COMMUNICATION MARK

Examples of Needs Sections

(some details changed to protect confidentiality)

Example 1

Community health care need the project addresses

Many new mothers with low incomes in Jefferson County, TN, lack the necessities to properly care for an infant upon leaving the hospital. Some mothers do not have approved car seats to safely transport their newborns home. According to the obstetric nursing staff at Jefferson County Hospital (JCH), more than 50% of JCH's homeward-bound new mothers do not have adequate infant care supplies at home. Due to a lack of income and parental education, mothers lack infant clothing, diapers, blankets, nursing and bathing supplies to properly care for their newborns. During the past year, JCH nurses have contributed more than $500 of their own pay so that new mothers go home with the items that they and their babies need.

The target population the project will serve including age, county of residence and other relevant demographic data

The project will serve female residents of Jefferson County who are of child-bearing age. In Jefferson County, there are 7,401 women ages 15 through 44. Jefferson County residents are 97.7% Caucasian, .3% African-American, .3% Asian, .3% Native American, .3% some other race and 1.1% are two or more races. Only Jefferson County residents with low incomes who are Medicaid-eligible or uninsured will be able to participate in the program.

In Jefferson County, 23.2% of the 40,716 residents have incomes below poverty level, compared to 13.8% nationwide and 16.5% in Tennessee (US Census). According to the Robert Wood Johnson Foundation 2012 County Health Rankings, 35% of Jefferson County children (less than 18 years of age) live in poverty compared to 26% statewide, and 58% are eligible for free lunch programs.

In March 2012, the county had a 10.9% unemployment rate compared to 7.9% statewide. Many residents live in government-subsidized housing, and approximately 34% of the residents in JCH's service area are Medicaid-eligible. A few years ago, 40,000 people in the JCH service area lost health insurance when the State of Tennessee implemented dramatic budget cuts to TennCare, its public insurance program.

Many new Jefferson County mothers are young, single parents. The teen birth rate in Jefferson County is high. According to County Health Rankings, 70 of 1,000 women ages 15 through 19 had children, compared to 55 per 1,000 statewide and 22 per 1,000 nationwide. Six percent (6%) of Jefferson County households are headed by single females with their own children who are less than 18 years of age (2010 US Census).

The number of people project is expected to serve directly

JCH expects to serve at least 280 Jefferson County mothers during the 5-year project. JCH expects to serve approximately 56 new mothers and their infants every year.

Example 2

SECTION B: Program Concept & Supportive Services Plan

a) *Estimate the need for Supportive Services for Veteran Families (SSVF) services. Include the basis for this estimate, highlighting areas of unmet need (for instance, overall numbers of homeless or at-risk Veteran families might be relatively low, but there may be few available services to meet these needs). How many household participants do you expect to serve?*

According to the *American Community Survey* (ACS) 2010 estimates **154,075 Veterans** live in the 10-county area served by the proposed project (3-year sample). Since the 2010 VA Annual Homeless Assessment Report (AHAR) indicates that 1 out of every 150 Veterans are homeless, ABC Organization estimates that there are **1,027 homeless Veterans** in the area. The Charlotte-Mecklenburg Continuum of Care (which represents the largest county in NC) 2012 Point in Time (PIT) count identified 373 Veterans in the area, a 50% increase from the 2011 count (248). ABC Organization calculates that **25,052 very low-income Veterans** [households with incomes below 50% of HUD Median Family Income (MFI)] live in the area to be served. This figure was calculated by comparing each county's HUD MFI, ACS data on the total Veteran population, and ACS data on household income. The Homelessness Research Institute and the National Alliance to End Homelessness have calculated the number of Veterans at risk of homelessness ("Vital Mission: Ending Homelessness Among Veterans," Nov. 2007 – pre-recession). The report illustrates that 2% of Veterans are not homeless, but are at-risk for economic reasons. **Thus, ABC Organization estimates that at least 501 households are at risk (2% of 25,052).** Mattie Shoreland, the coordinator of the Health Care for Homeless Veterans (HCHV) program at the VA Medical Center in Lincolnbury, NC, reports that more Veterans services are needed in Cleveland, Lincoln, Gaston, and Catawba Counties. A 2011 assessment of the local support network for Veterans and their families, funded by Foundation For The Carolinas, indicates that current supportive services do not meet the needs of Mecklenburg County's growing Veteran population. The assessment included interviews with over 30 agencies and focus groups held with a variety of Veteran groups. The greatest unmet service needs concern employment, behavioral health, and family supports. Goodwill's Operation Independence (OI) data confirms that employment is a critical need for Veterans. The 2010 CHALENG Report states that "Currently, many homeless Veterans find that their ability to move into permanent housing is compromised by old fines, debts, and other legal judgments related to non-payment of child support." Due to Veterans' legal obstacles, ABC Organization has chosen to subcontract services to LSSP. LSSP's staff will help Veterans resolve legal issues that might impede securing or sustaining permanent housing. The CHALENG Report reinforces the importance of legal services, stating that "Legal assistance around the issue of child support is one key to helping Veterans meet their obligation to society, while still having the means to avoid relapsing to homelessness." Through HVPR, ABC Organization and its subcontractors will address seven of the ten unmet needs identified by the VA and Community Partners. Those needs are long-term, permanent housing (7th), credit counseling (6th), help managing money (9th), legal assistance (for child support, outstanding warrants and fines, and helping to restore a driver's license - 2nd, 3rd, and 5th), and child care (1st).

Example 3

Statement of Need

Poverty and negative health outcomes are widespread in Leland County. A 2004 report from the New York Academy of Medicine states that "low-income children have fewer physician visits, less continuous care, less timely preventative care, and lower levels of primary health care utilization services." The Leland County Board of Education reports that 66.43% of students at the four elementary schools receive free or reduced lunch and 67.44% are on Medicaid. Additionally, 4.03% of students at the four schools (50 students) are uninsured.

The U.S. Census reports that 23.2% of people live below the poverty level in Leland County, compared to 18.1% in Kentucky and 14.3% in the United States. The median household income is $29,050 - compared to $42,248 in KY and $52,762 in the United States (U.S. Census, 2007-2011) - and 42% of adults are enrolled in Medicaid. Kentucky State Health Facts also states that 27% of adults in Leland County forgo medical treatment due to costs, versus 18% in Kentucky. In 2001, the Robert Johnson Wood Foundation concluded, based on a long-term longitudinal study, that "low income, not race or lifestyle, is the greatest threat to health."

Thirty-percent (30%) of youth smoke, compared to 25% in Kentucky and 23% in the United States, and the teen birth rate is 54.6, compared to 52.1 in Kentucky (Kentucky Health Facts, 2013). Additionally, 39% of adults are missing six or more teeth (Kentucky Health Facts, 2013). Leland County ranks 99th out of 120 counties in resident health, according to the 2013 County Health Rankings. The rates of asthma, diabetes, and heart disease in adults are all higher than the Kentucky and United States averages.

The student population at the four site schools will increase by an estimated 174 students during the 2013-2014 school year (from 1,231 to 1,405 students). Due to growing drug problems and other negative influences by high school students, all 8th grade students will be moved from the high schools to the elementary schools. This will increase the need for medical supplies provided by DEF Organization and staff time for purchasing supplies and coordinating services. Based on data from the 2011-2012 school year, 80% of students receive medical services at the School Based Health Centers (SBHCs). Therefore, it is estimated that medical supplies will be needed for an additional 139 students.

Leland County has only three pediatricians, a high resident to primary care provider ratio, and other barriers that prevent parents or guardians from accessing healthcare. The *Annals of Family Medicine* reports that "Barriers to health care can be insurmountable for low-income families, even those with insurance coverage. Patients who do not seek care in a family medicine clinic are not necessarily getting their care elsewhere" (2007). According to a 2011 estimate by the U.S. Census, there are 1,719 youth between the ages of 5-18, making the ratio of youth to pediatricians 1:573. Additionally, County Health Rankings reports that the overall ratio of primary care physicians to residents is 1:2,315, compared to 1:1,232 in KY, and 1:631 in the United States. Due to the high rate of poverty, additional barriers include the cost of transportation and ability for parents and guardians to miss work to take youth to a medical or dental appointment. Furthermore, staff at the school report that many students live with grandparents, aunts, uncles, or other family members and that many of these households are unstable and unsupportive (due to factors such as poverty and drug abuse). As a result, many parents and guardians do not take youth to medical or dental appointments regularly.

The elementary schools lack physical and health education departments. Due to a lack of community resources, schools cannot afford physical or health education programs or even pay a part-time staff member to offer classes to students. The only health education is offered by Leland Hospital staff with the support of DEF Organization.

Example 4

I. Community Need

Healthcare Needs

- *According to a 2006 report from the North Carolina Institute of Medicine, approximately 7,000 residents of southern Ireland County cannot afford healthcare.*

The report states that 19.9% of local residents ages 18-64 lack health insurance, compared to a statewide rate of 17.5%[1] among those under age 65 (Source: NC Institute of Medicine, 2004 data). These residents are the "working poor" who earn too much to receive Medicaid, but too little (less than 200% of the poverty level) to pay for medical insurance or costs, and do not qualify for Medicare. Most of the individuals in need of free health care hold minimum wage jobs or are migrant workers, and most have 1-2 children.

The number of local residents who need free or low-cost care exceeds the capacity of local providers who will see those without insurance. Due to the high rate of population growth in Ireland County (occurring mostly in the south end), local infrastructure and health services are over-taxed and cannot adequately accommodate many who need services. For example, county health department nurses can currently see as many as 240% more patients than the state average (Source: 2003 Ireland County Health Assessment, Ireland County Health Department). HealthyTime's evening medical clinic is filled to capacity, serving an average of about forty patients within a three-hour period. The population of patients who require assistance from HealthyTime for chronic-care issues continues to grow steadily, forcing the clinic to occasionally turn patients away.

The number of those without medical coverage is likely to continue to increase. HealthyTime primarily serves south Ireland, the part of Ireland County that consists of Jamesville and Mt. Mourne (zip codes 28115, 28117, 28123). Jamesville's population has grown by 125% since 1990, from 9,317 to 20,944. This compares to 32% growth in Ireland County since 1990.

- *Adults without insurance are twice as likely as those with insurance to be in poor or fair health and significantly less likely to access any form of basic care*.

According to The Commonwealth Fund's 2006 *Biennial Health Insurance Survey*, those without health insurance are: (1) more likely to have uncontrolled chronic health conditions, (2) less likely to access preventive and early detection services and thus more likely to be diagnosed with serious conditions such as end-stage cancer; and (3) more likely to have medical-related debt. These trends hold true for HealthyTime's clients. The Commonwealth Fund also found that "an alarmingly high proportion—59 percent—of uninsured adults who had a chronic illness, such as diabetes or asthma, did not fill a prescription or skipped their medications because they could not afford them . . . More than one-third (35%) of uninsured adults who had a chronic condition went to an emergency room or stayed overnight in the hospital in the past year because of their condition—about two times the rate of people with chronic health problems who were insured all year."

[1] As a point of reference, the rate of the uninsured in NC is growing at a faster rate than in most of the rest of the country, and the state has the nation's 8th highest rate of uninsured people.

The Behavioral Risk Factor Surveillance System (BRFSS) found that the total percentage of adults with diabetes in North Carolina has risen from 4.7% in 1994 to 8.4% in 2005 (data adjusted for incidence of disease with age). Heart disease is the leading cause of death in Ireland County and occurs at a rate 14.0% higher than the rest of North Carolina. Diabetes is the seventh highest cause of death in Ireland County, and diabetes is a major contributor to heart disease and stroke; as many as 70% of those with diabetes will die from heart disease (Source: 2003 Ireland County Health Assessment, Ireland County Health Department). For those with chronic conditions that require daily maintenance, such as diabetes, the challenges of being uninsured are particularly acute. Failure to monitor blood sugar can result in damage to organs and in the extreme lead to diabetic shock, amputations, coma, blindness, and death. However, the cost of such tests and treatment is prohibitive for Ireland County's low-income, uninsured residents.

Approximately 45% of HealthyTime patients are minorities, primarily African-American and Latino, compared to a combined presence in the county at less than 20%. According to the County's 2003 Community Health Assessment, Ireland County death rates for minorities are higher than for Anglo-Americans for heart disease (1.2 X), stroke (1.5 X), breast cancer (1.9 X), pancreatic cancer (1.2 X), prostate cancer (4.7 X), diabetes (2.2 X), liver disease (2.0 X), septicemia (1.7 X), kidney disease (2.0 X), and HIV (11.3 X). This correlation is attributed socio-economic factors such as low income and a lack of medical insurance. Latinos in Ireland County have a greater unmet need for healthcare than other populations, according to HealthyTime experience and *The North Mecklenburg/South Ireland Assets and Needs Assessment Report, 2002,* issued by the United Way of Central Carolinas.

Dental Needs:

- *South Ireland County residents have limited access to dental care and are frequently unable to obtain the care they need, leading to a variety of health problems.*

"Limited access to affordable dental care is a major problem in Ireland County", according to *the county's Community Health Assessment.* "A lack of dental care…for…adults often results in severe or persistent pain, inability to eat, swollen faces and increased susceptibility to other medical conditions," according to a special report issued by the North Carolina Institute of Medicine Task Force on Dental Care Access. In 2006, the United Way of Ireland County conducted a needs assessment and found that access to dental care is the second-greatest health concern of Ireland County residents. From 2003-2006, there was a 39% increase in the number of patients seen with dental pain from infections and abscesses at the three local hospital emergency departments. The 2003 Community Health Assessment found that 25% of children entering kindergarten 1999 – 2000 had tooth decay.

For those with low incomes, dental care needs are often prioritized after other health needs, either because of a lack of information about the importance of regular dental care or because other issues are more urgent. Thus, dental problems are neglected longer and people typically seek care only after pain has begun. In addition, North Carolina has the nation's 47th lowest ratio of dentists to patients; in some underserved areas there are very few dentists and the demand for dental care usually exceeds the availability of dental services (Task Force Report). The rising incidence of uncontrolled diabetes in North Carolina, which is linked to poor oral hygiene, is causing more patients to seek free dental treatment for serious oral diseases. Periodontitis is a significant risk factor for coronary artery disease (Source: Journal of Periodontology, 2004;75(9):1274-1280). Combined, the above needs exacerbate medical, dental and pharmacological problems experience by southern Ireland County residents.

Example 5

Need for funds

Jefferson Community Hospital estimates that its patients with low incomes miss 2,800 medical appointments and diagnostic tests annually due to a lack of transportation. Approximately 40% of the residents in JCH's service area are Medicaid-eligible and over 80% of the hospital's patients cannot pay for the care that they receive. Additionally, in the past two years, 40,000 people in the JCH service area lost health insurance when the State of Tennessee implemented dramatic budget cuts to TennCare, its public insurance program. Therefore, residents of the JCH service area struggle to pay for both health care and transportation, making the JCH Patient Transport program a crucial service that relieves suffering for many in this rural region of Tennessee. Missed appointments often lead to medical complications and health crises, particularly for patients with chronic conditions such as respiratory diseases, vascular diseases and diabetes. Types of missed appointments include follow-up blood sugar tests for diabetic patients; pre-operative diagnostic tests such as x-rays and MRIs; and stress test exams for cardiology patients. When individuals are finally able to access care, their conditions have often worsened, resulting in poorer health and the need for more costly, time-consuming and intensive procedures. To address this need, JCH developed the free Patient Transport program in 2002.

The population to be helped

With high rates of poverty—19.4% in Jefferson County and 23.1% in Wilford County, compared to 12 % nationally—and no form of public transportation or affordable shuttle service, JCH's service area includes many residents who struggle to find transportation for medical care.

Currently, the Patient Transport Program provides services to approximately 3,800 patients in its two-county service area. Patients range in age from birth to 89 years and their average income is less than $12,000. Many of these individuals live in government-subsidized housing. As a key healthcare provider in the region, JCH accommodates more than 29,000 patient visits a year. Per capita income and poverty rates for Jefferson County, TN, and Wilford County, KY, and the nation are listed below.

Geographic Area	Per Capita Income	% Living below poverty level
United States	$31,472	12.1
Jefferson County, TN (primary)	$21,186	21.6
Wilford County, KY (primary)	$19,372	25.4

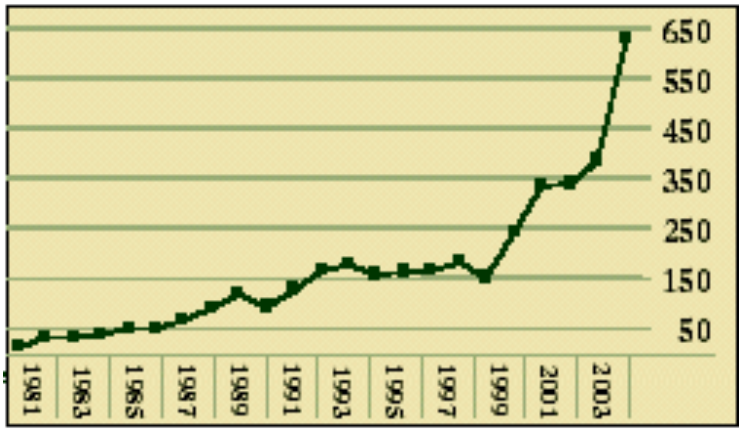
There are also elevated rates of the following conditions within the communities served by JCH: respiratory diseases including Chronic Obstructive Pulmonary Disease and Black Lung; vascular disease; diabetes; and obesity. The high incidence of Black Lung is a result of the significant number of local residents who were once employed in the coal mining industry. Disabilities are also disproportionately high among residents of these communities. The following statistical snapshot is based on US Census 2000 figures:

Geographic Area	People with Disabilities	Total Population	%
United States	89,142,962	281,941,906	31.6
Jefferson County, TN	25,106	39,854	63.0
Wilford County, KY	21,791	35,865	60.8

Example 6

1. Services provided and persons served: (Discuss fluctuations in demand for your programs and services. If there is a decrease in the number of people served or enrolled in your programs, provide a detailed plan to stabilize this trend.)

As the chart below illustrates, demand for our services has increased rapidly in recent years.



Patients Served

This trend in growth has continued during the past year. For instance, from July 30, 2004, to the first week of October, our number of hospice patients alone rose from 85 to 125, a 47% increase. In August 2004, we served 72% (68 of 95) of total deaths that occurred in Thompson County with Hospice In-home Care and Palliative Care. By contrast, the national average for Hospices is 25%, and North Carolina's average is 23%.

In addition to our Hospice In-home Care, which provides end-of-life services to the terminally ill, and Miller House, our 12-bed inpatient facility that serves those who are without a capable caregiver or need acute symptom management, our other established programs include: Heart Songs, which provides outreach bereavement support to children; Palliative Care, for chronically ill patients who do not yet meet Medicare requirements for hospice services; and the Watchman Program, our collaboration with places of worship to educate their congregations about hospice services. The Watchman Program has consistently collaborated with 40 area places of worship over the past five (5) years.

In FY 2002, we expanded our community outreach efforts, and since that time have experienced a substantial increase in the number of persons served by our Hospice In-home Care and Miller House, as detailed in the table below.

Fiscal Year	*Total Served*
2000	*335*
2001	340
2002	384
2003	627
2004	*709*

2. Identify the key issues facing your field and organization at this time:

The Size and Need of the Local Elderly Population Is Growing Rapidly. The growth of the older adult population in Thompson County is the greatest challenge facing our hospice, as the needs of this primary hospice constituency has exacerbated all of the other challenges faced by Thompson Hospice. **The combined total of patients served in the last four (4) years is greater than the total in our previous 20 years of operation**. In 1999, our agency served an average of 30 people a day. By the end of 2003-2004, we received 780 physician referrals and served approximately 200 patients daily. To achieve this rapid growth, Thompson Hospice has rented a series of new physical locations, leading us to our current dilemma of operating out of cramped quarters at seven (7) different facilities spread across Thompson County.

Our county, which includes Thompsonville and is only a few miles from Cartersville, is at the heart of an area recognized nationwide as a retirement haven (according to AARP, Barron's, Harris Poll, MSN, USA Today and others). Approximately 22% of Thompson County's population is already over 65. This is very significant compared to North Carolina (12% over 65) and the nation (12.4%), according to US Census 2000. By 2020, the percentage of people in Thompson County who are over age 65 is projected to reach 30.5%. In addition, the total population of our county grew 29% between 1990 and 2000 (from 69,285 to 89,173 people).

According to the US Census, North Carolina has the fourth fastest-growing elderly population in the United States after California, Florida and Texas. According to the NC Department of Aging and Adult Services, older adults are our state's fastest growing population, and our western North Carolina region's elderly population is growing the fastest, along with the state's coastal region. Thompson County's elderly population is projected to grow at a rapid clip for many years to come. Thus, the availability of affordable, end-of-life physical, emotional, social and spiritual care is a high priority for local older adults and their families.

Interdisciplinary Care Teams Lack Space and Human Resources Are Scarce. Another industry-wide challenge is the difficulty of attracting, supporting and retaining skilled personnel. Thompson Hospice currently has a 17% annual attrition rate, which is quite low compared to healthcare facilities in general (25%) but is high enough to make consistency of care a constant concern. Thompson Hospice's rapid growth has taxed our physical infrastructure, forcing staff to operate in close quarters and splitting up the staff on our interdisciplinary teams. These factors make stressful hospice work even more challenging for our workers and volunteers, adding to attrition in these areas. Currently we are in need of two (2) more Certified Nurse Hospice nurses, one (1) Homecare Nurse, two (2) additional Certified Nursing Assistants and one (1) Program Director for our facility team. These staff additions will create additional need for clinical services space.

Traditional Hospice Revenue Streams Do Not Fund Palliative Care. A key issue facing the hospice industry is the major paradigm shift in the way our population is dying. As The EPEC Project (Education on Palliative and End-of-life Care) reports, 90% of all deaths are now caused by protracted chronic illnesses. This is a shift from the shorter illnesses of the past, such as heart attacks and infectious diseases.

Our industry has responded to this change by addressing the need for *palliative care,* care that eases the pain of patients who are not ready for hospice care and may still desire to have aggressive treatment of an illness. Medicare and private insurance coverage have not yet adjusted to this change in care, so they do not adequately cover many of our palliative care costs. In time, this trend in coverage is likely to catch up with the realities of care needs, but it is likely that hospices will continue to bear the majority of palliative care costs for several more years. In addition, rural hospices like Thompson Hospice receive less reimbursement than those in urban areas. This fact, combined with the need to sustain palliative care services, has made it necessary for Thompson Hospice to increase its community fundraising and visibility.