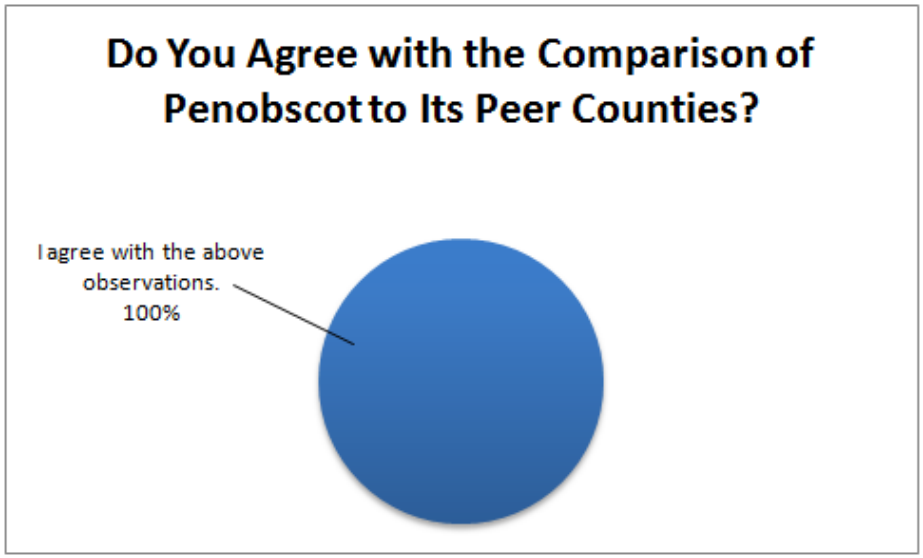
Advice Received from Local Experts

Q. Do you agree with the observations formed about the comparison of Penobscot County to all other State counties?



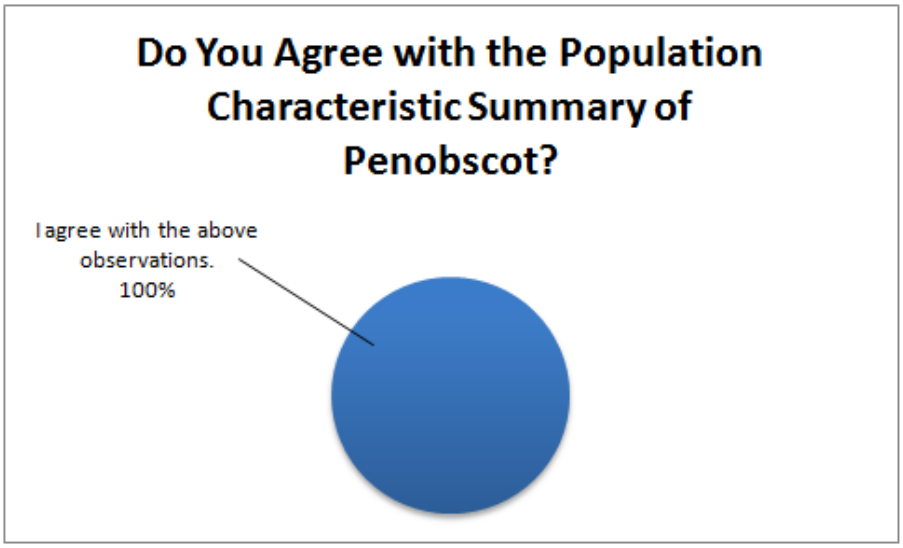
- These same conditions exist with people who tax all public services.
- Additional needs to consider: Access to inexpensive physical activity opportunities

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

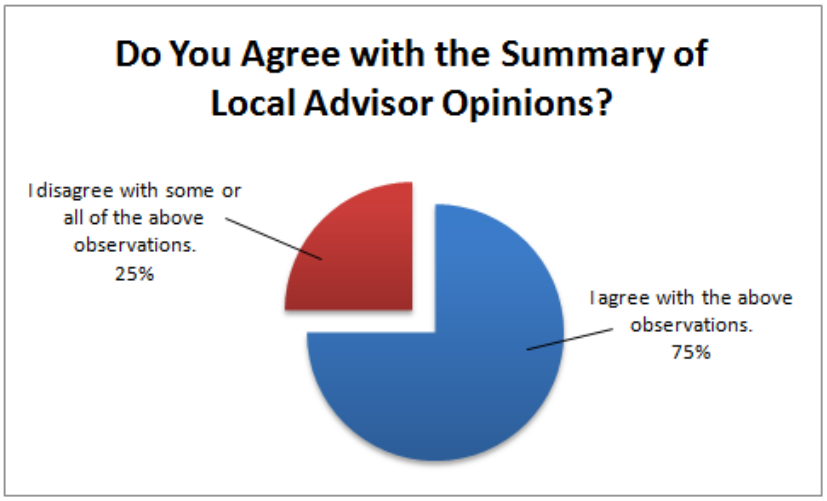


- Additional: More chronic disease comparisons.

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

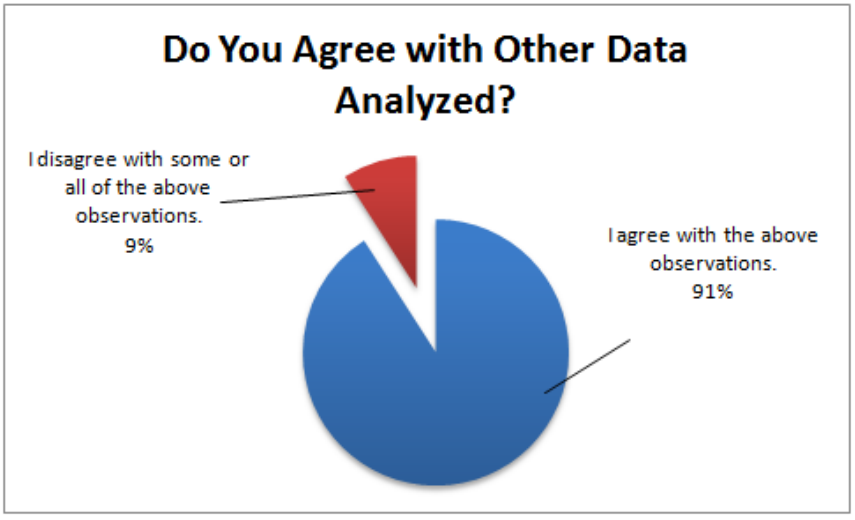


Q. Do you agree with the observations formed about the opinions from local residents?



- Given the identified three most important health problems I would add poor diet to the important risky behaviors as this has an impact on all three.
- I would add under most important health or medical issues lack of access to primary care.
- Eating junk food, fast food and drinking high sugar drinks should be a risky behavior.
- I agree with most of the indicators, tobacco is still one of the biggest killers. We need to stay focused on getting people to quit using tobacco.

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



- I believe there is a shortage of health professionals in Penobscot county.
- A lot of these causes of death stem back to poor diet and lack of exercise.

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

Illustrative IRS Schedule H Part V Section B (form 990)[23]

Community Health Needs Assessment Answers

1. ***During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9***

   Illustrative Answer – Yes

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

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

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

   1. a. – See Footnotes #13 (page 11) & #14 (page 11)

   1. b. – See Footnotes #15 (page 12)

   1. c. – See Footnote #20 (page 28)

   1. d. – See Footnotes #7 (page 6)

   1. e. – See Footnotes #11 (page 8)

   1. f. – See Footnotes #9 (page 8)

[23] Questions are drawn from 2012 f990sh.pdf Forms and may change when the hospital is to make its 990 h filing

1. g. – See Footnote #12 (page 9) & #22 (page 41)

1. h. – See Footnote #12 (page9) & #22 (page 41)

1. i. – See Footnote #6 (page 6)

1. j. – No response needed

2. ***Indicate the tax year the hospital facility last conducted a CHNA: 2013***

   Illustrative Answer – 2013
   See Footnote #1 (Title page)

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

   Illustrative Answer – Yes
   See Footnotes #10 (page 8) and page 42

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

   Illustrative Answer – No

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

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

   Illustrative Answer – check a. and b.
   The hospital will need to obtain Board approval of this report, document the date of approval, and then take action to make the report available as a download from its web site. It may also be prudent to place a notice in a paper of general circulation within the service area noting the report is available free upon request.

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

   a. ***Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA***
   b. ***Execution of an implementation strategy***
   c. ***Participation in the development of a community-wide plan***
   d. ***Participation in the execution of a community-wide plan***

e. Inclusion of a community benefit section in operational plans
f. Adoption of a budget for provision of services that address the needs identified in the CHNA
g. Prioritization of health needs in its community
h. Prioritization of services that the hospital facility will undertake to meet health needs in its community
i. Other (describe in Part VI)

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

6. a. – See footnote #21 (page 29)

6. b. – See footnote #21 (page 29)

6. g. – See footnote #12 (page 9)

6. h. – See footnote #12 (page 9)

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

Illustrative Answer – Yes
Part VI suggested documentation – See Footnote #21 (page 29)

8. a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
b. If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?
c. If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form4720 for all of its hospital facilities?

Illustrative Answers – 8. a, 8 b, 8 c – No