Jersey Shore Hospital

Jersey Shore, Pennsylvania

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution June 23, 2016[1]

[1]Response to Schedule h (Form 990) Part V B 4 & Schedule h (Form 990) Part V B 9

Dear Community Member:

At Jersey Shore Hospital (JSH), we have spent 105 years providing high-quality compassionate healthcare to the greater Jersey Shore community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how JSH 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, JSH, are meeting our obligations to efficiently deliver medical services.

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

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

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

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

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

Thank You,

Dave Shannon
Chief Executive Officer
Jersey Shore Hospital

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Executive Summary

Executive Summary

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

Data were gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. A second survey was distributed to the same group that reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The Significant Health Needs for Clinton County and Lycoming County are:

1. Mental Health/Substance Abuse
2. Cancer
3. Obesity/Overweight
4. Heart Disease
5. Education/Prevention

The Hospital has developed implementation strategies for four of the five needs including Cancer, Obesity/Overweight, Heart Disease, and Education/Prevention. The strategies include activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

The Hospital is not planning to address Mental Health/Substance Abuse at this time due to resource constraints, relative lack of expertise/competency to effectively address the need, and the availability of other resources to address the need. It is believed that the community will see more benefit if time and resources are devoted to the other four needs.

APPROACH

APPROACH

Jersey Shore Hospital ("JSH" 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 JSH 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
- 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

JSH partnered with Quorum Health Resources (Quorum) to:[4]

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

Overview of Community Health Needs Assessment

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

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

- An Emergency Room open to all, regardless of ability to pay

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

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

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

- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility is required to conduct a CHNA at least once every three taxable years and to 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).
- Each hospital facility is required to make the assessment widely available and downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[5]

Community Health Needs Assessment Subsequent to Initial Assessment

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

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to*

[5] Section 6652

the health needs of the community;

(2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and

(3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.[6]

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

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

To complete a CHNA:

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

(1) A definition of the community served by the hospital facility and a description of how the community was determined;

(2) a description of the process and methods used to conduct the CHNA;

(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and

(5) a description of resources potentially available to address the significant health needs identified through the CHNA.

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in

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

conducting the CHNA."[7]

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

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

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

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Represents the Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

Quorum also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing 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 existed in their portion of the

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

[8] Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) B 3 h

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

county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Clinton County and Western Lycoming County compared to all State counties	September 21, 2015	2010 to 2012
www.communityhealth.hhs.gov	Assessment of health needs of Clinton County and Western Lycoming County compared to its national set of "peer counties"	September 21, 2015	2005 to 2011
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 proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	November 16, 2015	2012 to 2015
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	September 21, 2015	2015
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	September 21, 2015	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	September 21, 2015	2000 to 2010

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

www.cdc.gov	To examine area trends for heart disease and stroke	September 21, 2015	2008 to 2010
http://svi.cdc.gov	To identify the Social Vulnerability Index value	September 21, 2015	2010
www.CHNA.org	To identify potential needs from a variety of resources and health need metrics	September 21, 2015	2003 to 2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	September 21, 2015	2015
www.wordlifeexpectancy.com	To determine relative importance among 15 top causes of death	September 21, 2015	CDC official final deaths 2013 published 1/26/2015

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

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 16 Local Expert Advisors. Survey responses started October 26, 2015 and ended with the last response on December 28, 2015.
- Information analysis augmented by local opinions showed how Clinton County and Western Lycoming County relate to their peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - There is a need for nutrition education/counseling among priority populations
  - Older, rural adults are having issues accessing healthcare
  - Lack of mental health services in the area

[12] Response to Schedule h (Form 990) Part V B 3 f

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[14] Consultation with 11 Local Experts occurred again via an internet-based survey (explained below) beginning February 22, 2016 and ending March 2, 2016.

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

In the JSH process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings. We developed a summary of all needs identified by any of the analyzed data sets. The Local Experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

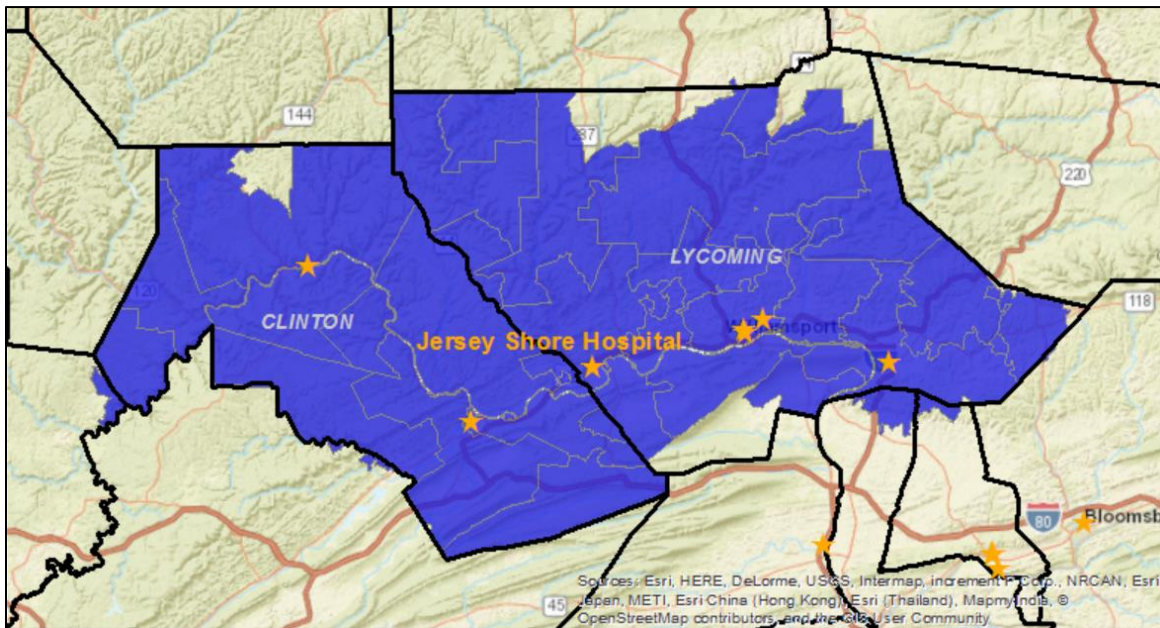
We dichotomized the rank order of prioritized needs into two groups: “Significant” and “Other Identified Needs.” Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation by QHR and the JSH executive team where a reasonable break point in rank order occurred.[16]

[13] Response to Schedule h (Form 990) Part V B 3 h
[14] Response to Schedule h (Form 990) Part V B 3 h
[15] Response to Schedule h (Form 990) Part V B 5
[16] Response to Schedule h (Form 990) Part V B 3 g

FINDINGS

FINDINGS

Definition of Area Served by the Hospital[17]



JSH, in conjunction with Quorum, defines its service area as Clinton County and Lycoming County in Pennsylvania, which includes the following ZIP codes:[18]

16822 Beech Creek	16871 Pottersdale	17700 3-Digit Zip in Lycoming, Clint
17701 Williamsport	17702 Williamsport	17721 Avis
17723 Cammal	17727 Cedar Run	17728 Cogan Station
17737 Hughesville	17740 Jersey Shore	17742 Lairdsville
17744 Linden	17745 Lock Haven	17747 Loganton
17751 Mill Hall	17752 Montgomery	17754 Montoursville
17756 Muncy	17763 Ralston	17764 Renovo
17771 Trout Run	17774 Unityville	17776 Waterville
17778 Westport		

In 2014, the Hospital received 85.0% of its patients from this area.[19]

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[17] Responds to IRS Schedule h (Form 990) Part V B 3 a
[18] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[19] Truven MEDPAR patient origin data for the hospital; Responds to IRS Schedule h (Form 990) Part V B 3 a

Demographic of the Community[20] [21]

	Clinton & Lycoming County	State	U.S.
2016 Population[22]	**155,153**	**12,806,163**	**322,431,073**
% Increase/Decline	**0.4%**	**0.8%**	**3.7%**
Estimated Population in 2021	**155,722**	**12,905,346**	**334,341,965**
% White, non-Hispanic	**91.7%**	**77.2%**	**61.3%**
% Black, non-Hispanic	**3.9%**	**10.7%**	**12.3%**
Median Age	**40.2**	**40.8**	**38.0**
Median Household Income	**$49,146**	**$54,912**	**$55,072**
Unemployment Rate	**5.5**	**5.0**	**5.0**
% Population >65	**18.2%**	**17.4%**	**15.1%**
% Women of Childbearing Age	**18.8%**	**18.7%**	**19.6%**

Demographics Expert 2.7
2016 Demographic Snapshot
Area: Clinton & Lycoming Counties
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	154,409	308,745,538
2016 Total Population	155,153	322,431,073
2021 Total Population	155,722	334,341,965
% Change 2016 - 2021	0.4%	3.7%
Average Household Income	$63,141	$77,135

	2016	2021	% Change
Total Male Population	76,232	76,578	0.5%
Total Female Population	78,921	79,144	0.3%
Females, Child Bearing Age (15-44)	29,200	29,313	0.4%

POPULATION DISTRIBUTION

Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	26,015	16.8%	25,572	16.4%	19.0%
15-17	5,598	3.6%	5,672	3.6%	4.0%
18-24	17,554	11.3%	16,571	10.6%	9.8%
25-34	19,196	12.4%	20,044	12.9%	13.3%
35-54	36,990	23.8%	34,853	22.4%	26.0%
55-64	21,522	13.9%	21,279	13.7%	12.8%
65+	28,278	18.2%	31,731	20.4%	15.1%
Total	155,153	100.0%	155,722	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	7,836	12.6%	12.3%
$15-25K	7,410	11.9%	10.4%
$25-50K	16,401	26.3%	23.4%
$50-75K	11,950	19.2%	17.6%
$75-100K	8,182	13.1%	12.0%
Over $100K	10,476	16.8%	24.3%
Total	62,255	100.0%	100.0%

EDUCATION LEVEL

2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	3,224	3.0%	5.8%
Some High School	9,624	9.1%	7.8%
High School Degree	45,176	42.6%	27.9%
Some College/Assoc. Degree	28,516	26.9%	29.2%
Bachelor's Degree or Greater	19,446	18.3%	29.4%
Total	105,986	100.0%	100.0%

RACE/ETHNICITY

Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	142,244	91.7%	61.3%
Black Non-Hispanic	5,998	3.9%	12.3%
Hispanic	2,885	1.9%	17.8%
Asian & Pacific Is. Non-Hispanic	1,197	0.8%	5.4%
All Others	2,829	1.8%	3.1%
Total	155,153	100.0%	100.0%

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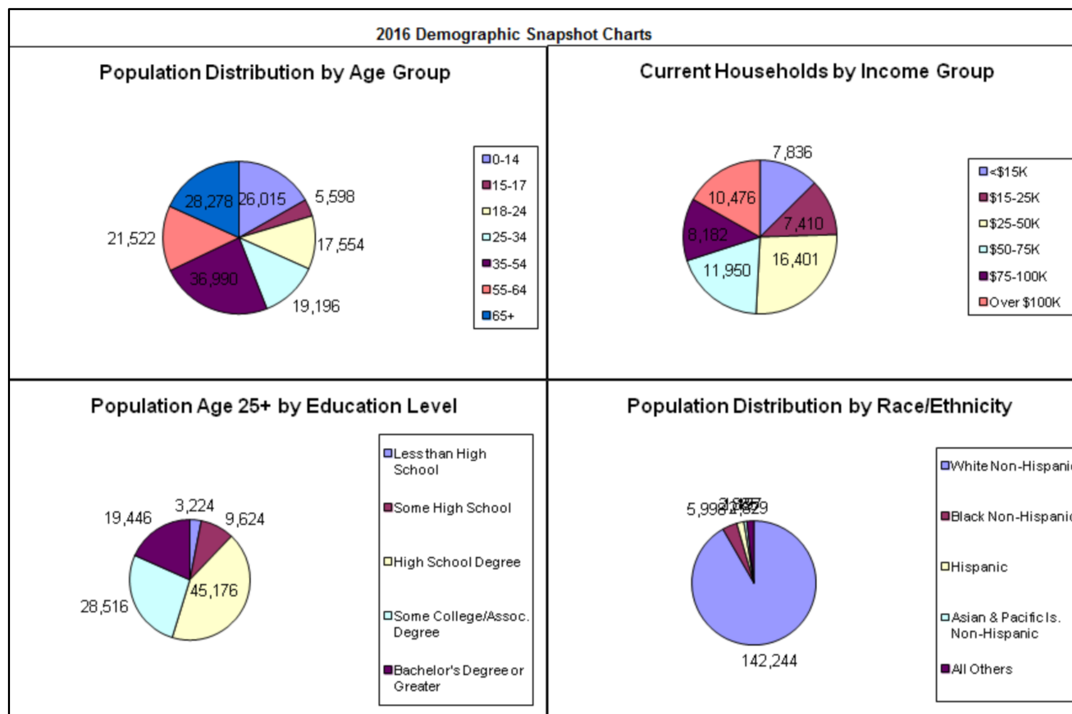
[20] Responds to IRS Schedule h (Form 990) Part V B 3 b
[21] The tables below were created by Truven Market Planner, a national marketing company
[22] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner



2016 Benchmarks
Area: Clinton & Lycoming Counties
Level of Geography: ZIP Code

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
Pennsylvania	0.8%	40.8	17.4%	13.5%	18.7%	-0.6%	$54,912	$66,625	$174,673
Selected Area	0.4%	40.2	18.2%	12.2%	18.8%	0.4%	$49,146	$61,235	$140,174

Demographics Expert 2.7
DEMO0003.SQP
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The population was also 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 determine probable lifestyle and medical conditions present in the population. The national average, or norm, is represented as 100%. Where Clinton County and Western Lycoming County vary more than 5% above or below that norm (that is, less than 95% or greater than 105%), it is considered significant.

Items in the table with red text are viewed as statistically important adverse potential findings—in other words, these are health areas that need improvement in the Clinton County and Western Lycoming County area. Items with blue text are viewed as statistically important potential beneficial findings—in other words, these are areas in which Clinton County and Western Lycoming County are doing better than other parts of the country. Items with black text are viewed as either not statistically different from the national norm or neither a favorable nor unfavorable finding—in other words more or less on par with national trends.

Health Service Topic	Demand as % of National	% of Population Effected	Health Service Topic	Demand as % of National	% of Population Effected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	103.8%	31.7%	Mammography in Past Yr	97.9%	44.6%
Vigorous Exercise	96.7%	55.2%	Cancer Screen: Colorectal 2 yr	98.3%	25.1%
Chronic Diabetes	114.1%	14.1%	Cancer Screen: Pap/Cerv Test 2 yr	91.6%	55.0%
Healthy Eating Habits	93.7%	27.8%	Routine Screen: Prostate 2 yr	96.4%	30.9%
Ate Breakfast Yesterday	100.4%	74.3%	**Orthopedic**		
Slept Less Than 6 Hours	110.2%	16.0%	Chronic Lower Back Pain	123.6%	29.1%
Consumed Alcohol in the Past 30 Days	91.7%	49.7%	Chronic Osteoporosis	117.8%	11.6%
Consumed 3+ Drinks Per Session	101.1%	28.2%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	101.9%	89.9%
I Will Travel to Obtain Medical Care	93.4%	21.6%	Used Midlevel in last 6 Months	103.5%	42.8%
I am Responsible for My Health	96.9%	63.3%	OB/Gyn 1+ Visit	90.2%	41.7%
I Follow Treatment Recommendations	98.0%	50.9%	Medication: Received Prescription	101.9%	59.7%
Pulmonary			**Internet Usage**		
Chronic COPD	119.0%	4.7%	Use Internet to Talk to MD	74.9%	9.2%
Tobacco Use: Cigarettes	104.7%	26.6%	Facebook Opinions	85.7%	8.8%
Heart			Looked for Provider Rating	84.9%	12.0%
Chronic High Cholesterol	114.7%	25.1%	**Emergency Service**		
Routine Cholesterol Screening	97.8%	49.7%	Emergency Room Use	101.3%	34.3%
Chronic Heart Failure	125.1%	5.2%	Urgent Care Use	96.6%	22.5%

Leading Causes of Death

Cause of Death			Rank among all counties in PA (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
PA Rank	Clinton Rank	Condition		PA	Clinton	
1	1	Heart Disease	18 of 67	179.0	241.6	As expected
2	2	Cancer	5 of 67	170.6	203.9	Higher than expected
4	3	Stroke	10 of 67	37.2	51.2	As expected
3	4	Lung	14 of 67	39.3	46.1	As expected
5	5	Accidents	44 of 67	44.9	40.9	As expected
6	6	Diabetes	33 of 67	22.6	25.8	As expected
7	7	Alzheimer's	24 of 67	17.4	21.5	As expected
9	8	Kidney	30 of 67	15.7	18.1	Higher than expected
8	9	Flu - Pneumonia	56 of 67	16.2	14.3	Lower than expected
11	10	Suicide	45 of 67	13.4	11.7	As expected
10	11	Blood Poisoning	62 of 67	13.2	9.3	As expected
14	12	Hypertension	24 of 67	6.5	6.7	As expected
12	13	Parkinson's	39 of 67	7.5	6.5	As expected
13	14	Liver	47 of 67	8.0	6.3	Lower than expected
15	15	Homicide	64 of 67	5.3	1.2	Lower than expected

Cause of Death			Rank among all counties in PA (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
PA Rank	Lycoming Rank	Condition		PA	Lycoming	
1	1	Heart Disease	45 of 67	179.0	211.9	As expected
2	2	Cancer	35 of 67	170.6	185.0	As expected
3	3	Lung	4 of 67	39.3	51.0	As expected
4	4	Stroke	20 of 67	37.2	48.9	As expected
5	5	Accidents	57 of 67	44.9	35.1	Lower than expected
6	6	Diabetes	23 of 67	22.6	27.7	As expected
7	7	Alzheimer's	4 of 67	17.4	27.5	As expected
9	8	Kidney	57 of 67	15.7	15.2	As expected
11	9	Suicide	54 of 67	13.4	10.7	As expected
8	10	Flu - Pneumonia	67 of 67	16.2	10.6	Lower than expected
10	11	Blood Poisoning	65 of 67	13.2	8.6	As expected
12	12	Parkinson's	16 of 67	7.5	7.9	Higher than expected
14	13	Hypertension	12 of 67	6.5	7.8	As expected
13	14	Liver	28 of 67	8.0	7.6	As expected
15	15	Homicide	30 of 67	5.3	2.4	As expected

National Healthcare Disparities Report – Priority Populations[23]

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

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

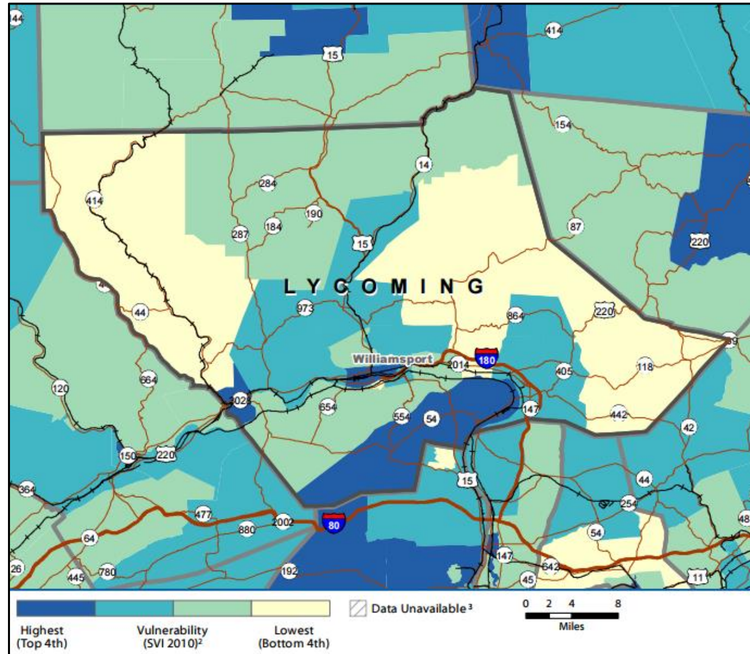
We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[24]

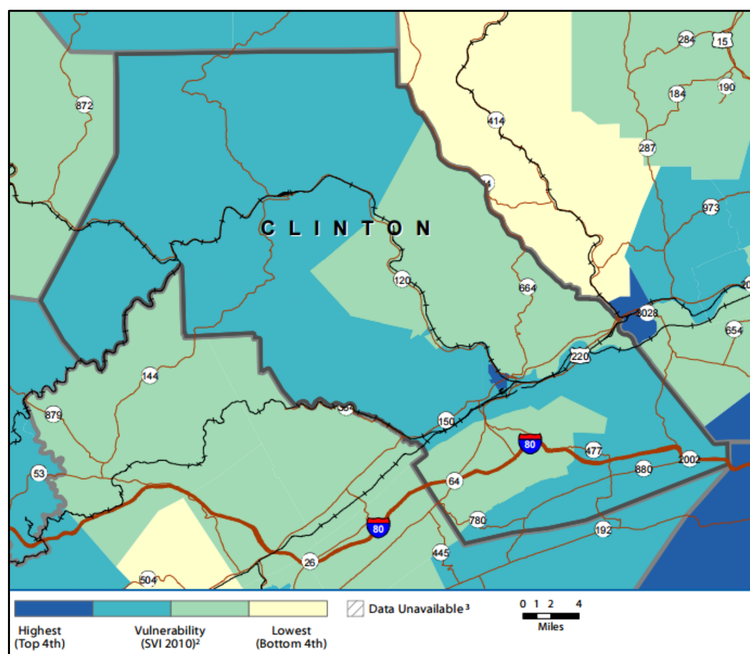
- There is a need for nutrition education/counseling among priority populations
- Older, rural adults are having issues accessing healthcare
- Lack of mental health services in the area

[23] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule h (Form 990) Part V B 3 i
[24] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability

All four quartiles of social vulnerability are dispersed fairly evenly throughout Lycoming County zip codes. However, Clinton County zip codes primarily fall within the second highest quartile of vulnerability. Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks.





Consideration of Written Comments from Prior CHNA

A group of 16 individuals provided written comment in regard to the 2012 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	10	13
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	9	13
3) Priority Populations	3	10	13
4) Representative/Member of Chronic Disease Group or Organization	1	12	13
5) Represents the Broad Interest of the Community	11	2	13
Other			
Answered Question			13
Skipped Question			3

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

- Asthma
- Cancer
- Diabetes
- Heart Disease
- Maternal/Infant Health
- Mental and Behavioral Health/Substance Abuse
- Obesity/Overweight

JSH received the following **verbatim** responses to the question: "*Comments or observations about this set of needs as being the most appropriate for the Hospital to take on in seeking improvements?*"

Should the hospital continue to consider each need identified as most important in the 2012 CHNA report as the most important set of health needs currently confronting residents in the county?

	Yes	No	No Opinion
Asthma	11	3	0
Cancer	13	0	1
Diabetes	14	0	0
Heart Disease	14	0	0
Maternal/Infant Health	12	2	0
Mental/Behavioral Health/Substance Abuse	14	0	0
Obesity/Overweight	14	0	0

- Specific comments or observations about Asthma as being among the most significant needs for the Hospital to work on to seek improvements?
    - I do not think that asthma is one of the most significant needs for our community.
    - Education concerning self-care and proper medication usage/administration. As a nurse, I've seen many who do not understand how to correctly manage and actually use their medication properly, leading to poor disease management. Perhaps educational sessions on asthma management to include medication management.
    - I don't believe that this disease is the most significant need for the Hospital to focus on. I believe that patient education would be the best way to address this issue.
    - I was not aware that Asthma was a significant need, but do understand how it could complicate the care of an individual with a respiratory illness. I think there are other more relevant needs that the hospital should address.
    - I notice a lot of our younger population suffers from asthma.
    - According to the HCI data Asthma does not appear to be a significant problem in either county for the young. It is higher especially in Clinton County for the Medicare population and somewhat higher for this population in Lycoming County.
    - Is the incidence due to higher than national smoking trends? Should our emphasis again be placed on preventive versus treatment measures
- Specific comments or observations about Cancer as being among the most significant needs for the Hospital to work on to seek improvements?
    - There are so many components to cancer itself, and it proves to be a leading health problem all over the world - it obviously needs attention.
    - I am not currently aware of any cancer treatment that the Hospital performs. However, I believe that cancer is a significant need for the Hospital. I believe that the focus should be placed on both the diagnostic spectrum, and the treatment of patients who are currently undergoing cancer treatment and the special needs that arise in their care.
    - I am not aware of any patients who receive cancer treatment at the Jersey Shore Hospital, however the Hospital may treat many patients who are receiving treatment for cancer. I think the focus should be on cancer prevention and the education of patients to help them understand which tests they should be receiving and when.
    - Many people in the area seem to be diagnosed with all types of cancer, but JSH has to send those patients to other facilities for treatment.
    - In Clinton County Cancer rates among males are higher than females. Colorectal and Lung cancer rates are above the HP 2020 recommendations. Lycoming County has high breast cancer rates.
    - Broad topic, should we narrow to specific types of cancer that have higher risk e.g. lung cancer, colorectal cancer etc. Further research needs to be done here that can allow us to target specific cancers, modify risk factors and screen appropriately

- Specific comments or observations about Diabetes as being among the most significant needs for the Hospital to work on to seek improvements?
  - Diabetes seems to be something most people do not understand and I support raising awareness.
  - I believe that Diabetes is a significant need for the Hospital to work on. This disease directly correlates to a patient's nutrition, and I believe that patient and community education is the best method that should be used to attack this disease.
  - I think that this disease is directly connected to obesity and lack of nutritional education and believe it to be a significant need.
  - Need for local endocrinologist to address diabetes issues
  - Diabetes is a nationwide issue that is present in this community too.
  - While the rates of Diabetes appear to be in the good range there the statistics show a higher death rate for Diabetes.
  - None
- Specific comments or observations about Heart Disease as being among the most significant needs for the Hospital to work on to seek improvements?
  - Heart health is definitely a key component to overall health and Lycoming and Clinton county suffer as a result of being uneducated on the matter, and frankly, stubborn about the severity.
  - I believe that Heart Disease is a significant need for the Hospital to work on. Because of the many causes of Heart Disease, advanced diagnostic tools and tests are crucial. Also, prompt treatment of this disease is very important, as it can result in saving a patient's life. Lastly, hospital employees need continuous training on how to recognize the sometimes subtle symptoms of this disease.
  - I think this is a significant need, but also feel that the general public is fairly well educated on this issue. The main need would be to treat patients who have heart disease and educate them on their medications and treatment options.
  - There appear to be some differences between the counties although Hyperlipidemia is high in both
  - As above. While we can facilitate interventional services, screening, treatment, we will not make an impact on incidence without addressing the two major risk factors above (Diabetes, Smoking (obesity))
- Specific comments or observations about Maternal/Infant Health as being among the most significant needs for the Hospital to work on to seek improvements?
  - I don't believe that Maternal/Infant Health is a most significant need in the community, but I do believe that patient education is the best way to address this need.
  - I was not aware that the Hospital had resources allocated to specifically treating
  - Children are born at other area hospitals and JSH has no pediatricians.
  - Lycoming County appears to have generally poorer rates than Clinton County for these indices. Both

counties need to improve prenatal care rates.

- Specific comments or observations about Mental/Behavioral Health/Substance Abuse as being among the most significant needs for the Hospital to work on to seek improvements?
    - I believe that mental health services are one of the most vital health concerns that faces our society, today. Unfortunately, it is overlooked and most people do not receive the help they need. Mental health is attached to so many other health concerns, and it should be utilized more. Substance abuse, particularly heroin, is completely out of control. Authorities can not combat the problem alone. Health centers need to recognize the connection between mental health patients and substance abuse. I am not sure exactly what will stop this epidemic, but clearly throwing people in prison is not the only answer. Mental health directly correlates to why people start using drugs and alcohol.
    - I believe that Mental and Behavioral Health/Substance Abuse is a significant need for the Hospital. Recognition and diagnosis of these types of diseases is often very challenging, and also sometimes a very sensitive issue. Staff must be educated to understand the importance of this disease, as it is usually not a life-threating issue, but if signs are not recognized and treated, it often can become one.
    - Clinton county is known for drug and alcohol abuse, and there seems to be many people in the area with mental health/disabilities.
    - Depression in the Medicare population is high in both counties. Drinking and smoking are both comparatively high in both counties.
- Specific comments or observations about Obesity/Overweight as being among the most significant needs for the Hospital to work on to seek improvements?
    - I believe there needs to be more support groups and less judgmental eyes on those who are victims of substance abuse.
    - I am not aware of any.
    - Again view best practices in HCI for implementation and suggestions.
    - PArtner with Lycoming County initiatives that are addressing both root causes, Naloxone use, education of lay and healthcare providers

Conclusions from Public Input

Our group of 16 Local Expert Advisors participated in an online survey to offer opinions about their perceptions of community health needs and the potential needs of unique populations. Complete verbatim written comments appear in the Appendix to this report.

JSH received the following responses to the question: *"Should the Hospital continue to consider each need identified as most important in the 2012 CHNA report as the most important set of health needs currently confronting residents in the county? Please add any additional information you would like us to understand."*

- I believe these all remain the predominant health issues in Clinton & Lycoming Counties. I would advocate that our maternal infant be changed to pre-conceptual care
- The Healthy People 2020 Data indicates that only seven of the 24 indicators have been met in Clinton and Lycoming Counties.
- Extreme need for increased mental/behavioral health/substance abuse services, educational programming and emphasis.

Summary of Observations: Comparison to Other Counties (Clinton)

Health Outcomes

In a health status classification termed "Health Outcomes," Clinton County ranks number 32 among the 67 ranked Pennsylvania counties (best being #1). Premature Death (deaths prior to age 75) presents worse values (shorter survivability) than on average for the US, but better than the Pennsylvania average.

Health Factors

In another health status classification "Health Factors," Clinton County ranks number 43 among the 67 ranked Pennsylvania counties. The following indicators compared to PA average and to national top 10% performance present such poor values it warrants investigating how to improve.

- Adult Smoking – Clinton 25% of residents compared to PA 20% and US best of 14%
- Adult Obesity – Clinton 35% of residents compared to PA 29% and US best of 25%
- Physical Inactivity – Clinton 26% which is higher than the PA avg. of 24% and US best of 20%
- Excessive Drinking – Clinton 25% of residents compared to PA 17% and US best of 10%
- Access to Exercise Opportunities – Clinton 82% which is lower than the PA avg. of 85% and US best of 92%

Clinical Care

In the "Clinical Care" classification, Clinton County ranks number 29 among the 67 ranked PA counties. The following indicators compared to PA average and to national top 10% performance present such poor values it warrants investigating how to improve.

- Preventable Hospital Stays (a measure of potential physician shortage) – Clinton 68 admissions per 1,000 compared to PA 63 and US best of 41
- Population to Primary Care Physician – Clinton 1,718:1 compared to PA 1,249:1 and US best of 1,045:1
- Population to Dentist – Clinton 2,350:1 compared to PA 1,600:1 and US best of 1,377:1
- Population to Mental Health Provider – Clinton 1,175:1 compared to PA 623:1 and US best of 386:1

Social and Economic Factors

In the "Social and Economic Factors" classification, Clinton County ranks number 41 among the 67 ranked PA counties. The following indicators compared to PA average and to national top 10% performance present such poor values it warrants investigating how to improve.

- Children in Poverty – Clinton 22% which is above the PA avg. of 19% and US best of 13%
- Unemployment – Clinton 8.5% compared to PA 7.4% and US best of 4%
- Some College – Clinton 52.1% which is significantly below the PA avg. of 61.9% and US best of 71%

Summary of Observations: Comparison to Other Counties (Lycoming)

Health Outcomes

In a health status classification termed "Health Outcomes," Lycoming County ranks number 23 among the 67 ranked Pennsylvania counties (best being #1). Premature Death (deaths prior to age 75) presents worse values (shorter survivability) than on average for the US, but better than the Pennsylvania average.

Health Factors

In another health status classification "Health Factors," Lycoming County ranks number 22 among the 67 ranked Pennsylvania counties. The following indicators compared to PA average and to national top 10% performance present such poor values it warrants investigating how to improve.

- Adult Smoking – Lycoming 22% of residents compared to PA 20% and US best of 14%
- Adult Obesity – Lycoming 31% of residents compared to PA 29% and US best of 25%
- Physical Inactivity – Lycoming 25% which is higher than the PA avg. of 24% and US best of 20%
- Alcohol-Impaired Driving Deaths – Lycoming 36% compared to PA 34% and US best of 14%
- Teen Births – Lycoming 33 births/1,000 females age 15 to 19 compared to PA 28 and US best of 20

Clinical Care

In the "Clinical Care" classification, Clinton County ranks number 29 among the 67 ranked PA counties. The following indicators compared to PA average and to national top 10% performance present such poor values it warrants investigating how to improve.

- Population to Primary Care Physician – Lycoming 1,502:1 compared to PA 1,249:1 and US best of 1,045:1
- Population to Dentist – Lycoming 2,484:1 compared to PA 1,600:1 and US best of 1,377:1
- Population to Mental Health Provider – Lycoming 865:1 compared to PA 623:1 and US best of 386:1

Social and Economic Factors

In the "Social and Economic Factors" classification, Clinton County ranks number 41 among the 67 ranked PA counties. The following indicators compared to PA average and to national top 10% performance present such poor values it warrants investigating how to improve.

- Children in Poverty – Lycoming 22% which is above the PA avg. of 19% and US best of 13%
- Children in Single-Parent Households – Lycoming 34% compared to PA 33% and US best of 20%
- Unemployment – Lycoming 7.8% compared to PA 7.4% and US best of 4%
- Some College – Lycoming 54.2% which is significantly below the PA avg. of 61.9% and US best of 71%

Summary of Observations: Peer Comparisons (Clinton)

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 Clinton County is compared to its national set of Peer Counties and compared to national rates result in the following:

Mortality

- *Better*
  - Nothing
- *Worse*
  - Coronary Heart Disease Deaths – 167.1 deaths per 1,000; 11th worst among 70 peer counties; US avg. 126.7

Morbidity

- *Better*
  - Adult Obesity; HIV; Preterm Births
- *Worse*
  - Syphilis – 2.6 rate per 100,000; 11th worst among 70 peer counties; US avg. 0.0

Healthcare Access and Quality

- *Better*
  - Nothing
- *Worse*
  - Nothing

Health Behaviors

- *Better*
  - Teen Births
- *Worse*
  - Adult Binge Drinking - 28.6% of adults; 3rd worst among 52 peer counties; US avg. 16.3%
  - Adult Female Pap Tests – 27% of adults; 15th worst among 66 peer counties; US avg. 21.7%

Social Factors

- *Better*
  - On Time High School Graduation
- *Worse*
  - High housing costs – 30.1% of individuals; 6th worst among 70 peer counties; US avg. 27.3%

  - Inadequate social support - 25.9% of adults; 10th worst among 63 peer counties; US avg. 19.6%
  - Unemployment – 8.6% unemployment rate; 17th worst among 70 peer counties; US avg. 7.1%

Physical Environment

- *Better*
  - Nothing
- *Worse*
  - Housing stress - 30.7% of housing defined as stress; 8th worst among 70 peer counties; US avg. 28.1%

Summary of Observations: Peer Comparisons (Lycoming)

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 Lycoming County is compared to its national set of Peer Counties and compared to national rates result in the following:

Mortality

- *Better*
  - Cancer Deaths; Male Life Expectancy; Unintentional Injury
- *Worse*
  - Motor Vehicle Deaths – 14.3 deaths per 100,000; 5th worst among 28 peer counties; US avg. 19.2

Morbidity

- *Better*
  - Adult Obesity; Adult Overall Health Status; Preterm Births
- *Worse*
  - HIV – 202.9 rate per 100,000; 2nd worst among 28 peer counties; US avg. 105.5
  - Older Adult Depression – 14.8% of older adults; 7th worst among 28 peer counties; US avg. 12.4
  - Syphilis – 6.9 rate per 100,000; worst among 28 peer counties; US avg. 0.0

Healthcare Access and Quality

- *Better*
  - Cost Barrier to Care; Older Adult Preventable Hospitalizations
- *Worse*
  - Nothing

Health Behaviors

- *Better*
  - Teen Births
- *Worse*
  - Adult Physical Inactivity – 26.9% of adults; 7th worst among 28 peer counties; US avg. 25.9%

Social Factors

- *Better*
  - Poverty; Violent Crime
- *Worse*
  - Nothing

Physical Environment

- *Better*
    - Air Quality
- *Worse*
    - Access to Parks – 18% of individuals; 6th worst among 28 peer counties; US avg. 14%
    - Living Near Highways – 4.8% of the population; 3rd worst among 28 peer counties; US avg. 1.5%

Conclusions from Demographic Analysis Compared to National Averages

We solicited opinions based on Quorum Truven database of population characteristics as we were unaware of Pennsylvania statistics indicating projected larger population growth rather than anticipating slow increase to a lower total projected population. The population commentary for which we obtained local opinions was as follows.

The combined 2016 population for Clinton County and Lycoming County is estimated to be 155,153 and expected to increase at a rate of 0.4% through 2021. This is lower than the 3.7% national rate of growth, while Pennsylvania's population is expected to increase by 0.8%. In 2021, the two counties anticipate a population of 155,722.

Population estimates indicate the 2016 median age for the area is 40.2 years, younger than the Pennsylvania median age (40.8 years) but higher than the national median age of 38.0 years. The 2016 Median Household Income for the area is $49,146, lower than the Pennsylvania median income of $54,912 and the national income of $55,072. Median Household Wealth value is higher than the national value, but lower than the Pennsylvania median. Median Home Value for the area ($140,174) is significantly lower than both the Pennsylvania median of $174,673 and the national median of $192,364. As of November 2015, Clinton County and Lycoming County both have an unemployment rate of 5.5%, which is higher than the 5.0% statewide and the 5.0% national civilian unemployment rate.

The portion of the population in the area over 65 is 18.2%, compared to Pennsylvania (17.4%) and the national average (15.1%). The portion of the population of women of childbearing age is 18.8%, slightly higher than the Pennsylvania average of 18.9% but lower than the national rate of 19.6%. 91.7% of the population is White non-Hispanic. The largest minority is the Black non-Hispanic population which comprises 3.9% of the total. The next largest minority is the Hispanic population which comprises 1.9% of the total.

The following areas were identified from a comparison of Clinton County and Lycoming County to national averages. Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered adverse:

- Cervical Cancer Screening in last two years is 8.4% below average impacting 55.0% of the population
- Had an OB/GYN Visit is 9.8% below average impacting 41.7% of the population

Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered beneficial:

- Consumed Alcohol in the Past 30 Days is 8.3% below average impacting 49.7% of the population

Conclusions from Other Statistical Data (Clinton)

Among the Top 15 Causes of Death in the U.S., 10 of 15 occurred at expected rates in Clinton County. However, Cancer and Kidney Disease occurred at higher rates than expected, and Flu/Pneumonia, Liver Disease, and Homicide occurred at lower rates. The Top 10 Causes of Death in Clinton County are:

1. Heart Disease with Clinton ranking #18 among 67 PA counties (where #1 is worst in state)
2. Cancer ranking #5 in PA
3. Stroke ranking #10 in PA
4. Lung Disease ranking #14 in PA
5. Accidents ranking #44 in PA
6. Diabetes ranking #33 in PA
7. Alzheimer's ranking #24 in PA
8. Kidney ranking #30 in PA
9. Flu/Pneumonia ranking #56 in PA
10. Suicide ranking #45 in PA

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 US counties or equivalents applying small area estimation techniques to the most recent county information.

Unfavorable Clinton County measures which are worse than the US avg. and had an unfavorable change:

- **Male Heavy Drinking** - As of 2012, 12.1% of males are heavy drinkers; value increased 2.2 pct. points since 2005
- **Female Binge Drinking** - As of 2012, 12.6% of females engage in binge drinking; value increased 1.2 pct. points since 2002
- **Male Obesity** - As of 2011, 37.4% of males are obese; value increased 8.9 pct. points since 2001
- **Female Obesity** - As of 2011, 41.2% of females are obese; value increased 10.9 pct. points since 2001
- **Female Physical Activity** - As of 2011, physical activity prevalence for females is at 47.7%; value decreased 0.4 pct. points since 2001

Unfavorable Clinton County measures which are worse than the US avg. but had a favorable change:

- **Male Binge Drinking** - As of 2012, 27.5% of males engage in binge drinking; value decreased 1.3 pct. points since 2002
- **Male Life Expectancy** - As of 2013, male life expectancy is at 75.2 years; value increased 4.2 years since 1985
- **Female Life Expectancy** - As of 2013, female life expectancy is at 80.9 years; value increased 2.7 years since 1985

- **Male Smoking** - As of 2012, male smoking is at 24.8%; value decreased 4.8 pct. points since 1996
- **Female Smoking** - As of 2012, female smoking is at 21.5%; value decreased 5.4 pct. points since 1996
- **Male Physical Activity** - As of 2011, recommended physical activity for males is at 55.8%; value increased 0.6 pct. points since 2001

Desirable Clinton County measures better than the US avg. but had an unfavorable change:

- **Female Heavy Drinking** - As of 2012, 5.3% of females are heavy drinkers; value increased 1.4 pct. points since 2005

Desirable Clinton County measures which are better than the US avg. and had a favorable change:

- **None**

Conclusions from Other Statistical Data (Lycoming)

Among the Top 15 Causes of Death in the U.S., 12 of 15 occurred at expected rates in Lycoming County. However, Parkinson's occurred at a higher rate than expected, and Accidents and Flu/Pneumonia occurred at lower rates. The Top 10 Causes of Death in Lycoming County are:

1. Heart Disease with Lycoming ranking #45 among 67 PA counties (where #1 is worst in state)
2. Cancer ranking #35 in PA
3. Lung Disease ranking #4 in PA
4. Stroke ranking #20 in PA
5. Accidents ranking #57 in PA
6. Diabetes ranking #23 in PA
7. Alzheimer's ranking #4 in PA
8. Kidney Disease ranking #57 in PA
9. Suicide ranking #54 in PA
10. Flu/Pneumonia ranking #67 in PA

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 US counties or equivalents applying small area estimation techniques to the most recent county information.

Unfavorable Lycoming County measures which are worse than the US avg. and had an unfavorable change:

- **Male Heavy Drinking** - As of 2012, 10.9% of males are heavy drinkers; value increased 1.2 pct. points since 2005
- **Male Obesity** - As of 2011, 36.9% of males are obese; value increased 7.0 pct. points since 2001
- **Female Obesity** - As of 2011, 40.9% of females are obese; value increased 9.9 pct. points since 2001
- **Male Physical Activity** - As of 2011, physical activity prevalence for males is at 54.3%; value decreased 4.8 pct. points since 2001

Unfavorable Lycoming County measures which are worse than the US avg. but had a favorable change:

- **Male Binge Drinking** - As of 2012, 27.2% of males engage in binge drinking; value decreased 1.6 pct. points since 2002
- **Male Life Expectancy** - As of 2013, male life expectancy is at 76.2 years; value increased 3.8 years since 1985
- **Female Life Expectancy** - As of 2013, female life expectancy is at 80.9 years; value increased 2.3 years since 1985
- **Male Smoking** - As of 2012, male smoking is at 24.5%; value decreased 6.2 pct. points since 1996

- **Female Smoking** - As of 2012, female smoking is at 20.2%; value decreased 6.6 pct. points since 1996
- **Female Physical Activity** - As of 2011, recommended physical activity for females is at 47.8%; value increased 0.7 pct. points since 2001

Desirable Lycoming County measures better than the US avg. but had an unfavorable change:

- **Female Heavy Drinking** - As of 2012, 4.7% of females are heavy drinkers; value increased 0.9 pct. points since 2005
- **Female Binge Drinking** - As of 2012, 11.6% of females engage in binge drinking; value decreased 0.2 pct. points since 2002

Desirable Lycoming County measures which are better than the US avg. and had a favorable change:

- **None**

Conclusions from Prior CHNA Implementation Activities

Worksheet 4 of Form 990 h can be used to report the net cost of community health improvement services and community benefit operations.

> *"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.*
>
> *"Community benefit operations" means:*
>
> - *activities associated with community health needs assessments, administration, and*
> - *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

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

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

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

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

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

Activities reported by the Hospital in its implementation efforts and/or its prior year tax reporting included:

- $662,956

EXISTING HEALTHCARE FACILITIES, RESOURCES, & IMPLEMENTATION STRATEGY

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 JSH.[25] The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies JSH current efforts responding to the need including any written comments received regarding prior JSH implementation actions
- Establishes the Implementation Strategy programs and resources JSH will devote to attempt to achieve improvements
- Documents the Leading Indicators JSH will use to measure progress
- Presents the Lagging Indicators JSH 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, JSH is the major hospital in the service area. Jersey Shore Hospital is a 25-bed, critical access hospital located in Jersey Shore, Pennsylvania. The next closest facilities are outside the service area and include:

- Lock Haven Hospital in Lock Haven, PA, 14 miles (20 minutes)
- Williamsport Regional Medical Center in Williamsport, PA, 17 miles (23 minutes)
- Muncy Valley Hospital in Muncy, PA, 30 miles (32 minutes)

All data items analyzed to determine significant needs are "Lagging Indicators," measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the JSH Implementation Strategy uses "Leading Indicators." Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

[25] Response to IRS Schedule h (Form 990) Part V B 3 e

Pennsylvania Community Benefit Requirements

Significant Needs

1. **MENTAL HEALTH/SUBSTANCE ABUSE** – 2012 Significant Need; excessive drinking (Clinton) above the PA avg. and US best rates; male binge drinking, male heavy drinking, and female binge drinking (Clinton) worse than US avg.; population to mental health provider ratio worse than US and PA avg.

Public comments received on previously adopted implementation strategy:

- I believe there needs to be more support groups and less judgmental eyes on those who are victims of substance abuse.
- I am not aware of any.
- Again view best practices in HCI for implementation and suggestions.
- PArtner with Lycoming County initiatives that are addressing both root causes, Naloxone use, education of lay and healthcare providers

BCH does not intend to develop an implementation strategy for this Significant Need

- We are choosing not to respond to this need at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

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

Other local resources identified during the CHNA process that are believed available to respond to this need: [26]

Organization	Contact Name	Contact Information
Susquehanna Health		(570) 323-3671, www.susquehannahealth.org
Lycoming & Clinton Counties MHID Services		(570) 326-7895, www.joinder.org
The Meadows		(800) 641-7529, www.themeadows.net
Mount Nittany Health System		(814) 231-7000, www.mountnittany.org
Geisinger Health System		(800) 275-6401, www.geisinger.org

[26] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (form 990) Part V Section B 3 c and Schedule h (Form 990) Part V Section B 11

2. CANCER – 2012 Significant Need; #2 leading cause of death; cervical cancer screening 8.4% below avg.

Public comments received on previously adopted implementation strategy:

- I strongly believe medical cannabis significantly improves cancer patients to cope with their disease and should be promoted as a non-addictive, safe way to manage cancer.
- I think that an overall emphasis on healthy lifestyles and education programs which focus on this as well as continued screenings when possible (e.g. the skin screening, home occult blood test) are helpful.
- Updated mammogram technology.
- Updated mammogram machine.
- Again view best practices in HCI for implementation and suggestions for early screening.
- None

JSH services, programs, and resources available to respond to this need include:

- Free mammograms for income-qualifying patients (partner with Komen Foundation)
- Financial Assistance policies for tests (colonoscopies, mammograms, pap smears, colorectal screenings)
- Community Health Fairs – educational materials provided including smoking cessation
- Participate in Breast Cancer Awareness activities including teaching breast self-exams
- Funds from “Dress Down Day” go to Relay for Life
- Monthly GYN clinic provided locally to reduce transportation

Additionally, JSH plans to take the following steps to address this need:

- Continue providing above services
- Provide skin cancer awareness materials at local golf tournament
- Provide more education in physician offices on the free mammograms

JSH evaluation of impact of actions taken since the immediately preceding CHNA:

- Updated Financial Assistance policies and included sliding-scale fees for physician practices

Anticipated results from JSH Implementation Strategy

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

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

The strategy to evaluate JSH intended actions is to monitor change in the following Leading Indicator:

- Number of free mammograms provided through the partnership with Komen in FY16 = 5 (0 in FY15, 13 in FY14)

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

- Number of breast cancer deaths in PA (statewide) in 2015 = 1,951

JSH anticipates collaborating with the following other facilities and organizations to address this Significant Need: [27]

Organization	Contact Name	Contact Information
Susan G. Komen Foundation		(877)465-6636, ww5.komen.org
American Cancer Society (Relay for Life)		http://relay.acsevents.org/

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

Organization	Contact Name	Contact Information
Susquehanna Health System		(570) 323-3671, www.susquehannahealth.org
Cancer Care of Central PA		(570) 769-6660
Cancer Centers of America		http://www.cancercenter.com/
Geisinger Health System		(800) 275-6401, www.geisinger.org
Mount Nittany Hospital		(814) 231-7000, www.mountnittany.org

[27] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (form 990) Part V Section B 3 c and Schedule h (Form 990) Part V Section B 11

3. OBESITY/OVERWEIGHT – 2012 Significant Need; adult obesity above the PA avg. and US best rates

Public comments received on previously adopted implementation strategy:

- More than anything, I think focusing on the youth would be the most beneficial move. People who have already adopted unhealthy eating habits and don't exercise are unlikely to change. I think resources would be better spent trying to sway obese children.
- None that I am aware.
- Again view best practices in HCI for implementation and suggestion

JSH services, programs, and resources available to respond to this need include:

- Medical Nutrition Services provided including classes on healthy recipes, etc.
- Partnered with Penn State for class on Dining with Diabetes.
- Registered Dietician goes into schools to provide education.
- Community can schedule appointments with dietician under Financial Assistance policy.
- Provide free diabetic education for patients.
- A1C community health screens provided twice each year at a reduced cost.
- Free BMI screens and foot screens provided once each year (Hunter Screening).
- Hospital provides reduced rates for YMCA memberships for employees and families.
- Provided educational materials at the Senior Expo.
- Free blood pressure checks provided monthly.

Additionally, JSH plans to take the following steps to address this need:

- Continue above activities.
- Investigate potential for expanding dietary education within the school district.
- Explore partnerships with universities in the area to expand healthy behaviors education.
- Providing Chronic Care Coordination services and education through participation in the NRACO.

JSH evaluation of impact of actions taken since the immediately preceding CHNA:

- Continually evaluated and tweaked programs as necessary.

Anticipated results from JSH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	

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

The strategy to evaluate JSH intended actions is to monitor change in the following Leading Indicator:

- Number of participants in the community health screens and Hunter Screen in FY16 = 388 health screens, 68 Hunter Screens

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

- Percentage of adult obesity – Clinton = 35%, Lycoming = 31%

JSH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Jersey Shore Area School District		(570) 398-1567, www.jsasd.k12.pa.us
Penn State Cooperative Extension		extension.psu.edu

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

Organization	Contact Name	Contact Information
YMCA		(570) 398-2150, www.rvrymca.org/jersey-shore
Susquehanna Health System		(570) 323-3671, www.susquehannahealth.org
Geisinger Health System		(800) 275-6401, www.geisinger.org
Wegmans		(570) 320-8778, www.wegmans.com
Weis Markets		(570) 398-4606, www.weismarkets.com

Central Susquehanna Surgical Associates (Bariatric surgery)		(717) 652-1107, www.centralpasurgicalassoc.com

4. HEART DISEASE – 2012 Significant Need; #1 leading cause of death; 11th (Clinton) worst among peer counties

Public comments received on previously adopted implementation strategy:

- None that I am aware of.
- I am not aware of any.
- Again view best practices in HCI for implementation and suggestions for early screening.
- More engagement in community civic groups to address health issues

JSH services, programs, and resources available to respond to this need include:

- Participate in Go Red for Women campaign
- Sponsorship of local run/walk events
- Free BMI screens provided once each year (Hunter Screening).
- Hospital provides reduced rates for YMCA memberships for employees and families.
- Provided educational materials at the Senior Expo.
- Free blood pressure checks provided monthly.
- Medical Nutrition Services provided including classes on healthy recipes, etc.
- Monthly vascular clinic provided locally to reduce transportation
- Cardiologist comes weekly to provide standard services and reduce transportation (services are covered under financial assistance policies)

Additionally, JSH plans to take the following steps to address this need:

- Identifying strategic affiliations with other providers to help with services.
- Potential partnerships with other local organizations to promote physical activity and wellness.
- Investigate partnership with Susquehanna River Valley Visitors' Bureau for promoting recreation.

Anticipated results from JSH Implementation Strategy

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

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

The strategy to evaluate JSH intended actions is to monitor change in the following Leading Indicator:

- Number of free blood pressure checks provided in 2015 = 218

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

- Number of deaths from heart disease in 2015 – Clinton = 241.6, Lycoming = 211.9 (per 100,000 adjusted)

JSH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Susquehanna Cardiology Associates		(570) 321-2800, http://www.susquehannahealth.org/heart-and-vascular/services/cardiology
Central Pennsylvania Surgical Associates (vascular services)		(717) 652-1107, www.centralpasurgicalassoc.com

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

Organization	Contact Name	Contact Information
Geisinger Health System		(800) 275-6401, www.geisinger.org
American Heart Association		http://www.heart.org/HEARTORG/Affiliate/Philadelphia/Pennsylvania/
Penn State Cooperative Extension		extension.psu.edu
Lycoming County Public Health Department		(570) 327-3400, www.health.state.pa.us
Clinton County Public Health Department		(518) 565-4840, http://www.clintonhealth.org/

5. EDUCATION/PREVENTION – Local Expert identified need

Public comments received on previously adopted implementation strategy:

- This was not a Significant Need identified in 2012 so no written public comments about this need were solicited

JSH services, programs, and resources available to respond to this need include:

- Educational materials provided on health and wellness through the patient portal
- Diabetes Health magazine provided in waiting rooms and lobbies
- Educational newsletters and flyers available in hospital and physician offices for patients
- Reduced cost education classes on CPR and first aid
- Reduced cost ‘Safe Sitter’ classes
- OB/GYN educational materials for soon-to-be parents
- Provide disease and treatment education for specific needs through the EMR
- Provider Portal communicates and coordinates access to patient information across regional Health Information Exchange
- Provide resources for local flu clinic

Additionally, JSH plans to take the following steps to address this need:

- Chronic Care Coordination
- Continue above activities.
- Consider increasing educational opportunities (smoking cessation, diabetes support groups) in the community

JSH evaluation of impact of actions taken since the immediately preceding CHNA:

- OB/GYN educational materials for soon-to-be parents
- Provider Portal communicates and coordinates access to patient information across regional Health Information Exchange
- Improved and expanded offerings through Patient Portal
- Provide disease and treatment education for specific needs through the EMR

Anticipated results from JSH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	

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

The strategy to evaluate JSH intended actions is to monitor change in the following Leading Indicator:

- Number of participants in Care Coordination Program (starting in 2016)

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

- Increase in metric "I am responsible for my own health" = 3.1% below average

JSH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Lock Haven Hospital (OB/GYN)		(570) 893-5000, http://www.lockhavenhospital.com/lock-haven-hospital/ havenhealthcareforwomen.aspx
Lycoming County Public Health Department		(570) 327-3400, www.health.state.pa.us
Clinton County Public Health Department		(518) 565-4840, http://www.clintonhealth.org/

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

Organization	Contact Name	Contact Information
Penn State Cooperative Expansion		extension.psu.edu
Pennsylvania Office of Rural Health (Flex program through Penn State)	Lawrence D. Baronner	http://porh.psu.edu/porh/ 814-863-8214, ldb10@psu.edu

HEN (Hospital Engagement Network) [Hospital & Healthsystem Association of Pennsylvania]	Janette Bisbee	(717) 561-5372, jbisbee@haponline.org, www.haponline.org
Susquehanna Health System		(570) 323-3671, www.susquehannahealth.org
Geisinger Health System		(800) 275-6401, www.geisinger.org

Other Needs Identified During CHNA Process

6. **MATERNAL/INFANT HEALTH**
7. **DIABETES**
8. **FLU/PNEUMONIA**
9. **ALZHEIMER'S**
10. **ASTHMA**
11. **STROKE**
12. **DENTAL**
13. **LUNG DISEASE**
14. **ACCIDENTS**
15. **SEXUALLY TRANSMITTED INFECTION**
16. **PHYSICAL INACTIVITY**
17. **KIDNEY DISEASE**
18. **PHYSICIAN**
19. **SMOKING**
20. **PRIORITY POPULATIONS**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[28]

2. Cancer
3. Obesity/Overweight
4. Heart Disease
5. Education/Prevention

Significant needs where hospital did not develop implementation strategy[29]

1. Mental Health/Substance Abuse

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

6. MATERNAL/INFANT HEALTH
7. DIABETES
8. FLU/PNEUMONIA
9. ALZHEIMER'S
10. ASTHMA
11. STROKE
12. DENTAL
13. LUNG DISEASE
14. ACCIDENTS
15. SEXUALLY TRANSMITTED INFECTION
16. PHYSICAL INACTIVITY
17. KIDNEY DISEASE
18. PHYSICIAN
19. SMOKING
20. PRIORITY POPULATIONS

[28] Responds to Schedule h (Form 990) Part V B 8
[29] Responds to Schedule h (Form 990) Part V Section B 8

APPENDIX

Appendix A – Written Commentary on Prior CHNA

Hospital solicited written comments about its 2012 CHNA.[30] 16 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, skip the indication and please continue to the next question.**

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	10	13
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	9	13
3) Priority Populations	3	10	13
4) Representative/Member of Chronic Disease Group or Organization	1	12	13
5) Represents the Broad Interest of the Community	11	2	13
Other			
Answered Question			13
Skipped Question			3

- Within the county, do you perceive the local Priority Populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.
  - I don't think that there are enough interactive services for disabled people. I think that group homes should be more closely monitored. There are several instances where I have personally seen negligence working in a group home and it was brushed under the rug. I wish it was possible to have cameras in group homes.
  - I believe that a need exists for nutrition counseling/education of the Priority Populations. Obesity has become a looming problem in the population, and many people either don't care to or don't know how to address this need in their own diets. I also believe that they need to be properly educated on the significant health risks that correlate to obesity.
  - I believe that there is a need for nutrition counseling for the Priority Populations as well as all populations. With obesity on the rise and the resulting health complications that result from this disease, I think that this should be a priority. Many people are not aware of nutrition facts such as the effect of excessive sugar in their diet, how many full meals a day they should be consuming, and what types of fats they should avoid, to name a few, and most have no idea where to obtain this information. I think that hospitals and family practices should assist not only their patients, but the general public as

[30] Responds to IRS Schedule h (Form 990) Part V B 5

well, in educating these individuals. I also think State and Federal agencies that aid these individuals; ie through EBT, LIHEAP, and other programs should bear some of this burden.

- Residents of rural areas with Mental health need better access to psychiatric services
- Older adults are a bigger part of the low-income groups, some of which have a hard time getting medications and are in poorer health. If there were more programs available to help these senior citizens. This could be achieved by the hospital and various community groups working with people from at the county and state levels.
- yes
- There is a need for treating mental health disorders, a pediatrician, and cancer treatment.
- Rural populations, Veterans, low income groups.
- Obviously we fit the rural, low income, older adult categories most closely. Mental Health needs are pervasive without adequate mental health counseling and prescribing support. We have a higher rate of many different types of cancer than national average. Obesity, diabetes, and cardiovascular disease prevalence are increased as well. Our future support structure will require addressing these all on both the preventive, screening as well as the therapeutic interventions in all of these areas.
- Our growing Amish population would benefit from mobile immunization clinics in their community. Community awareness of mental health issues impacting our at risk populations would also be advantageous. Wellness programming targeting children and other health education related would help to supplement our declining health curriculum in our school district (K-5th grade focus area).

2. **In the last process, several data sets were examined and a group of local people were involved in advising the Hospital. While multiple needs emerged, the Hospital had to determine what issues were of high priority and where it would be a valuable resource to assist in obtaining improvements.**

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

- Asthma
- Cancer
- Diabetes
- Heart Disease
- Maternal/Infant Health
- Mental Health/Substance Abuse
- Obesity/Overweight

Comments or observations about this set of needs being the most appropriate for the Hospital to take on in seeking improvements?

- Should the Hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronted residents in the county?

	Yes	No	No Opinion
Asthma	11	3	0
Cancer	13	0	1
Diabetes	14	0	0
Heart Disease	14	0	0
Maternal/Infant Health	12	2	0
Mental/Behavioral Health/Substance Abuse	14	0	0
Obesity/Overweight	14	0	0

- Specific comments or observations about Asthma as being among the most significant needs for the Hospital to work on to seek improvements?
    - I do not think that asthma is one of the most significant needs for our community.
    - Education concerning self-care and proper medication usage/administration. As a nurse, I've seen many who do not understand how to correctly manage and actually use their medication properly, leading to poor disease management. Perhaps educational sessions on asthma management to include medication management.
    - I don't believe that this disease is the most significant need for the Hospital to focus on. I believe that patient education would be the best way to address this issue.
    - I was not aware that Asthma was a significant need, but do understand how it could complicate the care of an individual with a respiratory illness. I think there are other more relevant needs that the hospital should address.
    - I notice a lot of our younger population suffers from asthma.
    - According to the HCI data Asthma does not appear to be a significant problem in either county for the young. It is higher especially in Clinton County for the Medicare population and somewhat higher for this population in Lycoming County.
    - Is the incidence due to higher than national smoking trends? Should our emphasis again be placed on preventive versus treatment measures
- Specific comments or observations about Cancer as being among the most significant needs for the Hospital to work on to seek improvements?
    - There are so many components to cancer itself, and it proves to be a leading health problem all over the world - it obviously needs attention.
    - I am not currently aware of any cancer treatment that the Hospital performs. However, I believe that cancer is a significant need for the Hospital. I believe that the focus should be placed on both the diagnostic spectrum, and the treatment of patients who are currently undergoing cancer treatment and the special needs that arise in their care.
    - I am not aware of any patients who receive cancer treatment at the Jersey Shore Hospital, however the Hospital may treat many patients who are receiving treatment for cancer. I think the focus should be on cancer prevention and the education of patients to help them understand which tests they should be receiving and when.

  - Many people in the area seem to be diagnosed with all types of cancer, but JSH has to send those patients to other facilities for treatment.
  - In Clinton County Cancer rates among males are higher than females. Colorectal and Lung cancer rates are above the HP 2020 recommendations. Lycoming County has high breast cancer rates.
  - Broad topic, should we narrow to specific types of cancer that have higher risk e.g. lung cancer, colorectal cancer etc. Further research needs to be done here that can allow us to target specific cancers, modify risk factors and screen appropriately
- Specific comments or observations about Diabetes as being among the most significant needs for the Hospital to work on to seek improvements?
  - Diabetes seems to be something most people do not understand and I support raising awareness.
  - I believe that Diabetes is a significant need for the Hospital to work on. This disease directly correlates to a patient's nutrition, and I believe that patient and community education is the best method that should be used to attack this disease.
  - I think that this disease is directly connected to obesity and lack of nutritional education and believe it to be a significant need.
  - Need for local endocrinologist to address diabetes issues
  - Diabetes is a nationwide issue that is present in this community too.
  - While the rates of Diabetes appear to be in the good range there the statistics show a higher death rate for Diabetes.
  - None
- Specific comments or observations about Heart Disease as being among the most significant needs for the Hospital to work on to seek improvements?
  - Heart health is definitely a key component to overall health and Lycoming and Clinton county suffer as a result of being uneducated on the matter, and frankly, stubborn about the severity.
  - I believe that Heart Disease is a significant need for the Hospital to work on. Because of the many causes of Heart Disease, advanced diagnostic tools and tests are crucial. Also, prompt treatment of this disease is very important, as it can result in saving a patient's life. Lastly, hospital employees need continuous training on how to recognize the sometimes subtle symptoms of this disease.
  - I think this is a significant need, but also feel that the general public is fairly well educated on this issue. The main need would be to treat patients who have heart disease and educate them on their medications and treatment options.
  - There appear to be some differences between the counties although Hyperlipidemia is high in both
  - As above. While we can facilitate interventional services, screening, treatment, we will not make an impact on incidence without addressing the two major risk factors above (Diabetes, Smoking (obesity))
- Specific comments or observations about Maternal/Infant Health as being among the most significant needs for

the Hospital to work on to seek improvements?

  - I don't believe that Maternal/Infant Health is a most significant need in the community, but I do believe that patient education is the best way to address this need.
  - I was not aware that the Hospital had resources allocated to specifically treating
  - Children are born at other area hospitals and JSH has no pediatricians.
  - Lycoming County appears to have generally poorer rates than Clinton County for these indices. Both counties need to improve prenatal care rates.

- Specific comments or observations about Mental/Behavioral Health/Substance Abuse as being among the most significant needs for the Hospital to work on to seek improvements?
  - I believe that mental health services are one of the most vital health concerns that faces our society, today. Unfortunately, it is overlooked and most people do not receive the help they need. Mental health is attached to so many other health concerns, and it should be utilized more. Substance abuse, particularly heroin, is completely out of control. Authorities can not combat the problem alone. Health centers need to recognize the connection between mental health patients and substance abuse. I am not sure exactly what will stop this epidemic, but clearly throwing people in prison is not the only answer. Mental health directly correlates to why people start using drugs and alcohol.
  - I believe that Mental and Behavioral Health/Substance Abuse is a significant need for the Hospital. Recognition and diagnosis of these types of diseases is often very challenging, and also sometimes a very sensitive issue. Staff must be educated to understand the importance of this disease, as it is usually not a life-threating issue, but if signs are not recognized and treated, it often can become one.
  - Clinton county is known for drug and alcohol abuse, and there seems to be many people in the area with mental health/disabilities.
  - Depression in the Medicare population is high in both counties. Drinking and smoking are both comparatively high in both counties.
- Specific comments or observations about Obesity/Overweight as being among the most significant needs for the Hospital to work on to seek improvements?
  - I believe there needs to be more support groups and less judgmental eyes on those who are victims of substance abuse.
  - I am not aware of any.
  - Again view best practices in HCI for implementation and suggestions.
  - PArtner with Lycoming County initiatives that are addressing both root causes, Naloxone use, education of lay and healthcare providers

3. Comments and observations about the implementation actions of the Hospital to seek health status improvement?

- Should the Hospital continue to allocate resources to assist improving the needs?

	Yes	No	No Opinion
Asthma	13	1	0
Cancer	13	0	1
Diabetes	14	0	0
Heart Disease	14	0	0
Maternal/Infant Health	12	1	1
Mental Health/Substance Abuse	12	0	2
Obesity/Overweight	14	0	0

- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Asthma?
  - Asthma, being related to lung health, correlates to heart health and anti-smoking awareness. So, I think a lot of the actions taken against asthma could be grouped in with heart health.
  - Included above
  - I am not aware of any.
  - I am not aware of any.
  - HCI has a list of best practices from across the nation. Consider reviewing these for implementation.
  - Focus on smoking intervention in all aspects of community care from offices to education
- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Cancer?
  - I strongly believe medical cannabis significantly improves cancer patients to cope with their disease and should be promoted as a non-addictive, safe way to manage cancer.
  - I think that an overall emphasis on healthy lifestyles and education programs which focus on this as well as continued screenings when possible (e.g. the skin screening, home occult blood test) are helpful.
  - Updated mammogram technology.
  - Updated mammogram machine.
  - Again view best practices in HCI for implementation and suggestions for early screening.
  - None
- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Diabetes?
  - None that I am aware of.

    - I am not aware of any.
    - Again view best practices in HCI for implementation and suggestions for early screening.
    - Focus on prevention and obesity reduction globally. These are related to lifestyle modification and eradication of the root cause
- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Heart Disease?
    - None that I am aware of.
    - I am not aware of any.
    - Again view best practices in HCI for implementation and suggestions for early screening.
    - More engagement in community civic groups to address health issues
- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Maternal/Infant Health?
    - None that I am aware of.
    - Again view best practices in HCI for implementation and suggestions.
- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Mental Health/Substance Abuse?
    - I believe there needs to be more support groups and less judgmental eyes on those who are victims of substance abuse.
    - I am not aware of any.
    - Again view best practices in HCI for implementation and suggestions.
    - PArtner with Lycoming County initiatives that are addressing both root causes, Naloxone use, education of lay and healthcare providers
- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Obesity/Overweight?
    - More than anything, I think focusing on the youth would be the most beneficial move. People who have already adopted unhealthy eating habits and don't exercise are unlikely to change. I think resources would be better spent trying to sway obese children.
    - None that I am aware.
    - Again view best practices in HCI for implementation and suggestions.
- Do you have opinions about new or additional implementation efforts or community needs the Hospital should pursue?
    - The Pennsylvania Office of Rural Health has been assisting Jersey Shore Hospital in subscribing to the Health Communities Institute system. Information is available for both Lycoming and Clinton Counties along with a number of other rural counties in Pennsylvania.

  - Continued communication to community regarding services, educational programming and service provider information provided by the hospital system in Jersey Shore.

- Finally, after thinking about our questions and the information we seek, is there anything else you think important as we review and revise our thinking about significant health needs within the county?
  - No additional needs
  - The community could benefit from a more reputable emergency room, and a friendlier more knowledgeable staff throughout the whole hospital.
  - The Pennsylvania Office of Rural Health would be pleased to assist Jersey Shore Hospital with training on the healthy Communities Institute system. We will soon have an exciting upgrade for all participating counties. Jersey Shore Hospital along with the other hospitals in these counties might want to consider doing a collaborative Community Health Needs Assessment as the hospitals around Blair and Indiana Counties have done.
  - Comprehensive Patient Centered Medical Home model that incorporates best practices in management and prevention of the various health issues listed above and focuses community resources on prevention

Appendix B – Identification & Prioritization of Community Needs

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health/Substance Abuse - 2012 Significant Need	169	19	16.90%	16.90%	Significant Needs
Cancer - 2012 Significant Need	163	18	16.30%	33.20%	
Obesity/Overweight - 2012 Significant Need	119	20	11.90%	45.10%	
Heart Disease - 2012 Significant Need	108	14	10.80%	55.90%	
Education/Prevention	60	15	6.00%	61.90%	
Maternal/Infant Health - 2012 Significant Need	57	10	5.70%	67.60%	Other Identified Needs
Diabetes - 2012 Significant Need	53	8	5.30%	72.90%	
Flu/Pneumonia	39	13	3.90%	76.80%	
Alzheimer's	37	12	3.70%	80.50%	
Asthma - 2012 Significant Need	35	6	3.50%	84.00%	
Stroke	32	8	3.20%	87.20%	
Dental	25	13	2.50%	89.70%	
Lung Disease	25	6	2.50%	92.20%	
Accidents	20	7	2.00%	94.20%	
Sexually Transmitted Infection	15	8	1.50%	95.70%	
Physical Inactivity	13	4	1.30%	97.00%	
Kidney Disease	11	6	1.10%	98.10%	
Physician	8	3	0.80%	98.90%	
Smoking	7	4	0.70%	99.60%	
Priority Populations	4	2	0.40%	100.00%	
Suicide	0	0	0.00%	100.00%	
Total	1000		100.00%		

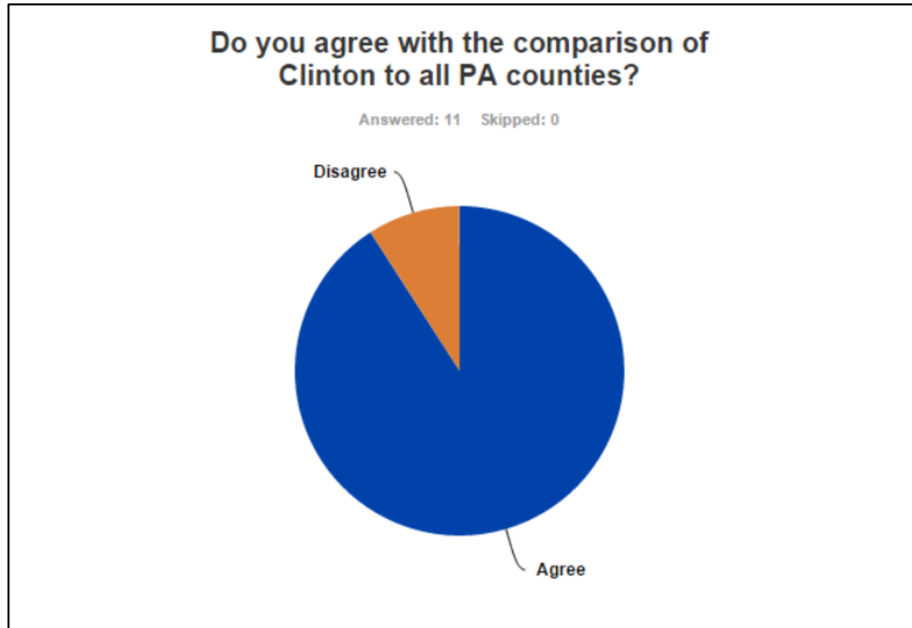
Individuals Participating as Local Expert Advisors[31]

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	6	9
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	1	8	9
3) Priority Populations	1	9	10
4) Representative/Member of Chronic Disease Group or Organization	2	8	10
5) Represents the Broad Interest of the Community	6	4	10
Other			
Answered Question			11
Skipped Question			0

[31] Responds to IRS Schedule h (Form 990) Part V B 3 g

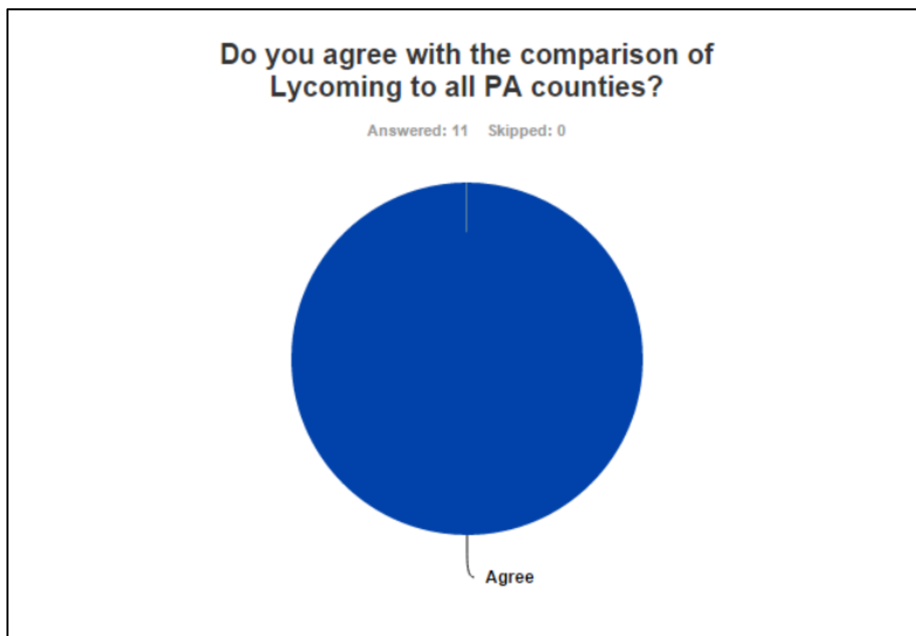
Advice Received from Local Expert Advisors

Question: *Do you agree with the observations formed about the comparison of Clinton County and Lycoming County to all other Pennsylvania counties?*



Comments:

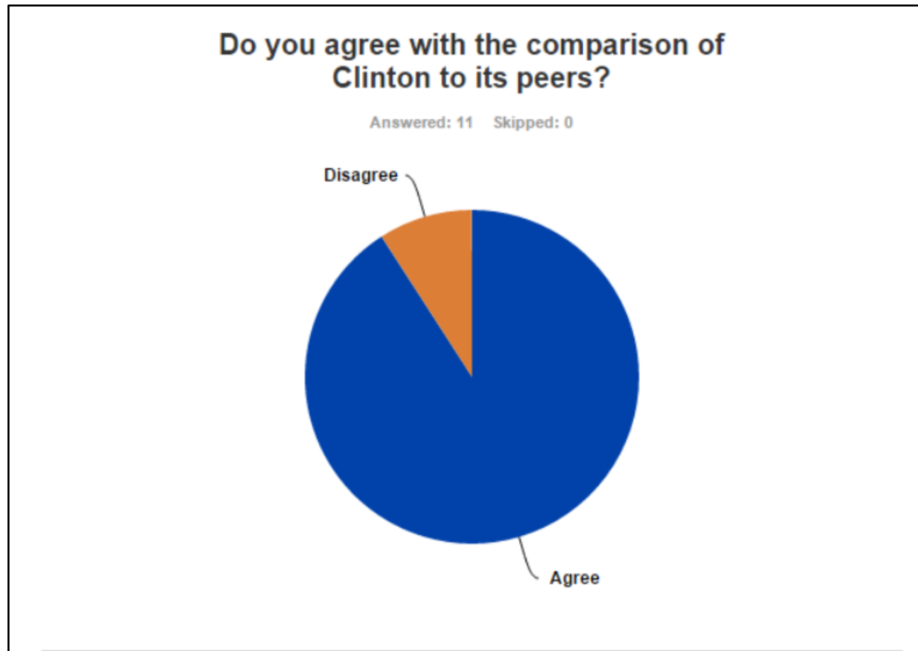
- I'm don't agree about below average "access to exercise opportunities". We have local YMCAs, rails to trails, and state parks which offer a variety of exercise opportunities in this area.
- There definitely seems to be a lot of obese people in this area.



Comments:

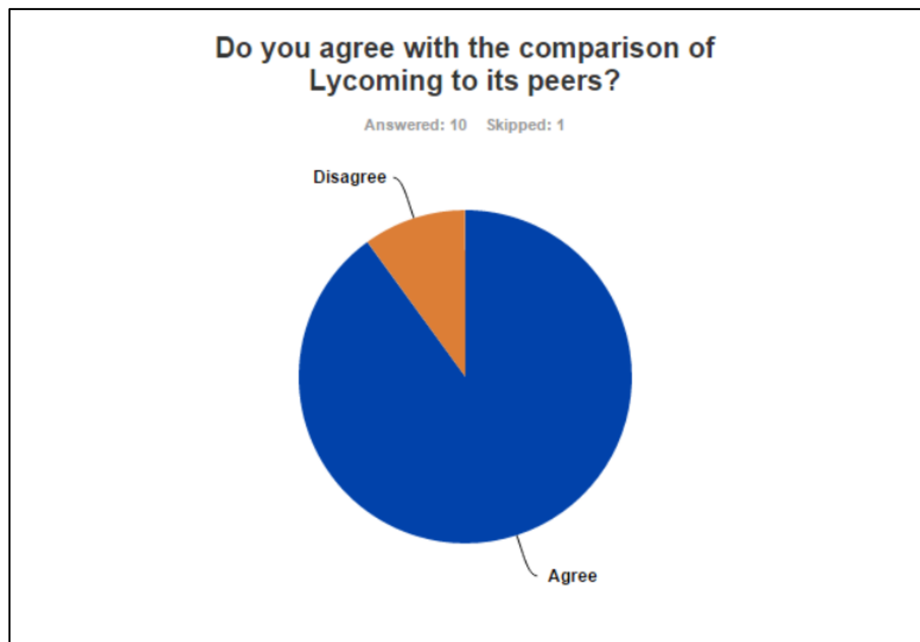
- There seem to be a lot of smokers, as well as under educated citizens in this area.

Question: *Do you agree with the observations formed about the comparison of Clinton County and Lycoming County to their peer counties?*



Comments:

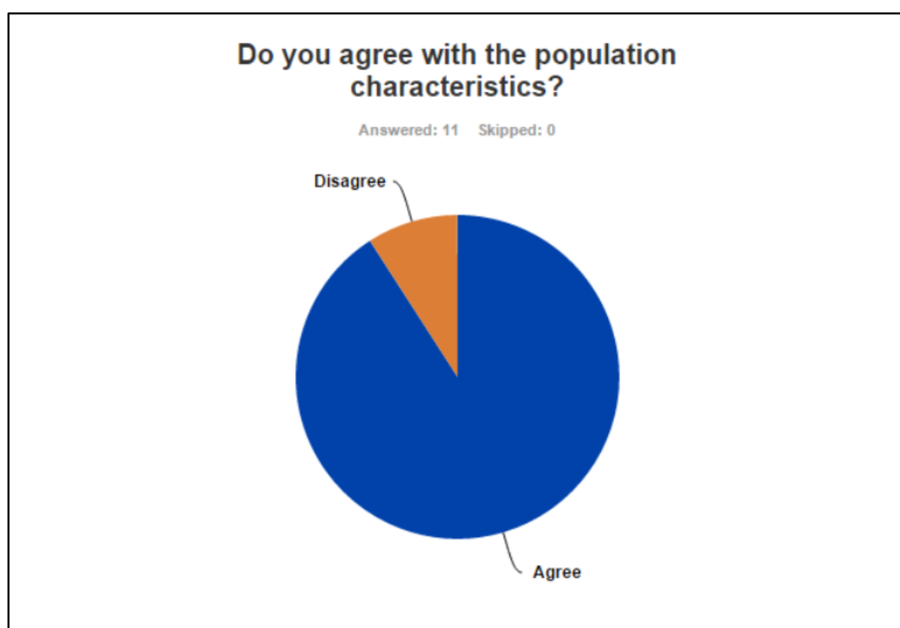
- I agree especially with the adult binge drinking; perhaps related to rural living, below average advanced education statistics, as well as income levels.
- Adult Binge Drinking does seem high in this area, but I did not realize it was that high.



Comments:

- The MVA statistic is not surprising considering the previously mentioned binge drinking (if related to alcohol). I have a hard time grasping that poverty/violent crime is "better" than peer counties, especially considering Williamsport (would love to know what the "peer counties" are).
- I agree with Older Adult Depression rates, as well as the rates of living near highways

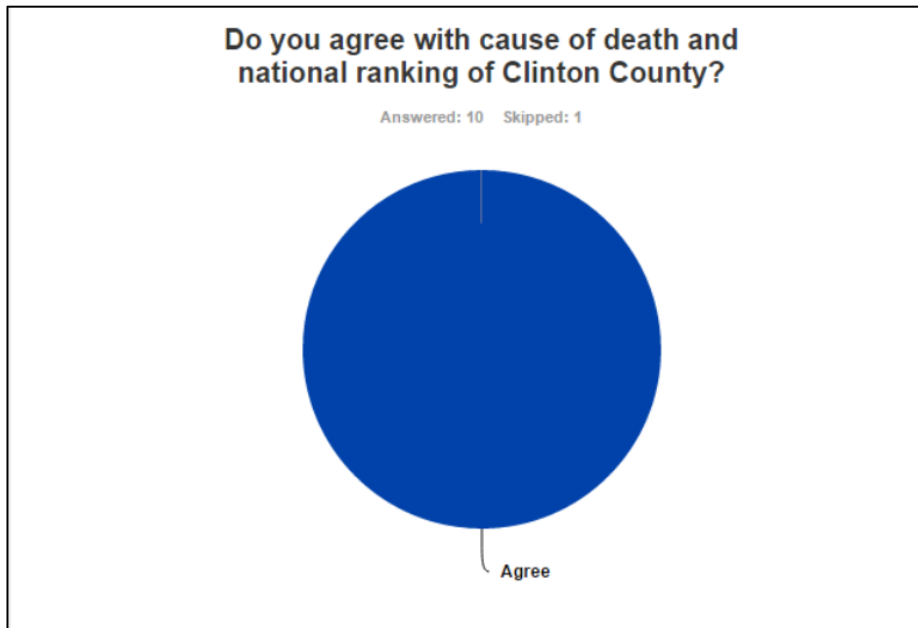
Question: *Do you agree with the observations formed about the population characteristics of Clinton County and Lycoming County?*

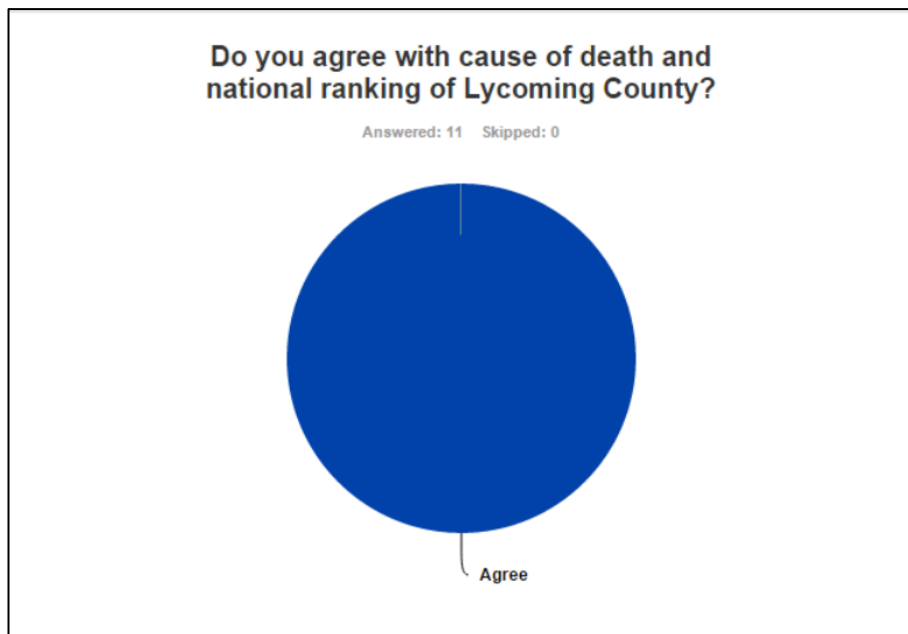


Comments:

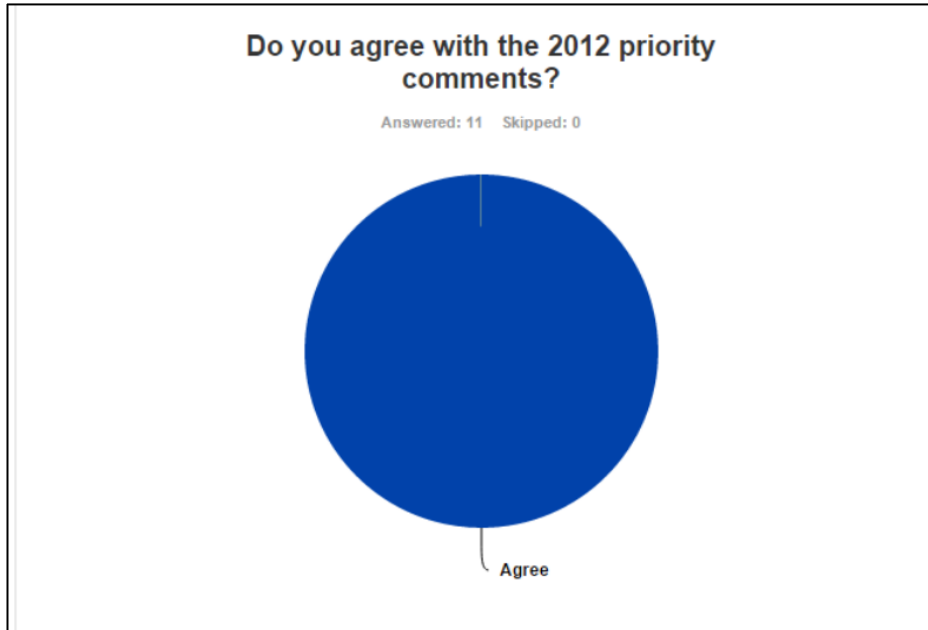
- It was my understanding that Clinton County had a very high alcohol consumption rate. http://wnep.com/2015/04/03/clinton-county-no-1-in-state-for-excessive-drinkingBULLET

Question: *Do you agree with the observations formed from the national ranking and leading causes of death?*

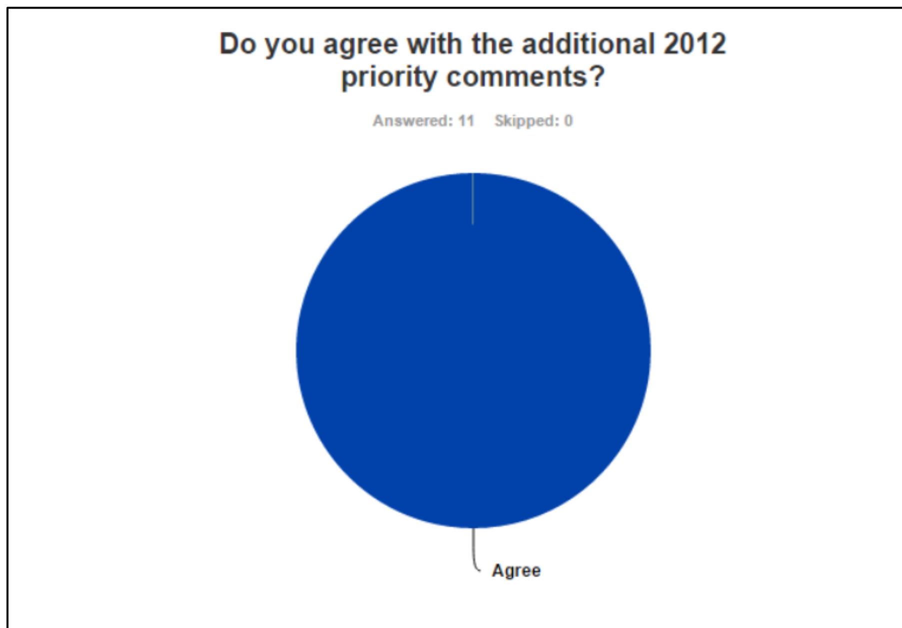




Question: *Do you agree with the written comments received on the 2012 CHNA?*



Question: *Do you agree with the additional written comments received on the 2012 CHNA?*



Comments:

- Mental Health needs to continue to be a major priority due to it being the root cause for many other illnesses.

Appendix C – National Healthcare Quality and Disparities Report

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

The reports are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

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

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

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

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

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

Trends

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

- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[32] consistent with these trends.

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

Trends

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

Disparities

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

Trends

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

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

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[33]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[34]

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

Disparities

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[32] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.
[33] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.
[34] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

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

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

Disparity Trends

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

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

Trends

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

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

Trends

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

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

Achieved Success

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

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

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

Improving Quickly

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

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

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

Worsening

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

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

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

Disparities

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

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

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.

- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

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

Disparities Trends

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

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

Geographic Disparities

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

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

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[35]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

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

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

Trends

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

Disparities

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

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

Disparities Trends

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

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

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

Trends

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

Disparities

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

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

Trends

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

Disparities

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

Disparities Trends

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

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

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.
- About half of all Healthy Living measures tracked in the QDR improved.

- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

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

Disparities Trends

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

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

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

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[36]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines who indicated a financial or insurance reason for the problem was:

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

- Higher among uninsured people and people with public insurance compared with people with any private insurance.
- Higher among poor, low-income, and middle-income families compared with high-income families.

CONCLUSION

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

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

Appendix D – Illustrative Schedule h (Form 990) Part V B Potential Response

Illustrative IRS Schedule h Part V Section B (Form 990)[37]

Community Health Need Assessment Illustrative Answers

1. **Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?**

   Suggested Answer – No

2. **Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C**

   Suggested Answer – No

3. **During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply)**

   a. **A definition of the community served by the hospital facility**

      Suggested Answer – see footnotes 17 and 19 on page 12

   b. **Demographics of the community**

      Suggested Answer – see footnote 20 and page 13

   c. **Existing health care facilities and resources within the community that are available to respond to the health needs of the community**

      Suggested Answer – see footnote 26 on page 41 and footnote 27 on page 43

   d. **How data was obtained**

      Suggested Answer – see footnote 11 on page 8

   e. **The significant health needs of the community**

      Suggested Answer – see footnote 25 on page 39

   f. **Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups**

      Suggested Answer – see footnote 12 on page 9

   g. **The process for identifying and prioritizing community health needs and services to meet the community health needs**

      Suggested Answer – see footnote 31 on page 63

   h. **The process for consulting with persons representing the community's interests**

      Suggested Answer – see footnotes 8 and 9 on page 7

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[37] Questions are drawn from 2014 Federal 990 schedule h.pdf and may change when the hospital is to make its 990 h filing

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

Suggested Answer – see footnote 10 on page 8, footnotes 13 and 14 on page 10, and footnote 23 on page 18

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

Suggested Answer –

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

Suggested Answer – 2012

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

Suggested Answer – see footnote 15 on page 10 and 30 on page 55

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

Suggested Answer – see footnote 4 on page 4 and footnote 7 on page 7

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

Suggested Answer – No

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

Suggested Answer – Yes

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

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

Suggested Answer – www.jsh.org

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

Suggested Answer – No other website

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

Suggested Answer – Yes

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

Suggested Answer – No other efforts

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

Suggested Answer – see footnotes 28 and 29 on page 53

9. **Indicate the tax year the hospital facility last adopted an implementation strategy:**

   Suggested Answer – 2012

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

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

       Suggested Answer – www.jsh.org

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

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

    Suggested Answer – see footnote 26 on page 41

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

    Suggested Answer – None incurred

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

    Suggested Answer – Nothing to report

    c. If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form4720 for all of its hospital facilities?

    Suggested Answer – Nothing to report