JOHNSTON HEALTH
SMITHFIELD, NORTH CAROLINA

2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

ADOPTED BY BOARD RESOLUTION (SEPTEMBER 26, 2013)[1]

[1] Response to Schedule H (Form 990) Part V B 2

Dear Community Resident:

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

The "2013 Community Health Needs Assessment" identifies local health and medical needs and provides a plan to indicate how JH 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, JH, are meeting our obligations to efficiently deliver medical services.

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

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

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

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

Thank you.

Table of Contents

EXECUTIVE SUMMARY

Executive Summary

Johnston Health (JH) is organized and governed as an asset of the Johnston Memorial Hospital Authority. A "hospital authority" is a government organization, and as such, is not required to produce evidence of providing an adequate amount of "community benefit" to justify retention of their not-for-profit tax status. However, JH has elected to voluntarily complete a Community Health Needs Assessment to assure it is responding to the primary health needs of its residents. This study is designed to comply with standards required of a not-for-profit hospital. We assume JH acts as a not-for-profit hospital solely for purposes of producing this report. Tax reporting citations in this report do not apply to JH.

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

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

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

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

Project Objectives

JH partnered with Quorum Health Resources (QHR) for the following:[4]

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

Brief Overview of Community Health Needs Assessment

Typically, nonprofit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c) 3 of the Internal Revenue Code; however, the term "Charitable Organization" is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided to the less fortunate without means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

[2] Part 3 Treasury/IRS – 2011 – 52 Notice … Community Health Needs Assessment Requirements…
[3] As of the date of this report Notice of proposed rulemaking was published 6/26/2012 and available at http://federalregister.gov/a/2012-15537
[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

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

- Emergency room open to all, regardless of ability to pay;
- Surplus funds used to improve patient care, expand facilities, train, etc.;
- Control by independent civic leaders; and
- All available and qualified physicians are privileged.

Specifically, the IRS requires:

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

[5] Section 6652

APPROACH

Approach

To complete a CHNA, the hospital must:

- Describe processes and methods used to conduct the assessment:
  - Sources of data and dates retrieved;
  - Analytical methods applied;
  - Information gaps impacting ability to assess the needs; and
  - Identify with whom the Hospital collaborated.
- Describe how the hospital gained input from community representatives:
  - When and how the organization consulted with these individuals;
  - Names, titles and organizations of these individuals; and
  - Any special knowledge or expertise in public health possessed by these individuals.
- Describe the process and criteria used in prioritizing health needs;
- Describe existing resources available to meet the community health needs; and
- Identify programs and resources the hospital facility plans to commit to meeting each identified need and the anticipated impact of those programs and resources on the health need.

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

The data displays used in our analysis are presented in the Appendix. Data sources include:[7]

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Johnston County compared to all NC counties	August 10, 2013	2002 to 2010

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

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.communityhealth.hhs.gov	Assessment of health needs of Johnston County compared to its national set of "peer counties"	August 10, 2013	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the contribution each group makes to the entire area; and, to access population size, trends and socio-economic characteristics	August 10, 2013	2012
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	August 10, 2013	2012
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	August 10, 2013	2012
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	August 10, 2013	1989 through 2009
www.dataplace.org	To determine availability of specific health resources	August 10, 2013	2005
www.cdc.gov	To examine area trends for heart disease and stroke	August 10, 2013	2007 to 2009
www.CHNA.org	To identify potential needs among a variety of resource and health need metrics	August 10, 2013	2003 to 2010
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	August 10, 2013	2013
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	August 10, 2013	2010 published 11/29/12

Federal regulations surrounding CHNA have evolved to require local input from representatives of particular sectors. For this reason, Quorum has refined a 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 local 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[8] and the Hospital's desire to represent the regions geographically and ethnically diverse population.
- We received community input from 14 Local Expert Advisors. Survey responses started Wednesday May 1, 2013 at 8:25 a.m. and ended with the last response on Thursday May 30, 2013 at 3:17 p.m.

- Information analysis augmented by local opinions showed how Johnston County relates to its peers in terms of primary and chronic needs, as well as other issues of uninsured persons, low-income persons and minority groups; respondents commented on if they believe certain population groups (or people with certain situations) need help to improve their condition and if so, who needs to do what.[9]

When the analysis was complete, we put the information and summary conclusions before our local group of experts[10] who were asked to agree or disagree with the summary conclusions. Experts were free to augment potential conclusions with additional statements of need; and, new needs did emerge from this exchange.[11] Consultation with 15 local experts occurred again via an internet based survey (explained below) during the period beginning Thursday, August 20, 2013 at 5:35 a.m. and ending Friday, August 30, 2013 at 12:35 p.m.

With the prior steps identifying potential community needs, the Local Experts participated in a structured communication technique called a Delphi method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts who answer questionnaires in a series of rounds. We contemplated and implemented one round as referenced during the above dates. After each round, we provided an anonymous summary of the experts' forecasts from the previous round, as well as the reasons provided for their judgments. The process encourages experts to revise their earlier answers in light of the replies of other members of their panel. Typically, this process decreases the range of answers and moves the expert opinions toward a consensus "correct" answer. The process stops when we identify the most pressing, highest priority community needs.

In the JH process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and to challenge conclusions developed from

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

the data analysis. A rank order of priorities emerged, with some needs receiving none or virtually no support and other needs receiving identical point allocations.

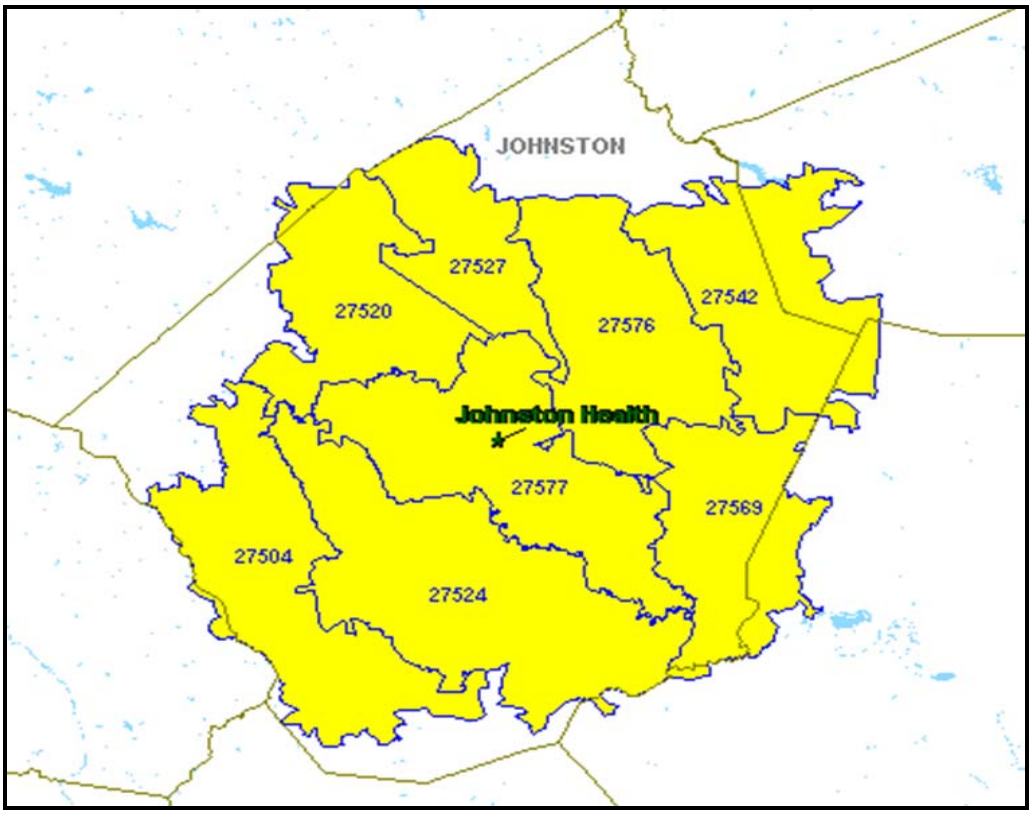
The proposed regulations clarify a CHNA need only identify significant health needs, and need only prioritize, and otherwise assess, those significant identified health needs. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in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

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

FINDINGS

Findings

Definition of Area Served by the Hospital Facility[13]



Johnston Health, in conjunction with QHR, defines its service area as Johnston County in North Carolina which includes the following ZIP codes:

27504	Benson	27520	Clayton	27524	Four Oaks	27527	Clayton
27542	Kenly	27569	Princeton	27576	Selma	27577	Smithfield

In 2011, the Hospital received 83.5% of its patients from this area.[14]

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

Demographic of the Community[15]

The 2013 population for Johnston County is estimated to be 145,265[16] and expected to increase at a rate of 6.6%. This is in contrast to the 3.3% national rate of growth and the North Carolina growth rate of 4.6%. Johnston County in 2018 anticipates a population of 154,873.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2013 median age for Johnston County is 37.1 years, which is younger than the North Carolina median age (37.8 years) and the national median age (37.5 years). The 2013 Median Household Income for the area is $41,679 which is lower than the North Carolina median income of $41,990 and the national median income of $49,223. Median Household Wealth value is below the national, but above the North Carolina values. The Median Home Values are below both the North Carolina and national values. Johnston County Unemployment Rate as of April 2013 was 7.5%[17], which is better than the 8.5% North Carolina rate and slightly better than the national rate of 7.1%.

The portion of the population in the county over 65 is 12.1%, below the North Carolina and national averages, which are both at 13.9%. The portion of the population of women of childbearing age is 19.5%, below the North Carolina average of 20.0% and the National average of 19.8%. 15.4% of the population is Black Non-Hispanic (the largest minority), and 14.5% is Hispanic (the second-largest minority). The White Non-Hispanic population comprises 67.5% of the total.

Demographics Expert 2.7
2013 Demographic Snapshot
Area: Johnston County, NC
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	139,192	308,745,538
2013 Total Population	145,265	314,861,807
2018 Total Population	154,873	325,322,277
% Change 2013 - 2018	6.6%	3.3%
Average Household Income	$52,098	$69,637

	2013	2018	% Change
Total Male Population	71,541	76,315	6.7%
Total Female Population	73,724	78,558	6.6%
Females, Child Bearing Age (15-44)	28,323	28,578	0.9%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2013	% of Total	2018	% of Total	USA 2013 % of Total
0-14	32,733	22.5%	33,815	21.8%	19.6%
15-17	6,489	4.5%	7,077	4.6%	4.1%
18-24	12,162	8.4%	14,270	9.2%	10.0%
25-34	16,965	11.7%	16,934	10.9%	13.1%
35-54	42,734	29.4%	42,481	27.4%	26.9%
55-64	16,659	11.5%	18,654	12.0%	12.4%
65+	17,523	12.1%	21,642	14.0%	13.9%
Total	145,265	100.0%	154,873	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2013 Household Income	HH Count	% of Total	USA % of Total
<$15K	8,671	18.0%	14.9%
$15-25K	1,896	3.9%	4.7%
$25-50K	15,939	33.0%	27.3%
$50-75K	10,055	20.8%	19.5%
$75-100K	6,069	12.6%	12.6%
Over $100K	5,616	11.6%	21.0%
Total	48,246	100.0%	100.0%

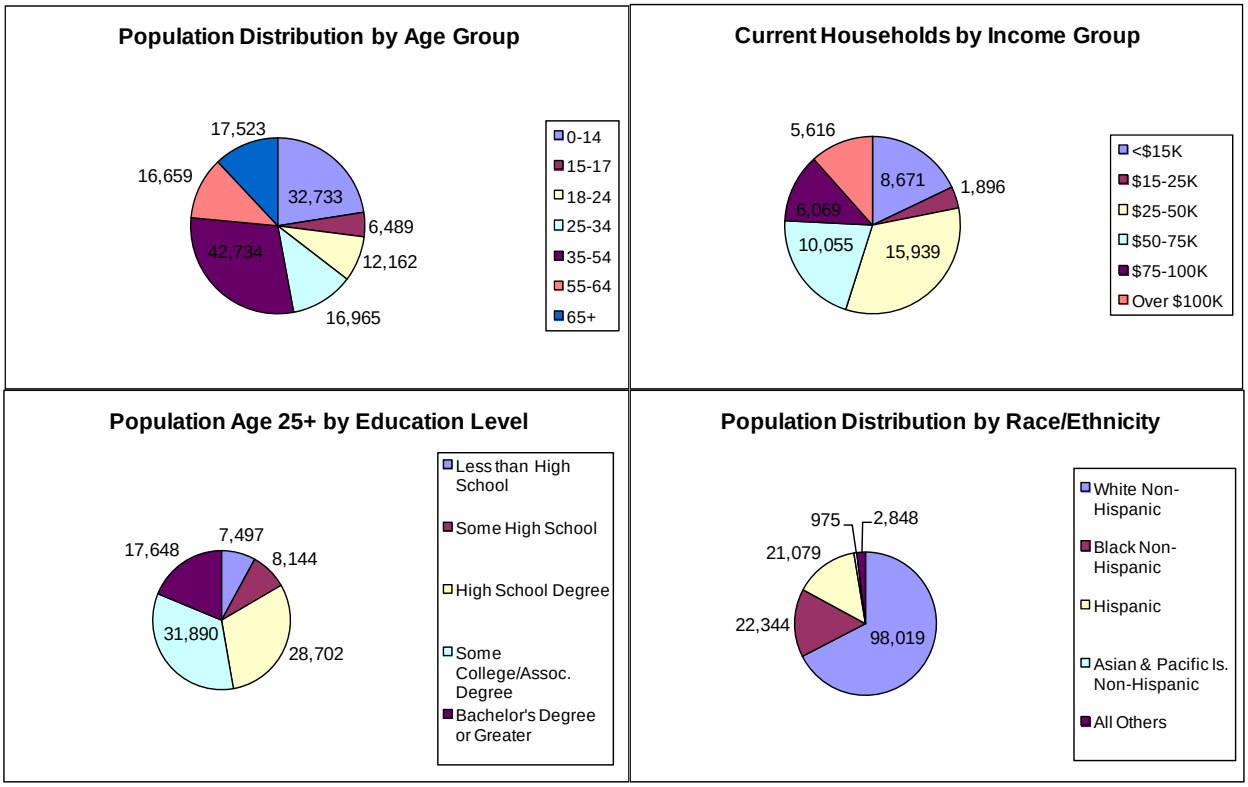
EDUCATION LEVEL

	Education Level Distribution		
2013 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	7,497	8.0%	6.2%
Some High School	8,144	8.7%	8.4%
High School Degree	28,702	30.6%	28.4%
Some College/Assoc. Degree	31,890	34.0%	28.9%
Bachelor's Degree or Greater	17,648	18.8%	28.1%
Total	93,881	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2013 Pop	% of Total	USA % of Total
White Non-Hispanic	98,019	67.5%	62.3%
Black Non-Hispanic	22,344	15.4%	12.3%
Hispanic	21,079	14.5%	17.3%
Asian & Pacific Is. Non-Hispanic	975	0.7%	5.1%
All Others	2,848	2.0%	2.9%
Total	145,265	100.0%	100.0%

[15] Responds to IRS Form 990 (h) Part V B 1 b
[16] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[17] http://research.stlouisfed.org/fred2/series/NCJOHN0URN, http://research.stlouisfed.org/fred2/graph/?id=UNRATENSA, http://research.stlouisfed.org/fred2/graph/?id=UNRATENSA,



2013 Benchmarks
Area: Johnston County, NC
Level of Geography: ZIP Code

Area	2013-2018 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2013-2018	Females 15-44 % of Total Population	Females 15-44 % Change 2013-2018	Median Household Income	Median Household Wealth	Median Home Value
USA	3.3%	37.5	13.9%	16.3%	19.8%	-0.1%	$49,233	$54,682	$169,011
North Carolina	4.6%	37.8	13.9%	18.3%	20.0%	0.4%	$41,990	$47,816	$148,822
Selected Area	6.6%	37.1	12.1%	23.5%	19.5%	0.9%	$41,679	$52,767	$135,970

Demographics Expert 2.7
DEMO0003.SQP

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

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Heart**		
BMI: Morbid/Obese	106.7%	27.2%	Routine Screen: Cardiac Stress 2yr	89.2%	14.0%
Vigorous Exercise	98.8%	50.1%	Chronic High Cholesterol	88.6%	19.7%
Chronic Diabetes	104.1%	10.8%	Routine Cholesterol Screening	95.3%	48.4%
Healthy Eating Habits	90.5%	26.8%	Chronic High Blood Pressure	97.8%	25.7%
Very Unhealthy Eating Habits	109.6%	3.0%	Chronic Heart Disease	89.9%	7.5%
Behavior			**Routine Services**		
I Will Travel to Obtain Medical Care	98.2%	30.5%	FP/GP: 1+ Visit	103.0%	91.0%
I Follow Treatment Recommendations	95.4%	38.5%	Used Midlevel in last 6 Months	102.9%	44.7%
I am Responsible for My Health	98.6%	62.1%	OB/Gyn 1+ Visit	98.0%	45.8%
Pulmonary			Ambulatory Surgery last 12 Months	108.0%	20.8%
Chronic COPD	86.4%	5.3%	**Internet Usage**		
Tobacco Use: Cigarettes	110.4%	28.6%	Use Internet to Talk to MD	80.7%	11.8%
Chronic Allergies	115.4%	24.2%	Facebook Opinions	95.3%	9.8%
Cancer			Looked for Provider Rating	93.6%	13.5%
Mammography in Past Yr	94.1%	42.8%	**Misc**		
Cancer Screen: Colorectal 2 yr	90.0%	22.7%	Charitable Contrib: Hosp/Hosp Sys	98.0%	23.4%
Cancer Screen: Pap/Cerv Test 2 yr	94.2%	56.7%	Charitable Contrib: Other Health Org	96.4%	37.6%
Routine Screen: Prostate 2 yr	98.8%	31.5%	HSA/FSA: Employer Offers	97.4%	50.2%
Orthopedic			**Emergency Service**		
Chronic Lower Back Pain	100.8%	22.7%	Emergency Room Use	104.8%	35.5%
Chronic Osteoporosis	94.9%	9.2%	Urgent Care Use	107.8%	25.4%

Leading Causes of Death

Cause of Death			Rank among all counties in NC (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
NC Rank	Johnston Co. Rank	Condition		NC	Johnston Co.	
1	1	Heart Disease	9 of 100	178.4	271.3	Higher than expected
2,11,12,17,22,27, 29,30,31,32,34, 36,37,44	2	Cancer	51 of 100	178.0	197.2	As expected
13, 23, 24	3	Accidents	52 of 100	43.7	54.1	Higher than expected
4	4	Stroke	72 of 100	46.6	52.0	As expected
3	5	Lung	52 of 100	45.2	47.8	As expected
7	6	Diabetes	54 of 100	21.6	26.1	As expected
10	7	Flu - Pneumonia	45 of 100	18.4	22.0	As expected
6	8	Alzheimer's	68 of 100	28.4	20.3	As expected
8	9	Kidney	51 of 100	19.1	17.2	Higher than expected
14	10	Blood Poisoning	53 of 100	13.7	13.1	Higher than expected
16	11	Suicide	72 of 100	12.4	10.4	As expected
9	12	Hypertension	41 of 100	8.3	9.6	Higher than expected
21	13	Liver	62 of 100	9.2	8.2	As expected
28	14	Homicide	56 of 99	6.1	5.6	As expected
25	15	Parkinson's	89 of 100	6.4	3.2	Lower than expected

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

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

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

Nationally, this report observes the following trends:

- Measures for which Blacks were worse than Whites and are getting better:
  - Diabetes – Hospital admissions for short-term complications of diabetes per 100,000 population;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over; and
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.
- Measures for which Blacks were worse than Whites and staying the same:
  - Cancer – Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over ; breast cancer deaths per 100,000 female population per year; adults age 50 and over who ever received colorectal cancer screening; colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over; colorectal cancer deaths per 100,000 population per year;
  - Diabetes – Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes;
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year; Children ages 19-35 months who received all recommended vaccines;
  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months; people age 12 and over treated for substance abuse who completed treatment course;

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

  - Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
  - Supportive and Palliative Care – High-risk long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
  - Timeliness – Adults who needed care right away for an illness, injury or condition in the last 12 months who got care as soon as wanted; emergency department visits where patients left without being seen; and
  - Access – People with a usual primary care provider; people with a specific source of ongoing care.
- Measures for which Asians were worse than Whites and getting better:
  - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  - Patient Safety – Adult surgery patients who received appropriate timing of antibiotics.
- Measures for which Asians were worse than Whites and staying the same:
  - Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and
  - Access – People with a usual primary care provider.
- Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and staying the same:
  - Heart Disease – Hospital patients with heart failure who received recommended hospital care;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  - Respiratory Diseases – Hospital patients with pneumonia who received recommended hospital care;
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement;
  - Supportive and Palliative Care – Hospice patients who received the right amount of medicine for pain; high-risk, long-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; and
  - Access – People under age 65 with health insurance.

- Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and getting worse:
  - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  - Patient safety – Adult surgery patients who received appropriate timing of antibiotics.
- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and getting better:
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;
  - Lifestyle Modification – Adult current smokers with a checkup in the last 12 months who received advice to quit smoking; adults with obesity who ever received advice from a health provider about healthy eating; and
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.
- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and staying the same:
  - Cancer – Women age 40 and over who received a mammogram in the last 2 years; adults age 50 and over who ever received colorectal cancer screening;
  - Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
  - Heart Disease – Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge; hospital patients with heart failure who received recommended hospital care;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months;
  - Respiratory Disease – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
  - Lifestyle Modification – Adults with obesity who ever received advice from a health provider to exercise more;
  - Supportive and Palliative Care – Long-stay nursing home residents with physical restraints; high-risk, long-stay nursing home residents with pressure sores; short-stay

nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;

- Patient Safety – Adult surgery patients who received appropriate timing of antibiotics;
- Timeliness – Adults who needed care right away for an illness, injury or condition in the last 12 months who got care as soon as wanted;
- Patient Centeredness – Adults with ambulatory visits who reported poor communication with health providers; children with ambulatory visits who reported poor communication with health providers; and
- Access – People under age 65 with health insurance; people under age 65 who were uninsured all year; people with a specific source of ongoing care; people with a usual primary care provider; people unable to get or delayed in getting needed care due to financial or insurance reasons

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

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

- Low income access to mental health and physical health care resulting in emergency department becoming doctor's office
- Diabetes and obesity repeatedly mentioned with less frequent mentions of heart disease, substance abuse, dental and pulmonary conditions
- Children, Hispanic, Elderly and Uninsured specifically noted as having greater needs than others

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

Vulnerable Populations: Johnston County, NC

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

Vulnerable Populations Include People Who[1]	
Have no high school diploma (among adults age 25 and older)	25,579
Are unemployed	4,489
Are severely work disabled	3,613
Have major depression	9,215
Are recent drug users (within past month)	9,411

nda No data available.

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

Statistical information about special populations:

Access to Care: Johnston County, NC

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

Uninsured individuals (age under 65)[1]	32,190
Medicare beneficiaries[2]	
Elderly (Age 65+)	14,008
Disabled	4,917
Medicaid beneficiaries[2]	25,953
Primary care physicians per 100,000 pop[2]	37.3
Dentists per 100,000 pop[2]	16.5
Community/Migrant Health Centers[3]	Yes
Health Professional Shortage Area[3]	No

nda No data available.

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

Findings

Upon completion of the CHNA, QHR identified several issues within the Johnston Health community:

Conclusions from Public Input to Community Health Needs Assessment

Our group of 14 Local Experts participated in an online survey to offer opinions about their perceptions of community health needs and potential needs of unique populations. Local Experts Responses were first obtained to the question: "What do you believe to be the most important health or medical issue confronting the residents of your County?" In summary, we receive the following commentary regarding the more important health or medical issues:

- Leading concern is Affordability problems which limit access to medical and prevention services.
- Multiple mentions of concerns about the lack of Mental Health Care including Substance Abuse services
- A lower order of priority set of various concerns probably best summarized by the following response "Quality health care and ability to deliver it to the people of this community/county."

Responses were then obtained to the question: "Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low income persons, minority groups and/or other population groups (i.e. people with certain situations) which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what?" In summary, we received the following commentary regarding the more important health or medical issues:

- Children, Hispanic, Elderly and Uninsured specifically noted as having greater needs than others
- Limited low income access to mental health and physical health care resulting in emergency department becoming doctor's office
- Diabetes and obesity repeatedly mentioned with less frequent mentions of heart disease, substance abuse, dental and pulmonary conditions

Summary of Observations from Johnston County Compared to All Other North Carolina Counties, in Terms of Community Health Needs

In general, Johnston County residents are better than average compared to the healthiest in North Carolina.

In a health status classification termed "Health Outcomes", Johnston ranks number 30 among the 100 North Carolina ranked counties (best being #1). Premature Death (deaths prior to age 75)

presented slightly better values (longer survivability) than on average for NC, but worse than the US benchmark. County values exceeded both NC and US values for Poor or fair health, Poor physical health days, and Poor mental health days. Low Birth Weight Births show Johnston residents presenting with apparently lower values than NC (favorable indicator), but significantly higher than the US average.

In another health status classification "Health Factors", Johnston County again ranks not quite as well but still better than average, ranking number 38 among the 100 North Carolina counties. Health Behaviors and Clinical Care are the groups of indicators lowering the ranking for Johnston County. Conditions where improvement remains to achieving state average and then national goals include:

- Adult smoking (impacts 24% of residents vs. NC @ 21% & US @ 13%)
- Adult obesity (impacts 34% of residents vs. NC @ 29% & US @ 25%)
- Physical inactivity (impacts 28% of residents vs. NC @ 25% & US @ 21%)
- Excessive drinking (impacts 15% of residents vs. NC @ 13% & US @ 7%)
- Motor vehicle crash death rate (21 deaths per 100,000 vs. NC @ 17 & US @ 10)
- Teen birth rate (50 births per 1,000 teens vs. NC @ 46 & US @ 21)
- Uninsured (20% of residents vs. NC @ 19% & US @ 11%)
- Primary care physicians (3,263 people : 1 doctor vs. NC @ 1,480:1 & US @ 1,067:1) indicates physician shortage
- Dentists (5,195 people : 1 dentist vs. NC @ 2,171:1 & US @ 1,516:1) indicates dentist shortage
- Preventable hospital stays (93 admissions per 1,000 Medicare residents for preventable conditions vs. NC @ 63 & US @ 47) indicates potential physician shortage

Sexually transmitted infections per 100,000 residents ranked below NC (desirable) but above US (undesirable) average. Diabetic screening and Mammography screening rates of participants per 100,000 ranked below US (undesirable), but at or above the NC average (desirable).

Social and Economic factors are much more positive. High school graduation ranked slightly higher than NC average, although some college ranked below NC and significantly below US. Unemployment, Children in poverty, Inadequate social support, Children in single parent households, and Violent crime rate are excessive compared to US and NC (undesirable).

Overall, Physical Environment metrics are better than average for NC. Air pollution, Drinking water safety, and Limited access to healthy foods rank below NC averages (desirable) but above US (undesirable). Access to recreational facilities is lower than NC and US (both undesirable). The portion of Restaurants which are fast food is higher than NC and significantly higher than US average (both undesirable).

Summary of Observations from Johnston County Peer Comparisons

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

UNFAVORABLE observations occurring at rates worse than national AND worse than among Peers (Please note this list of adverse indicators is much shorter than observed in other hospital studies):

- PREMATURE BIRTHS (<37 weeks)
- NO CARE IN FIRST TRIMESTER
- COLON CANCER
- CORONARY HEART DISEASE
- LUNG CANCER
- MOTOR VEHICLE INJURIES
- STROKE
- SUICIDE

SOMEWHAT A CONCERN observations because occurrence is worse than national average BUT better than the Peer group average, OR, better than national average BUT worse than Peer group average (NOTE: This list is shorter than typically observed):

- BLACK NONHISPANIC
- INFANT MORTALITY
- NEONATAL INFANT MORTALITY
- BIRTHS TO WOMEN UNDER 18
- HOMICIDE

FAVORABLE observations as occurrence are better than national and Peer group average (NOTE: This list is longer than typically observed):

- LOW BIRTH Wt. (<2500 g)
- VERY LOW BIRTH Wt. (<1500 g)
- BIRTHS to WOMEN AGE 4054
- BIRTHS to UNMARRIED WOMEN
- INFANT MORTALITY

- WHITE Non HISPANIC INFANT MORTALITY
- HISPANIC INFANT MORTALITY
- POSTNEONATAL
- INFANT MORTALITY
- BREAST CANCER (Female)
- UNINTENTIONAL INJURY

Johnston Population Characteristics

Johnston County in 2013 comprises 145,265 residents. Since 2010 the population has grown and the county anticipates better than average growth for NC through the next five years to achieve 154,873 residents. The population is 67.5% Non-Hispanic White. Asian & Pacific Island Non-Hispanics constitute 0.7% of the population. Black Non-Hispanic comprises the largest minority population at 15.4% of the population. Hispanic is at 14.5%. 12.1% of the population is age 65 or older. This is a smaller population segment than the elderly comprise elsewhere in North Carolina on average but it is in line with the national average. 19.5% of the women are in the childbirth population segment. This segment is slightly smaller than elsewhere on average in North Carolina but approaches the national average. The median household income and median home values are below their respective North Carolina and national averages; however, the Median household wealth is higher than the North Carolina average but lower than the national average.

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

Metrics impacting more than 25% of the population and statistically significantly different from the national average include the following. All are considered adverse:

- Obtained a pap/cervix test in last 2 years 5.8% below average impacting 57% of the population
- Obtained a mammography in past year 5.9% below average impacting 43% of the population
- Use tobacco products / smoke is 10.4% above average impacting 29% of the population
- Morbid obesity is 6.7% above average impacting 27% of the population
- Healthy eating habits is 9.5% below average impacting 27% of the population

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

- Chronic allergies 15.4% above average impacting 24% of population

- Obtained a colorectal cancer screen in last 2 years 10.0% below average impacting 23% of the population
- Obtained routine cardiac stress test in last 2 years 10.8% above average impacting 14% of population
- Very unhealthy eating habits 9.6% above average impacting 3% of the population

Situations and Conditions statistically significantly different from the national average impacting less than 25% of the population beneficially include the following.

- Chronic High Cholesterol 11.4% below average impacting 20% of the population
- Chronic Osteoporosis 5.1% below average impacting 9% of the population
- Chronic Heart Disease 10.1% below average impacting 8% of the population
- Chronic COPD 13.6% below average impacting 5% of the population

Key Conclusions from Consideration of Other Statistical Data Examinations

Additional observations of Johnston County found:

- Palliative Care (programs focused on serious illness relief of symptoms, pain and stress) do not exist in the County. Hospice Care (programs providing terminal disease comfort care) do exist in the County.
- Among the leading causes of death, Johnston County has a significantly higher death rate in 5 of the 15 leading causes and a significantly lower death rate in 1 of the 15 leading causes. Ranking the causes of death in Johnston County finds the leading causes to be the following (in descending order of occurrence):

    1. Heart Disease 271.3 (rate per 100,000) – a rate higher than expected, Johnston County ranks #9 of 100 ranked Counties in NC (#1 rank = worse in state), the death rate from this disease is above NC avg.
    2. Cancer 197.2 – not significantly different than expected, rank #51, above NC avg.
    3. Accidents 54.1 – higher than expected, rank #52, above NC avg.
    4. Stroke52.0– as expected, rank #72, above NC avg.
    5. Lung 47.8 – as expected, rank #52, above NC avg.
    6. Diabetes 26.1 – as expected, rank #54, above NC avg.
    7. Flu / Pneumonia 22 – as expected, rank #45, above NC avg.
    8. Alzheimer's 20.3 – as expected, rank #68, below NC avg.
    9. Kidney 17.2 – significantly higher, rank #51, below NC avg.
    10. Blood Poisoning 13.1– significantly higher, rank #53, slightly below the NC avg.

- Heart Disease Mortality for all races during 2008 through 2010 (463.2) is significantly higher than the NC (349) and US avg. (358.6). The Black (non-Hispanic) rate exhibits the same higher rate comparisons (488.6 deaths per 100,000; NC = 396.7, US = 461.3). The White (non-Hispanic) rate (463.4 deaths per 100,000) is considerably higher than the NC and US average. The American Indian / Alaskan Native death rate (471.6) and the Asian / Pacific Islander death rate (354.6) also greatly exceed NC and US avg. Conversely, Hispanic death rate (106.6) is below the US average.
- Stroke deaths (90.8) for all races are higher than the US rate (78.2). The Black (non-Hispanic) rate is significantly higher (113.1), the White (non-Hispanic) rate is higher (86.2), the Hispanic rate is lower (70.1), and the Asian / Pacific Islander rate is significantly lower (8.3). No statistics were available for the American Indian / Alaskan Native group.
- Life expectancy for both Men and Women has increased. However, males have improved much better than females. Male life expectancy rose from 68.8 in 1989 to 73.7 in 2009, gaining 4.9 years and placing it 7.9 years behind the top counties. Female life expectancy rose at a slower rate from 77.5 in 1989 to 79.4 in 2009, gaining 1.9 years and placing it 6.4 years behind the top counties.
- Johnston County is designated as a Health Professional Shortage Area (HPSA) for primary care, dental and mental health, and it qualifies as a Medically Underserved Area (MUA). Primary care physicians per capita is at about half the NC average (31.3 physicians per 100,000 vs. NC average of 76.2), and a higher than average percent of residents are without a consistent source of primary care (both indicate doctor shortages). 15.2% of Johnston county residents and 21.8% of its children, both below NC average, live in poverty.
- Pollution indicators are of little concern. However, a below average for NC number of grocery stores accept WIC payments and accept supplemental nutrition assistance benefits. A higher than average portion of the population live in "food deserts". Heavy Alcohol consumption is above average for NC. A higher than average for NC percentage of residents use tobacco.

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EXISTING HEALTH CARE FACILITIES, RESOURCES AND JH IMPLEMENTATION PLAN

Significant Health Needs

We used the priority ranking of area health needs to organize the search for locally available resources.[20] The following list identifies locally available resources corresponding to each priority need:

- 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 JH current efforts responding to the need;
- Establishes the Implementation Plan programs and resources JH will devote to attempt to achieve improvements;
- Documents the Leading Indicators JH will use to measure progress;
- Presents the Lagging Indicators JH 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, JH is the major hospital in the service area. JH is a 199 bed regional medical center located in Smithfield, NC. The next closest facilities are primarily outside the service area and include:

- Wayne Memorial Hospital a 270 bed acute care facility located in Goldsboro, NC (25.6 miles, 34 minutes)
- Betsy Johnson Regional Hospital a 101 bed acute care facility located in Dunn, NC (26.4 miles, 32 minutes)
- Wilson Medical Center a 274 bed acute care facility located in Wilson, NC (28.8 miles, 31 minutes)
- WakeMed Raleigh Campus a 647 bed acute care facility located in Raleigh, NC (33 miles, 35 minutes)

In rank order of need, the local resources, listed in the tables beginning on the next page, could be available to respond to the need. 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 JH Implementation Plan utilizes "Leading Indicators". Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR

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

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

Significant Needs

1. AFFORDABILITY and Accessibility – Leading Local Expert concern with limited access to medical and prevention services; Uninsured above NC and US average

Problem Statement: Local residents should not be denied access to care because of limited payment ability

JH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- JH Emergency Departments
- Referrals to FQHC
- Project Access
- Financial policies, charity care policies of JH
- JH Clinics
- JH physician recruitment incentives

JH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Recruit midlevel providers.
- Recruit health care professionals from minority groups which relates to cultural competency.
- Partner with Community Care of NC
- Explore implementation of medical homes, an approach to providing comprehensive primary care for children, youth, and adults in a setting that facilitates partnerships between individual patients, their personal physicians, and (when appropriate) patients' families.
- Expand Project Access
- Explore use of telemedicine as a way for patients to access qualified health and mental health professionals.
- Encourage enrollment in existing programs such as Medicaid and health exchanges via outreach/education and expedited enrollment.

ANTICIPATED RESULTS FROM JH IMPLEMENTATION PLAN

- JH efforts can help address the symptoms of and results from problems of affordability and access but it can do little to impact the underlying causes of this problem which stem from unemployment, limited education, adverse lifestyle choices and other factors.

LEADING INDICATOR JH WILL USE TO MEASURE PROGRESS:

- Volume of charity care patient financial assistance efforts should increase from 2012 volumes.
  - 2012 charity care amount = $ 26,263,489

LAGGING INDICATOR JH WILL USE TO IDENTIFY IMPROVEMENT

- Percent of County population below Federal poverty guideline
  - 15.22% http://assessment.communitycommons.org/CHNA/Report.aspx?page=2&id=779

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:

Johnston County Health Department	517 N Brightleaf Blvd Smithfield, NC	919.989.5200
CommWell Health	507 N Brightleaf Blvd Smithfield, NC	919.934.0850
Benson Area Medical Center	3333 NC 242 Benson, NC	919.894.2011

2. CORONARY HEART DISEASE – leading cause of death, higher than expected; Johnston ranks #9 of 100 NC counties (#1 rank = worse in state); Local experts cite the disease as secondary concern among disadvantaged; Unfavorable death rate compared to US and Peers; death rate above NC average; All race groups, except Hispanic, mortality significantly above NC and US average; below expected death rate for 8% of pop

Problem Statement: The death rate from coronary heart disease should decrease

JH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- JH emergency departments
- JH cardiology program
- JH community education programs
- WellnessWorks
- HealthQuest
- JH smoke cessation program
- Medical Mall Walking Program
- Community Wellness Fair Screenings

JH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Continue chest pain emergency certification
- Pursue stroke certification
- Continue above programs
- Pursue congestive heart certification
- Explore PCI service delivery

ANTICIPATED RESULTS FROM JH IMPLEMENTATION PLAN

- JH efforts can help address the symptoms of and results of heart disease but it can do little to impact the underlying causes of this problem which stem from adverse lifestyle choices and other factors.
- JH efforts will increase awareness of disease and its risk factors.

- Implement a tracking program for chest pain patients receiving blood clot drugs within 30 minutes

LEADING INDICATOR JH WILL USE TO MEASURE PROGRESS:

- Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival.
    - 2013 patients = baseline being established

LAGGING INDICATOR JH WILL USE TO IDENTIFY IMPROVEMENT

- Death rate from Coronary Heart Disease
    - 2012 = 271.3 www.worldlifeexpectancy.com/usa-health-rankings

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Johnston County Health Department	517 N Brightleaf Blvd Smithfield, NC	919.989.5200
Primary care physicians and specialty physicians	Hospital web site	
Benson Area Medical Center	3333 NC 242 Benson, NC	919.894.2011
CommWell Health	507 N Brightleaf Blvd Smithfield, NC	919.934.0850

3. DIABETES – 6th cause of death, at expected rate, ranks #54 (#1 = worst), above NC average; Local experts cite disease concern among disadvantaged; Diabetic screening ranked below US, but at NC average

Problem Statement: An increased number of confirmed diabetic patients need to actively monitor their condition

JH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- JH Diabetes Center
- JH inpatient counseling service
- JH certified outpatient program

JH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how JH services can benefit their initiatives.
- Continue with current services
- Pursue inpatient diabetic certification

ANTICIPATED RESULTS FROM JH IMPLEMENTATION PLAN

- Increase in compliance with disease management initiatives

LEADING INDICATOR JH WILL USE TO MEASURE PROGRESS:

- Number of patients receiving education
  - 2012 patients = 1,036

LAGGING INDICATOR JH WILL USE TO IDENTIFY IMPROVEMENT

- Percent of diabetic Medicare enrollees that receive HbA1c screening
  - 2010 = 87.88% http://www.countyhealthrankings.org

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Horizon Family Medicine	410 Canterbury Rd Smithfield, NC	919.934.5149
Johnston County Health Department	517 N Brightleaf Blvd Smithfield, NC	919.989.5200
Dr. R. Tomar	11618 US 70 Business Suite 202 Clayton, NC	919.359.0291
JH Medical Staff	JH web site	

4. CANCER – 2nd cause of death, but at expected rate, ranks #51 in NC (#1 = worst); Unfavorable rate compared to US and Peers for COLON CANCER and LUNG CANCER; Favorable rate comparisons for BREAST CANCER (Female), Obtain pap/cervix test 6% below average impacts 57% of pop; Obtain mammogram 6% below average impacts 43% of pop; Mammography screening ranked below US, but at NC average

Problem Statement: Cancer detection and screening services need greater participation

JH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- JH Cancer Programs in partnership with Rex/UNC & Duke

- JH community screening and education programs
- "Doctor Talks" education programs

JH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Pursue ACOS cancer certification
- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how JH services can benefit their initiatives.
- Allocating resources to acquire educational material to distribute to patients receiving a cancer diagnosis or interested in the disease
- Providing a schedule of educational seminars to patients and interested residents

ANTICIPATED RESULTS FROM JH IMPLEMENTATION PLAN

- An increase in the use of screening and cancer detection services leading to earlier intervention and increased survival

LEADING INDICATOR JH WILL USE TO MEASURE PROGRESS:

- Volume of mammography exams should increase from 2012 volumes.
  - 2012 mammography exams = 6,830

LAGGING INDICATOR JH WILL USE TO IDENTIFY IMPROVEMENT

- Cancer death rate per 100,000
  - 2012 = 197.2 www.worldlifeexpectancy.com/usa-health-rankings

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Cancer Centers of North Carolina	555 Medical Park Place Suite 201 B Clayton, NC	919.781.7070
JH medical staff	See hospital web site	
Dr. S. Tomar	11618 US 70 Business Suite 202 Clayton, NC	919.359.0291

5. PHYSICIANS – Local experts cite physician shortage transforms the ER into a physician clinic; About half number of physicians per capital in NC; higher portion of resident do not have usual source of primary care; Federal physician shortage area, qualifies as medically underserved; Primary care physicians inadequate supply compared to NC and US average; Preventable hospital stays excessive indicates physician shortage

Problem Statement: Increase the Primary Care physician to population ratio

JH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- JH physician and midlevel recruitment

JH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Implement the medical staff development plan
- Implement a suite of programs designed to aid physician retention
- JH will review the success of its physician recruitment process and enter discussions with the medical staff about how to construct the most desirable practice environment.

ANTICIPATED RESULTS FROM JH IMPLEMENTATION PLAN

- Increase in the primary care medical resources in Johnston County

LEADING INDICATOR JH WILL USE TO MEASURE PROGRESS:

- Number of practitioners interviewed for positions in Johnston County.
  - 2012 = 38

LAGGING INDICATOR JH WILL USE TO IDENTIFY IMPROVEMENT

- Percentage of adults aged 18 and older who self-report that they do not have at least one person who they think of as their personal doctor or health care provider.
  - Johnston County 2012 = 27.42% http://assessment.communitycommons.org

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Local physicians	Visit hospital web site	
Johnston County Health Department	517 N Brightleaf Blvd Smithfield, NC	919.989.5200
Benson Area Medical Center	3333 NC 242 Benson, NC	919.894.2011
CommWell Health	507 N Brightleaf Blvd Smithfield, NC	919.934.0850

6. MENTAL HEALTH / SUICIDE – Multiple Local Expert concerns mentioned about lack of Mental Health Care / Substance Abuse services; Unfavorable rate compared to US and Peers for SUICIDE; Local experts cite disease a secondary concern among disadvantaged; Local Experts cite extensive use of ER for mental health needs; Federal mental health professional shortage area;

Excessive Poor Mental Health days compared to both NC and US average

Problem Statement: Suicide death rate needs to decrease

JH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- JH partnership with Johnston County Mental Health Center and Alliance Behavioral Health
- JH inpatient Behavioral Medicine Unit
- JH Emergency Departments screening and stabilization

JH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how JH services can benefit their initiatives.
- Emergency service staff will be trained in suicide tendency identification and awareness of intervention strategies
- Establish patient tracking system

ANTICIPATED RESULTS FROM JH IMPLEMENTATION PLAN

- JH efforts can help address the symptoms of and results from adverse lifestyle choices and other factors.
- Increased awareness of suicide desire and prevention

LEADING INDICATOR JH WILL USE TO MEASURE PROGRESS:

- Volume of patients and volunteers involves in suicide prevention.
    - 2013/2014 patient presenting with suicide ideations in JH emergency departments = base line being established

LAGGING INDICATOR JH WILL USE TO IDENTIFY IMPROVEMENT

- Suicide death rate
    - 10.4 per 100,000 www.worldlifeexpectancy.com/usa-health-rankings

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Alliance Behavioral Health care	4600 Emperor Blvd Durham, NC	919.560.7100
Day by Day	1101 River Road Selma, NC	919.965.6550
Johnston County Mental Health Center	521 N. Bright Leaf Blvd Smithfield, NC	919.989.5500

JH medical staff	See hospital web site	

7. OBESITY/OVERWEIGHT – Local experts cite disease concern among disadvantaged; Number of grocery stores below average for NC; few accept WIC payments or nutrition assistance benefits; above average percent of population live in "food deserts"; Morbid obesity 7% above average impacts 27% of pop; Healthy eating habits 10% below average impacts 27% of pop; Adult obesity above NC and US average; Physical inactivity above NC and US average; Limited access to healthy foods rank below NC average (desirable) but above US (undesirable); Number of fast food restaurants higher than NC and significantly higher than US (undesirable)

Problem Statement: Increase awareness of maintaining a healthy weight and lifestyle.

JH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- JH HealthQuest
- JH Nutritional Counseling
- JH Medical Mall walking program
- JH Screening programs
- JH Women's Pavilion Lactation Services

JH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- JH will establish an integrated approach to obesity by coordinating its efforts with diabetic reduction efforts formulating a multi-component obesity prevention intervention initiative.[21]
- JH will lead by example by fostering employee involvement in a worksite prevention intervention.[22]
- Label foods to show serving size and nutritional content: availability and awareness of nutritional information content may decrease calorie consumption.
- Implement employee wellness program
- Implement breastfeeding programs to increase breastfeeding initiation, exclusive breastfeeding, and duration of breastfeeding.
- Implement multi-component interventions that target both diet and physical activity: multi-component interventions include combinations of activities and support such as nutrition education, prescriptions for aerobic/strength training, training in behavioral techniques, self-help materials, specific dietary prescriptions, group or supervised exercise sessions, and healthy cooking classes.

ANTICIPATED RESULTS FROM JH IMPLEMENTATION PLAN

- JH anticipates a greater percentage of residents will no longer be obese

[21] http://www.countyhealthrankings.org/policies/multi-component-obesity-prevention-interventions
[22] http://www.countyhealthrankings.org/app/#/new-mexico/2013/measure/factors/11/policies

LEADING INDICATOR JH WILL USE TO MEASURE PROGRESS:

- Annual enrollment in JH HealthQuest
  - 2012 = 3,413

LAGGING INDICATOR JH WILL USE TO IDENTIFY IMPROVEMENT

- Reduction in the percent of Johnston residents adults aged 18 and older self-report that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight)
  - Johnston 2012 = 35.45% http://assessment.communitycommons.org

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Smithfield Recreation and Aquatic Center	600 Booker Dairy Rd Smithfield, NC	919.934.1408
Johnston County School System	PO Box 1336 Smithfield, NC	919.934.6031
Gold's Gym	11694 US 70 Business Clayton, NC	919.359.1300
YMCA of the Triangle	951 Heather Park Drive Garner, NC	919.773.3621
Curves	1252 N Bright Leaf Blvd Smithfield, NC	919.938.3115
Clayton Fitness	1370 Cameron Way Clayton, NC	919.359.6060
Four Oaks Fitness Center	305 N Main Street Four Oaks, NC	919.963-2583
Fit for Life	101 Professional Court Garner, NC	919.772.9900
Woodall's Fitness Studio	34 Oleander Dr Clayton, NC	919.553.0700
Body Fit	259 Venture Dr Smithfield, NC	919.934.7554

8. MATERNAL AND INFANT MEASURES – Unfavorable rate compared to US and Peers for PREMATURE BIRTHS (<37 weeks) and NO CARE IN FIRST TRIMESTER; Some

concern as rate exceeds US or Peer avg. for BLACK NON-HISPANIC INFANT MORTALITY and NEONATAL INFANT MORTALITY and BIRTHS TO WOMEN UNDER 18; Favorable rate comparisons for LOW BIRTH Wt. and VERY LOW BIRTH Wt. and BIRTHS to WOMEN AGE 40-54 and BIRTHS to UNMARRIED WOMEN and INFANT MORTALITY and WHITE Non HISPANIC INFANT MORTALITY and HISPANIC INFANT MORTALITY and POST-NEONATAL INFANT MORTALITY; Teen birth rate above NC and US average

Problem Statement: Teen birth rate needs to decrease

JH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- JH emergency services and outpatient diagnostic services
- JH education programs

JH DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASON(S):

- Need is addressed by other facility or organization

ANTICIPATED RESULTS FROM JH IMPLEMENTATION PLAN

- None

LEADING INDICATOR JH WILL USE TO MEASURE PROGRESS:

- None

LAGGING INDICATOR JH WILL USE TO IDENTIFY IMPROVEMENT

- Lower the percent of pregnant women in Johnston County not seeking prenatal care during their first trimester from
  - 2008 = 18.6%

http://wwwn.cdc.gov/CommunityHealth/MeasuresOfBirthAndDeath.aspx?GeogCD=37101&PeerStrat=14&state=North%20Carolina&county=Johnston

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Johnston County Health Department	517 N Brightleaf Blvd Smithfield, NC	919.989.5200
Johnston County Department of Social Services	714 North Street Smithfield, NC	919.989.5301
I Choose Pregnancy Support Services	540 NC 42 Clayton, NC	919.585.4353

In His Hand Pregnancy Support Center	13 Dail Street Smithfield, NC	919.989.9897

Other Needs Identified During the CHNA Process Presented in Rank Order of Need

9. PRIORITY POPULATION – Local Experts cite Children, Hispanic, Elderly and Uninsured specifically noted as having greater needs than others; 15.2% of residents and 21.8% of children, both below NC average, live in poverty; +Use newly developed technologies to connect patients with circle of care providers (hospitals, doctors, family, neighbors, church, etc). Target those areas indicated by items 13 (Palliative & Hospice Care) & 9 (Priority Populations) above.
10. ALCOHOL ABUSE inc. prescription drugs – Heavy Alcohol consumption above NC avg; Excessive drinking above NC and US average; abuse and addiction of prescribed and illegal drugs
11. PREVENTION – residents are better than average health, Johnston ranks 30 (best being #1) Premature Death present longer survivability on average for NC, but worse than US rate; Poor or fair health and Poor physical health days values exceeded both NC and US values; Health Factors Johnston County ranks better than average; Children in poverty, Inadequate social support, Children in single-parent households, at NC average but do not achieve US average + Collaborate & partner with providers of technologies identified above, rather than invent a new department to accomplish this.
12. DENTAL – Local experts cite dental as a secondary concern among disadvantaged; Federal dental shortage area; Dentists inadequate supply compared to NC and US average
13. PALLIATIVE CARE & HOSPICE – Palliative Care does not exist in County; Hospice Care does exist +Use newly developed technologies to connect patients with circle of care providers (hospitals, doctors, family, neighbors, church, etc). Target those areas indicated by items 13 (Palliative & Hospice Care) & 9 (Priority Populations) above.
14. STROKE – 4th cause of death, at expected rate, ranks #72 (#1 = worst), above NC average; Death rate above US average; Blacks significantly higher, White above average, Hispanic rate below average and Asian / Pacific Islanders significantly below average death rates; Unfavorable rate compared to US and Peers for STROKE
15. SMOKING / TOBACCO USE – Adult smoking above NC and US average; above average percent of residents use tobacco.
16. KIDNEY – 9th cause of death, significantly higher than expected, rank #51 (1st = worst), below NC average

17. ACCIDENTS – 3rd cause of death, higher than expected, ranks #52 in NC (#1 = worst), above NC average; Unfavorable rate compared to US and Peers for Motor Vehicle Injuries; Favorable rate comparisons for Unintentional Injury; Motor vehicle crash death rate above NC and US average
18. CHOLESTEROL (HIGH) – beneficial finding for 20% of pop
19. LUNG – 5th cause of death, at expected rate, rank #52 (#1 = worst), above NC average; Local experts cite disease a secondary concern among disadvantaged
20. CHRONIC COPD / (LUNG DISEASE) / PULMONARY – beneficial finding for 5% of people
21. ALZHEIMER'S – 8th cause of death, at expected rate, ranks #68 (#1 = worst), below NC average
22. FLU / PNEUMONIA – 7th cause of death, at expected rate, ranks #45 (#1 = worst), above NC average
23. QUALITY – A Lower order of priority concern among Local Experts
24. HOMICIDE – some concern as rate exceeds US or Peer average; violent crime rate excessive
25. CHRONIC OSTEOPOROSIS (bone disease) – beneficial finding for 9% of population
26. PHYSICAL ENVIRONMENT – No pollution concern; Physical Environment metrics better than average for NC; Access to recreational facilities is lower than NC and US (undesirable)
27. SEXUALLY TRANSMITTED DISEASE – Sexually transmitted infections ranked below NC but above US average
28. BLOOD POISONING – 10th cause of death, significantly higher than expected, rank #53 (1st = worst), slightly below NC average
29. LIFE EXPECTANCY / PREMATURE DEATH – Life expectancy increased but men improved faster than women; Social and Economic factors are positive

Overall Community Need Statement and Priority Ranking Score:

<u>Significant Needs Where Hospital Has an Implementation Plan</u>

1. AFFORDABILITY and Accessibility
2. CORONARY HEART DISEASE
3. DIABETES
4. CANCER
5. PHYSICIANS
6. MENTAL HEALTH / SUICIDE

7. OBESITY/OVERWEIGHT

Significant Needs Where Hospital Did Not Develop an Implementation Plan[23]

8. MATERNAL AND INFANT MEASURES

Other Needs Where Hospital Developed an Implementation Plan

(none)

Other Needs Where Hospital Did Not Develop an Implementation Plan

9. PRIORITY POPULATION including technology use connecting patients & providers
10. ALCOHOL ABUSE inc. prescription drugs
11. PREVENTION inc. collaboration to connect patients with providers
12. DENTAL
13. PALLIATIVE CARE & HOSPICE inc. technology connect patients & providers
14. STROKE
15. SMOKING / TOBACCO USE
16. KIDNEY
17. ACCIDENTS
18. CHOLESTEROL (HIGH)
19. LUNG
20. CHRONIC COPD / (LUNG DISEASE) / PULMONARY
21. ALZHEIMER'S
22. FLU / PNEUMONIA
23. QUALITY
24. HOMICIDE
25. CHRONIC OSTEOPOROSIS (bone disease)
26. PHYSICAL ENVIRONMENT
27. SEXUALLY TRANSMITTED DISEASE
28. BLOOD POISONING
29. LIFE EXPECTANCY / PREMATURE DEATH

[23] Reference Schedule H (Form 990) Part V Section B 7

APPENDIX

Appendix A – Area Resident Survey Response[24]

A total of 14 local expert advisors participated in an online survey offering opinions regarding their perceptions of community health needs. The following is an analysis of their responses:

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

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

Specific verbatim comments received were as follows:

- From the Hispanic perspective, the alcohol and depression is a common among immigrants
- Affordability of healthcare and third party coverage for indigent and low income individuals. These issues prevent health professionals from reaching a significant portion of the

[24] Responds to IRS Schedule H (Form 990) Part V B 1 h

population with basic, proactive services for health maintenance and prevention, and forces much of health care into crisis treatment.

- Too many of our residents are without health insurance and do not have access to a doctor.
- There are two areas which I think are cause for concern. The first is a lack of providers willing to add more Medicaid and Medicare patients to their practice. Many practices have capped their quota of low income and/or non-insured families. The second issue is a lack of quality mental health providers. The public isn't aware of mental health services that are available to them.
- Diabetes
- The number of uninsured and underinsured patients. This is the same problem of course that confronts communities everywhere. Worried about the decision of our state legislature not to expand Medicaid.
- Mental Health and Substance Abuse services. With federal and state changes services are not as available and accessible as they once were. 90% of the child welfare cases deal with substance abuse and domestic violence. The children and their families we serve have significant mental health issues. The lack of substance abuse and mental health services are impairing our ability to assist families to remain together. Reunification efforts for our foster children and their families are being damaged by the lack of services. We are guardians of the person for 36 adult mentally ill adults. 24 hour care coordination is a significant issue at times for these individuals.
- Lack of Access to healthcare resulting in untreated chronic diseases and use of the Emergency Room for nonemergent care.
- Affordable access to medical, dental and behavioral health services
- Affordability of health care
- From my perspective, our county must better prepare itself for the increased demand that is resulting from the baby boomer generation entering their senior years at a rate faster that historic funding levels can support.
- Lack of specialty care resources primarily for those who are uninsured.
- Childhood Obesity, Mental Health issues especially among youth; ADD, ADHD, many health issues not being diagnose in early stages due to a lack of awareness or insurance
- Quality health care and ability to deliver it to the people of this community/county.

Our second question to the local experts was, "Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e., people with certain situations), which need

help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what."

The responses generated the following image:

Specific verbatim comments received were as follows:

- Diabetes and heart problems are also illnesses to be taken into consideration among the Hispanic population
- As explained in question 2, I believe assuring healthcare for the uninsured, low income population is the major need in this community. Since my agency is the mental health/substance abuse authority for the county, I will speak to that area. A high percentage of those with substance abuse issues fall into the category of having no resources to cover treatment of any kind. The relatively small amount of state and federal funding for indigent/uninsured does not nearly cover the need for services to this population. Additional funding through the state or federal sources is needed until such time that these individuals qualify for Medicaid or similar "insurance" coverage.
- There is a high rate of diabetes, obesity and heart diseases in the county among minorities. The Federal and State Government should make available low cost insurance as well increase the Medicaid budget.
- Diabetes continues to increase in our young children. Our service area needs a pediatric endocrinologist to assist these families. Early and proper management of this disease will prevent many long term ill-effects. Mental health for our young and old is also needed. The

Mental Health Society and other groups need to increase consumer awareness of local providers and their services.

- None that we have not identified and are already addressing.
- The primary disease states that affect our community include hypertension, diabetes, and coronary artery disease. These are particularly challenging to treat in the uninsured population.
- There is a significant population of uninsured individuals in our community. Many are undocumented immigrants. Medicaid only pays for emergency services as defined by the state and federal government. This appears to result in a disproportionate utilization of the emergency department for primary care services. Many substance abusers and mentally ill who don't have any sort of health coverage use the emergency department in an effort to get access for services.
- Uninsured and low income persons have needs for access to primary care and specialty care. This is also an issue for Medicare and Medicaid recipients as many providers limit the percentage of Medicare and Medicaid clients due to reimbursement concerns. The county has a significant percentage of Latinos with similar issues. As a county, we need to recruit to expand the number of providers and services available to the community.
- Heart and Pulmonary disease, Diabetes, Obesity, Dental Health, Substance Abuse Treatment and Rehabilitation, Behavioral Health needs are identified as concern for uninsured and insured populations in county. HIV/AIDs prevention, detection and treatment needs to be address for all populations. Collaborative efforts between Hospital, FQHC Community Health Center and Public Health, Local Management Entity for Behavioral Health, other supporting Non profits and Private healthcare entities working together to develop a comprehensive care and compliment services.
- Access to affordable health care is a concern of all the above mentioned groups. More access for preventive care is a need.
- Of the elderly population that we serve, many of whom are also low-income; I am concerned about malnutrition, disease, and injuries that may go undetected on a timely basis. I am also concerned that our county does not coordinate all of its resources among agencies as well as it should. Example, Johnston County is one of the few counties in the Triangle-J region that does not have an 'aging plan'.
- The lack of specialty care physician services.
- Yes, among minority groups, the uninsured and low income groups the lack of preventive care often means they are diagnose with an illness or disease usually after it has progress to a serious stage. These groups normally end up in the emergency or have the symptoms over an extended period of time before seeking medical care. The medical community, insurance

companies, and Health Department has addressed this issues, however many from this group often do not take advantage of preventive care. Health care professionals should continue stressing the importance of preventive care and offering opportunities among this population, to include Health Fairs and pamphlets at local business. Many youth are affected and are among those suffering from illnesses or diseases that may have been preventive. Childhood obesity is among one of the largest health care issues facing our youth, and it leads to many other health issues. Many of the people in the groups aforementioned can't afford the food that makes a healthy diet. The school system has addressed this issue by providing healthier meals and this should be promoted throughout the county through agency that serves families. Youth diagnose with ADHD and behavioral problems are a major health concern, and the number of using needing medication. The Health Department should probably be the lead agency, but all entities of our health care system should be proactive in remedying the problem.

- Too often, the Emergency Department has been used as a "Dr. Office" for those who are uninsured. My family has been frustrated with ability to get assistance with so many there with what appear to be minimal needs. I know Project Access is just starting up. Hope it does well. Somehow, there needs to be a way to get minor needs met, but not in the ED. Another Concern: Don't see why we do heart caths if the hospital can't also do stents. Makes no sense to do heart cath here and have to go somewhere else to do it all over again for a stent. Also think hospital needs to be able to give realistic bills for work done in the ED. Several years ago, my son needed two staples in his scalp. We tried to get into two Urgent Care centers before going to Johnston Health. After three hours we saw the Dr. and got two staples in his scalp. No x-rays, just an observation and fix it. The bill was $325 for that. I questioned the hospital about the bill. Was told that the hospital contracts out the services for its Emergency Personnel. I know there is a fee for use of the facilities (~$80), but the remainder for what was done was way out of line. If the hospital wants to have a better image, it needs to get fees in line (my opinion, but also held by many others.)

Appendix B – Process to Identify and Prioritize Community Need[25]

Community Health Need Topic	Total Points Allocated	Number of Local Experts Allocating Points	Cumulative Percentage of Points	Break Point From Higher Need	Need Determination
1. AFFORDABILITY	142	12	9.5%		SIGNIFICANT
2. CORONARY HEART DISEASE	131	13	18.2%	11	
3. DIABETES	121	14	26.3%	10	
4. CANCER	121	12	34.3%	0	
5. PHYSICIANS	108	14	41.5%	13	
6. MENTAL HEALTH / SUICIDE	101	12	48.3%	7	
7. OBESITY/OVERWEIGHT	73	11	53.1%	28	
8. MATERNAL AND INFANT MEASURES	65	12	57.5%	8	
9. PRIORITY POPULATION inc technology use connecting patients & providers	65	7	61.8%	0	Other Identified Needs
10. ALCOHOL ABUSE inc. prescription drugs	62	9	65.9%	3	
11. PREVENTION inc. collaboration to connect patients with providers	60	11	69.9%	2	
12. DENTAL	56	11	73.7%	4	
13. PALLIATIVE CARE & HOSPICE inc. technology connect patients & providers	48	6	76.9%	8	
14. STROKE	42	9	79.7%	6	
15. SMOKING / TOBACCO USE	39	9	82.3%	3	
16. KIDNEY	34	9	84.5%	5	
17. ACCIDENTS	30	8	86.5%	4	
18. CHOLESTEROL (HIGH)	30	8	88.5%	0	
19. LUNG	23	9	90.1%	7	
20. CHRONIC COPD / (LUNG DISEASE) / PULMONARY	22	7	91.5%	1	
21. ALZHEIMER'S	20	7	92.9%	2	
22. FLU / PNEUMONIA	19	7	94.1%	1	
23. QUALITY	18	5	95.3%	1	
24. HOMICIDE	15	6	96.3%	3	
25. CHRONIC OSTEOPOROSIS (bone disease)	13	6	97.2%	2	
26. PHYSICAL ENVIRONMENT	13	5	98.1%	0	
27. SEXUALLY TRANSMITTED DISEASE	11	5	98.8%	2	
28. BLOOD POISONING	9	5	99.4%	2	
29. LIFE EXPECTANCY / PREMATURE DEATH	9	5	100.0%	0	
Total	1,500	15			

Note Need statements presented in capital letters originate from data analysis. Need statements presented in lower case type originate from local expert opinions.

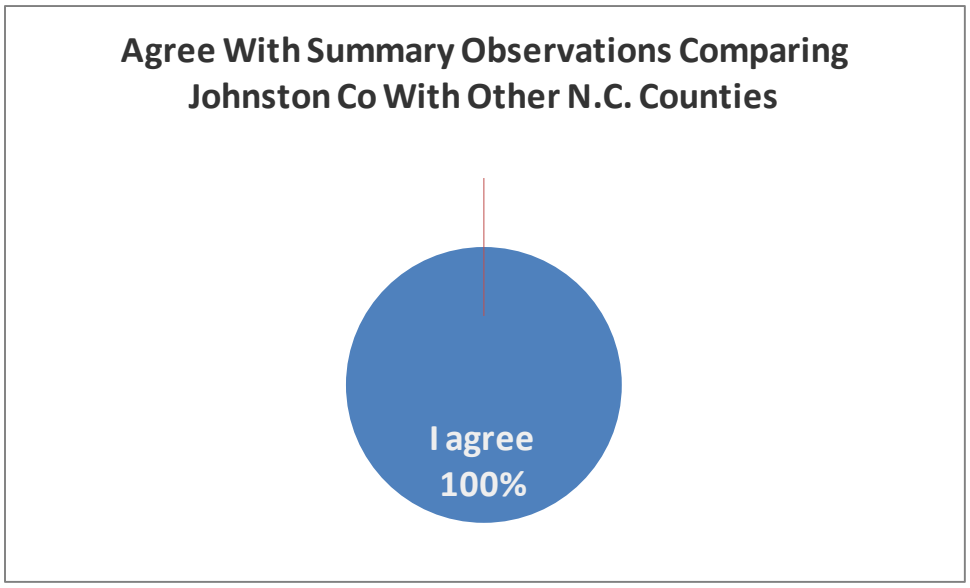
Individuals Participating as Local Expert Advisors

Count	Organization	Title	Area of Expertise
1	Horizon Family Medicine	physician	local physician and long time resident of the county
2	Partnership for Children	Executive Director	Non-profit
3	Johnston County Department of Social Services	Director	Public Assistance. Child Welfare. Adult Welfare. Aging services.
4	N C House of Representatives	Member for District 28	Elected official for 17 years
5	Johnston County Mental Health	Area Director	mental health, substance abuse and intellectual/developmental disability services and employed in county agency for 37 years
6	County of Johnston	County Commissioner	banking and long-term resident
7	First Baptist Smithfield	Pastor	minister
8	Johnston County Schools	Lead School Nurse	public health - school nurse
9	Stephenson General Contractors	President	Long term area resident
10	Boys & Girls Club	Director	Youth Development Professional
11	Johnston County Health Department	Health Director	Public Health
12	Community & Senior Services of Johnston County, Inc.	Executive Director	Human services to senior citizens
13	CommWell Health	CEO	Non Profit Healthcare and Federally Qualified Community Health Center Leader
14	Civic Leader	None	Long term area resident
15	Catholic Church	Pastor	Councelor
16	Johnston County Industries	President	persons with disabilities
17	Benson Area Medical Center, Inc	CEO	primary care

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

Advice Received from Local Experts

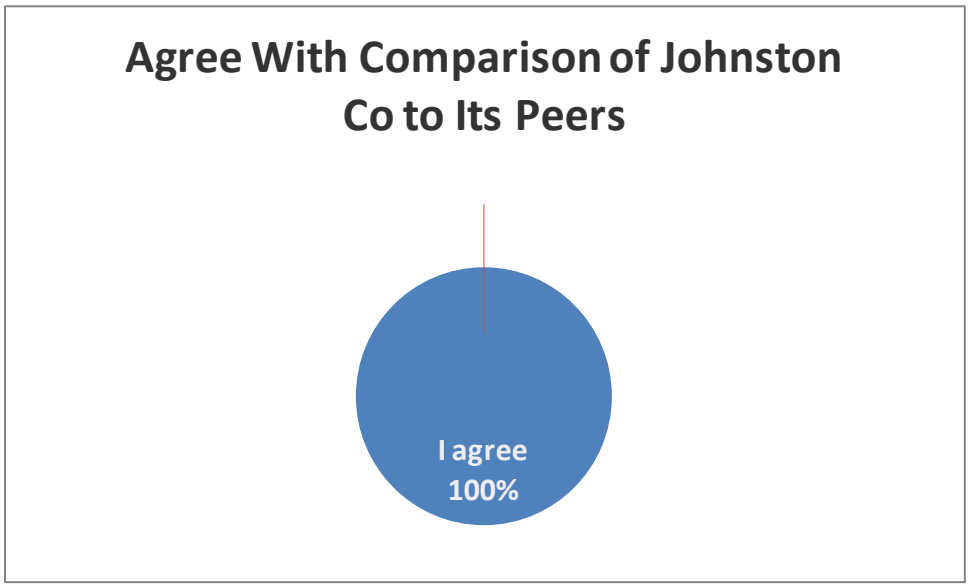
Q. Do you agree with observations formed about the comparison of Johnston County to all other North Carolina counties?



Clarifying Comments:

- Statically Johnston County does not rank well compared to State statistics and well below national statistics. According to info provided to me thru unofficial sources, Johnston County ranks among the State & Nations highest in heart attacks. If so, we need to expand heart treatment capability. We now have "cath" lab. Need heart surgery ability.
- The observations seemed to fit with the state of the families that I have contact with through in my workplace.
- Abuse of prescribed and illegal drugs should be included.

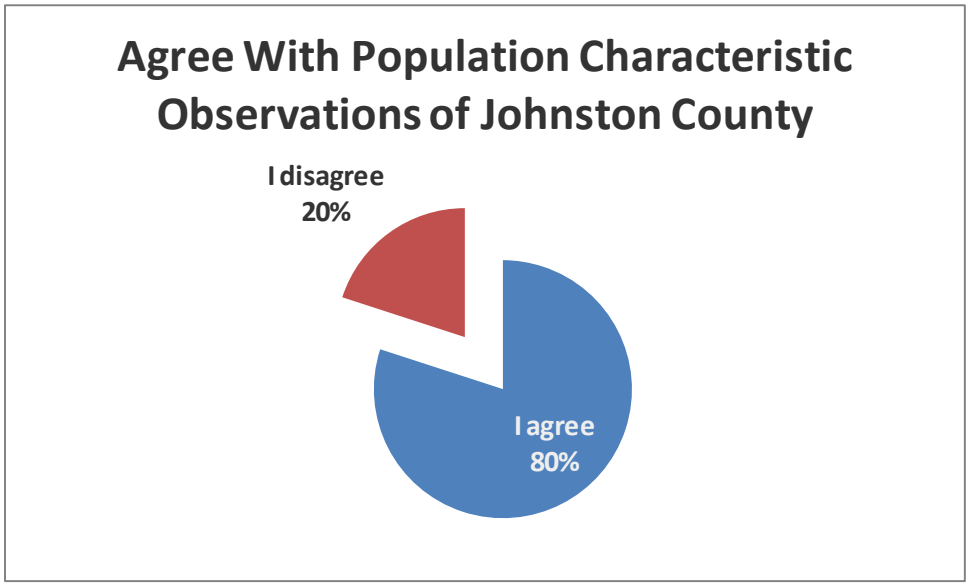
Q. Do you agree with observations formed about the comparison of Johnston County to its Peer counties?



Clarifying Comments:

- The problem areas seem to be concentrated in minority population. Poor eating habits, a product too often, of poverty coupled with bad life style choices and lack of knowledge of healthy conduct skews the unfavorable in this community. As a long-time activist in minority communities, I am very aware of many of the reasons for ill-health in that community and the role of culture in many of these wrong choices.
- The lack of knowledge in some of these areas and some a lack of education. Not enough preventive care or early detection.

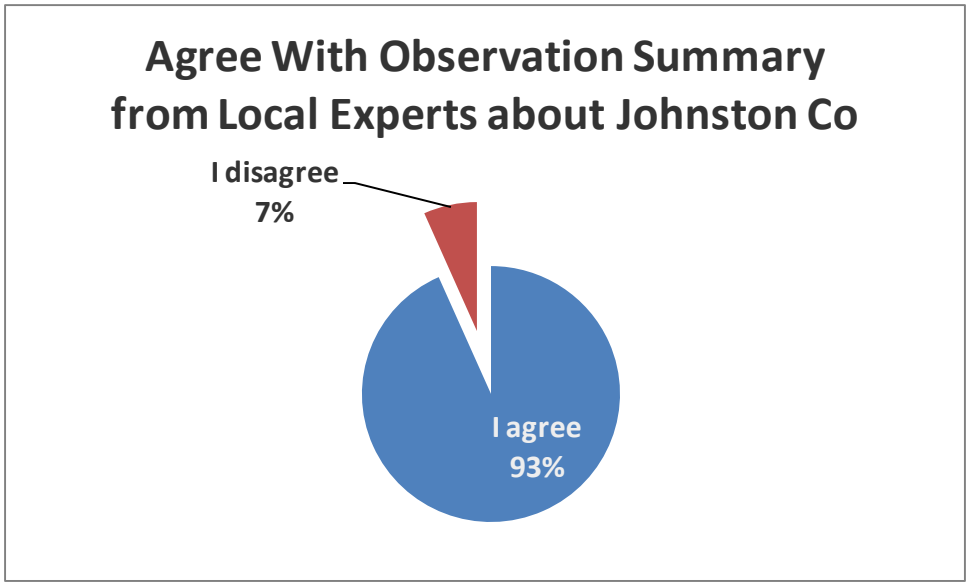
Q. Do you agree with observations formed about population characteristics of Johnston County?



Clarifying Comments:

- I am actively involved in the medical community for the past 20 years with development and construction of diverse health care facilities and organizations. Some of the statistics do not agree with data provided unofficially by health-care providers. Frequently they support conclusions with reading material which I voraciously devour. I do not purport to have any expertise in health care matters, but do generally accept what I am told by those actually practicing health-care.
- The population is currently @175,000. What were the data sources used for the comparisons?
- Many are not eating healthy diet, mostly due to cost; also more children/families are eating fast food and junk food.
- From my perspective, the above seem to be consistent with what I see.

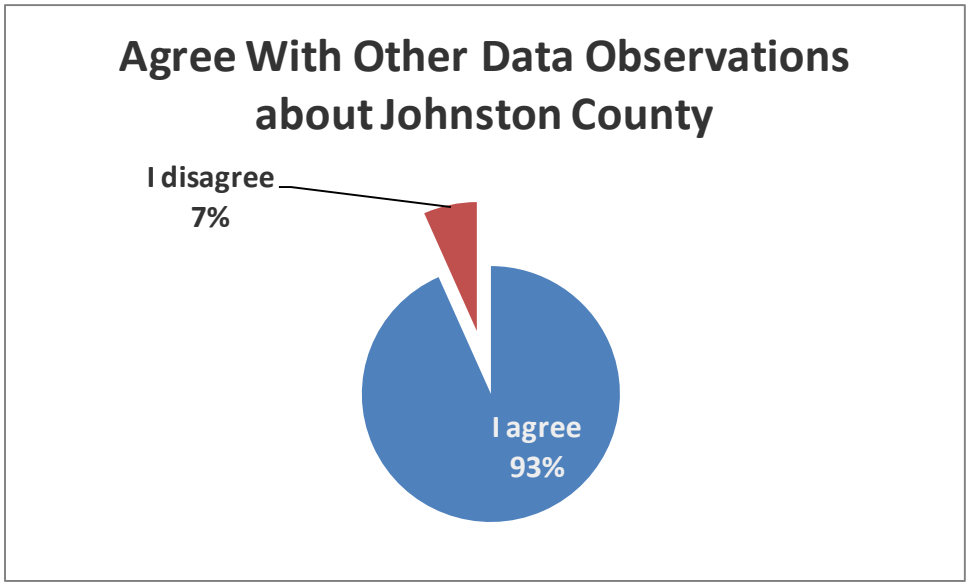
Q. Do you agree with observations formed about the opinions from local residents?



Clarifying Comments:

- Higher needs population, especially minority populations, must be better educated on preventive health care. A new program has recently been commenced by an individual in Smithfield-Selma communities to encourage and educate total community, but concentrated in minority population to encourage healthy exercise and good eating habits. The purpose is to focus on obesity, diet and to improve community relations. A noble purpose and cause.
- I have noticed that many people do not take advantage of preventive care, or they wait until a problem or concern is so great that it is diagnosed at a later stage.

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



Clarifying Comments:

- I am not sure how the determination of "food deserts" is determined. Except for the most rural areas, all of our towns have access to quality grocery stores. I would question this statistics.
- Lack of education and awareness of health risk and precautions and the importance of early detection is a key problem especially in some peer groups.