Gerald Champion Regional Medical Center

Alamogordo, NM

Community Health Needs Assessment

Adopted by Board Resolution June 29, 2018[1]

Gerald Champion Regional Medical Center
Our Family Caring for Yours

[1]Response to Schedule H (Form 990) Part V B 4

TABLE OF CONTENTS

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Gerald Champion Regional Medical Center ("Gerald Champion" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community.

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

The 2018 Significant Health Needs identified for Otero County are:

1. Access to Primary Care – 2015 Significant Need
2. Behavioral Health – 2015 Significant Need
3. Obesity – 2015 Significant Need
4. Cancer – 2015 Significant Need
5. Diabetes – 2015 Significant Need

The Hospital will develop implementation strategies for these five needs including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

APPROACH

Gerald Champion Regional Medical Center ("Gerald Champion" or the "Hospital") is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA helps the hospital identify and respond to the primary health needs of its residents.

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designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent Schedule H (Form 990) filings made by the hospital.

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

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

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

Project Objectives

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

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

Overview of Community Health Needs Assessment

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

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

---

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

[3] As of the date of this report all tax questions and suggested answers relate to 2017 Draft Federal 990 Schedule H instructions i990sh—dft(2) and tax form

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

- An Emergency Room open to all, regardless of ability to pay
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*

[5] Section 6652

(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the

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

assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."[7]

Additionally, all CHNAs developed after the very first CHNA must consider written commentary on the prior Assessment and Implementation Strategy efforts. The Hospital followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

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

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

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

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

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

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

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

Other (please specify)

The methodology also takes a comprehensive approach to assess community health needs. Perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis. Local expert area residents were asked to note if they perceived the problems or needs identified by secondary sources

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

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

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

existed in their portion of the county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Otero County compared to all New Mexico counties	May 3, 2018	2012-2014
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	May 2, 2018	2017
http://svi.cdc.gov	To identify the Social Vulnerability Index value	May 8, 2018	2010-2014
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	May 9, 2018	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	May 8, 2018	2016

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

- A CHNA "Round 1" survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 60 Local Expert Advisors was received.

[10] Response to Schedule H (Form 990) Part V B 3 i

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

Survey responses started April 19, 2018, and ended with the last response on May 4, 2018.

- Information analysis augmented by local opinions showed how Otero County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - Low income residents, older adults, and women are the most prevalent priority groups
  - Mental Health among these populations is also common

When the analysis was complete, the information and summary conclusions were put before the Hospital's Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need.[14] Consultation with 22 Local Experts occurred again via an internet-based survey (explained below) beginning May 15, 2018, and ending June 6, 2018.

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

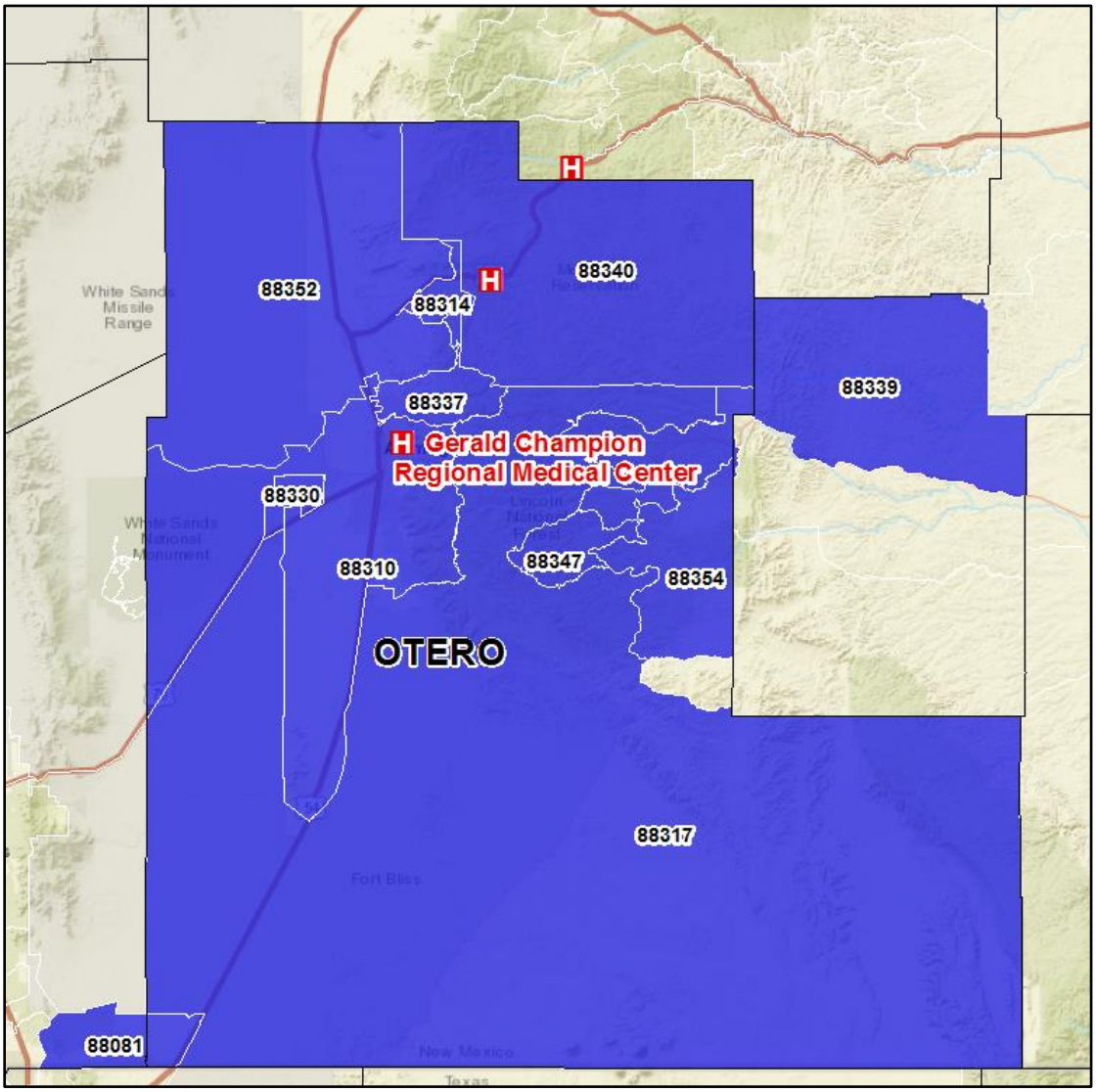
In the Gerald Champion process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list of all needs identified by any of the analyzed data was developed. The Local Experts then allocated 100 points among the list of health needs, including the opportunity to list additional needs that were not identified from the data.

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

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



For the purposes of this study, Gerald Champion Regional Medical Center defines its service area as Otero County in New Mexico, which includes the following ZIP codes:[18]

88081 – Chaparral	88310 – Alamogordo	88317 – Cloudcroft	88330 – Holloman Air Force Base
88337 – La Luz	88339 – Mayhill	88340 – Mescalero	88347 – Sacramento
88352 – Tularosa	88354 – Weed		

(Zip codes 88300, 88311, 88325, 88342, 88349, and 88350 are included in the above zip codes)

During 10/1/2015 – 9/30/2016, the Hospital received 80.2% of its patients from this area.[19]

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

Demographics of the Community[20] [21]

	Otero County	New Mexico	U.S.
2018 Population[22]	**72,599**	**2,081,335**	**325,139,271**
% Increase/Decline	**1.3%**	**1.0%**	**3.5%**
Estimated Population in 2023	**73,537**	**2,101,415**	**337,393,057**
Median Age	**37.0**	**37.8**	**38.3**
Median Household Income	**$41,708**	**$49,242**	**$60,315**
Median Home Value	**$112,335**	**$179,346**	**$209,770**
% Population over age 65	**17.0%**	**16.8%**	**15.9%**
% Women of Childbearing Age	**18.0%**	**18.9%**	**19.6%**
% White, non-Hispanic	**45.0%**	**32.7%**	**60.8%**
% Hispanic	**43.1%**	**48.9%**	**18.0%**
Unemployment Rate (December 2017)	**5.7%**	**6.1%**	**4.1%**

2018 Benchmarks
Area: Gerald Champion Regional Medical Center- 2018 CHNA
Level of Geography: ZIP Code

Area	2018-2023 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2018-2023	Females 15-44 % of Total Population	Females 15-44 % Change 2018-2023	Median Household Income	Median Household Wealth	Median Home Value
USA	3.5%	38.3	15.9%	17.0%	19.6%	1.4%	$60,315	$67,773	$209,770
New Mexico	1.0%	37.8	16.8%	12.6%	18.9%	0.6%	$48,242	$58,392	$179,346
Otero County	1.3%	37.0	17.0%	10.1%	18.0%	1.8%	$41,708	$48,400	$112,335

Demographics Expert 2.7
DEMO0003.SQP

[20] Responds to IRS Schedule H (Form 990) Part V B 3 b
[21] The tables below were created by IBM Watson Health
[22] All population information, unless otherwise cited, sourced from IBM Watson Health (formally Truven)

Demographics Expert 2.7
2018 Demographic Snapshot
Area: Gerald Champion Regional Medical Center- 2018 CHNA
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	70,784	308,745,538
2018 Total Population	72,599	326,533,070
2023 Total Population	73,537	337,947,861
% Change 2018 - 2023	1.3%	3.5%
Average Household Income	$51,058	$86,278

	2018	2023	% Change
Total Male Population	37,023	37,476	1.2%
Total Female Population	35,576	36,061	1.4%
Females, Child Bearing Age (15-44)	13,100	13,334	1.8%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2018	% of Total	2023	% of Total	USA 2018 % of Total
0-14	15,116	20.8%	15,582	21.2%	18.7%
15-17	2,762	3.8%	2,943	4.0%	3.9%
18-24	7,523	10.4%	7,051	9.6%	9.7%
25-34	10,285	14.2%	10,171	13.8%	13.4%
35-54	15,828	21.8%	16,147	22.0%	25.5%
55-64	8,723	12.0%	8,036	10.9%	12.9%
65+	12,362	17.0%	13,607	18.5%	15.9%
Total	72,599	100.0%	73,537	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2018 Household Income	HH Count	% of Total	USA % of Total
<$15K	5,360	19.2%	10.9%
$15-25K	4,039	14.4%	9.5%
$25-50K	7,039	25.2%	22.1%
$50-75K	5,003	17.9%	17.1%
$75-100K	3,468	12.4%	12.3%
Over $100K	3,044	10.9%	28.2%
Total	27,953	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2018 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	4,812	10.2%	5.6%
Some High School	4,805	10.2%	7.4%
High School Degree	12,045	25.5%	27.6%
Some College/Assoc. Degree	17,682	37.5%	29.1%
Bachelor's Degree or Greater	7,854	16.6%	30.3%
Total	47,198	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2018 Pop	% of Total	USA % of Total
White Non-Hispanic	32,651	45.0%	60.4%
Black Non-Hispanic	2,435	3.4%	12.4%
Hispanic	31,260	43.1%	18.2%
Asian & Pacific Is. Non-Hispanic	1,068	1.5%	5.8%
All Others	5,185	7.1%	3.2%
Total	72,599	100.0%	100.0%

Customer Segmentation[23]

Claritas Prizm uses Census data, sources of demographic and consumer information, and 30 years of annual consumer surveys to classify all U.S. households into 68 demographically and behaviorally distinct groups. These segments represent clusters of at least 250 households that have comparable characteristics and exhibit similar behaviors. The top segments in Otero County are:

Claritas Prizm Segments	Characteristics	
Back Country Folks (18.5%)	• Urbanicity: Rural • Income: Downscale • Household Technology: Lowest • Income Producing Assets: Low • Age Ranges: 55+	• Presence of Kids: Mostly without Kids • Homeownership: Mostly Owners • Employment Levels: Mostly Retired • Education Levels: High School
Young & Rustic (11.0%)	• Urbanicity: Rural • Income: Low Income • Household Technology: Below Average • Income Producing Assets: Low • Age Ranges: Age <55	• Presence of Kids: Family Mix • Homeownership: Mix • Employment Levels: Mix • Education Levels: High School
Toolbelt Traditionalist (9.7%)	• Urbanicity: Metro Mix • Income: Upper Mid-Scale • Household Technology: Average • Income Producing Assets: Low • Age Ranges: Age 55+	• Presence of Kids: Mostly without Kids • Homeownership: Mostly Owners • Employment Levels: Mix • Education Levels: Some College
Country Strong (9.5%)	• Urbanicity: Rural • Income: Lower Mid-Scale • Household Technology: Below Average • Income Producing Assets: Below Avg • Age Ranges: Age <55	• Presence of Kids: Family Mix • Homeownership: Mostly Owners • Employment Levels: Blue Collar Mix • Education Levels: High School
Struggling Singles (7.5%)	• Urbanicity: Second City • Income: Low Income • Household Technology: Average • Income Producing Assets: Low • Age Ranges: Age <55	• Presence of Kids: Mostly without Kids • Homeownership: Mix • Employment Levels: Mix • Education Levels: High School
Bedrock America (6.9%)	• Urbanicity: Town • Income: Low Income • Household Technology: Below Average • Income Producing Assets: Low • Age Ranges: Age <55	• Presence of Kids: Mostly withouth Kids • Homeownership: Mostly Renters • Employment Levels: Mix • Education Levels: High School

[23] IBM Watson Health

Each of the 68 Claritas Prizm segments exhibits prevalence toward specific health behaviors. In the second column of the chart below, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

Where Otero County varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered noteworthy. Items in the table with **red text** are viewed as **adverse** findings. Items with **blue text** are viewed as **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	114%	34.7%	Cancer Screen: Skin 2 yr	78.0%	8.3%
Vigorous Exercise	89.5%	51.1%	Cancer Screen: Colorectal 2 yr	89.8%	18.4%
Chronic Diabetes	124.5%	19.5%	Cancer Screen: Pap/Cerv Test 2 yr	85.4%	41.2%
Healthy Eating Habits	96.9%	22.6%	Routine Screen: Prostate 2 yr	87.5%	24.9%
Ate Breakfast Yesterday	94.7%	74.9%	**Orthopedic**		
Slept Less Than 6 Hours	125.2%	17.1%	Chronic Lower Back Pain	112.4%	34.7%
Consumed Alcohol in the Past 30 Days	80.2%	43.1%	Chronic Osteoporosis	131.9%	13.4%
Consumed 3+ Drinks Per Session	124.3%	35.0%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	102.3%	83.2%
Search for Pricing Info	85.2%	22.9%	NP/PA Last 6 Months	102.5%	42.5%
I am Responsible for My Health	99.7%	90.3%	OB/Gyn 1+ Visit	84.3%	32.4%
I Follow Treatment Recommendations	99.2%	76.4%	Medication: Received Prescription	102.0%	61.8%
Pulmonary			**Internet Usage**		
Chronic COPD	132.0%	7.1%	Use Internet to Look for Provider Info	78.6%	31.4%
Chronic Asthma	101.8%	12.0%	Facebook Opinions	109.2%	11.0%
Heart			Looked for Provider Rating	74.3%	17.4%
Chronic High Cholesterol	109.5%	26.8%	**Emergency Services**		
Routine Cholesterol Screening	91.6%	40.6%	Emergency Room Use	109.4%	38.0%
Chronic Heart Failure	162.1%	6.6%	Urgent Care Use	92.7%	30.6%

Leading Causes of Death[24]

The Leading Causes of Death are determined by official Centers for Disease Control and Prevention (CDC) final death total. New Mexico's Top 15 Leading Causes of Death are listed in the table below in Otero county's rank order. Otero county was compared to all other New Mexico counties, New Mexico state average and whether the death rate was higher, lower or as expected compared to the U.S. average.

Cause of Death			Rank among all counties in NM (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
NM Rank	Otero Rank	Condition		NM	Otero	
36	1	Heart Disease	8 of 32	150.5	207.4	Higher than expected
47	2	Cancer	11 of 32	138.8	169.4	Higher than expected
23	3	Lung	14 of 32	44.4	52	Higher than expected
3	4	Accidents	30 of 32	69.5	49.3	As expected
33	5	Stroke	21 of 32	35.5	36.4	As expected
5	6	Diabetes	11 of 32	27.2	34.9	Higher than expected
4	7	Suicide	12 of 32	22.4	24.1	Higher than expected
1	8	Liver	20 of 32	24.8	16.2	Higher than expected
17	9	Flu - Pneumonia	25 of 32	14.6	14.5	As expected
29	10	Kidney	17 of 32	11.6	13.1	As expected
39	11	Alzheimer's	25 of 32	23.4	12.5	Lower than expected
43	12	Hypertension	4 of 32	5.9	8.5	As expected
28	13	Blood Poisoning	21 of 32	9.4	7.6	Lower than expected
7	14	Homicide	24 of 32	9.4	6.1	As expected
33	15	Parkinson's	19 of 32	7.8	5.9	Lower than expected

[24] www.worldlifeexpectancy.com/usa-health-rankings

Priority Populations[25]

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

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

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[26]

- Low income residents, older adults, and women are the most prevalent priority groups
- Mental Health among these populations is also common

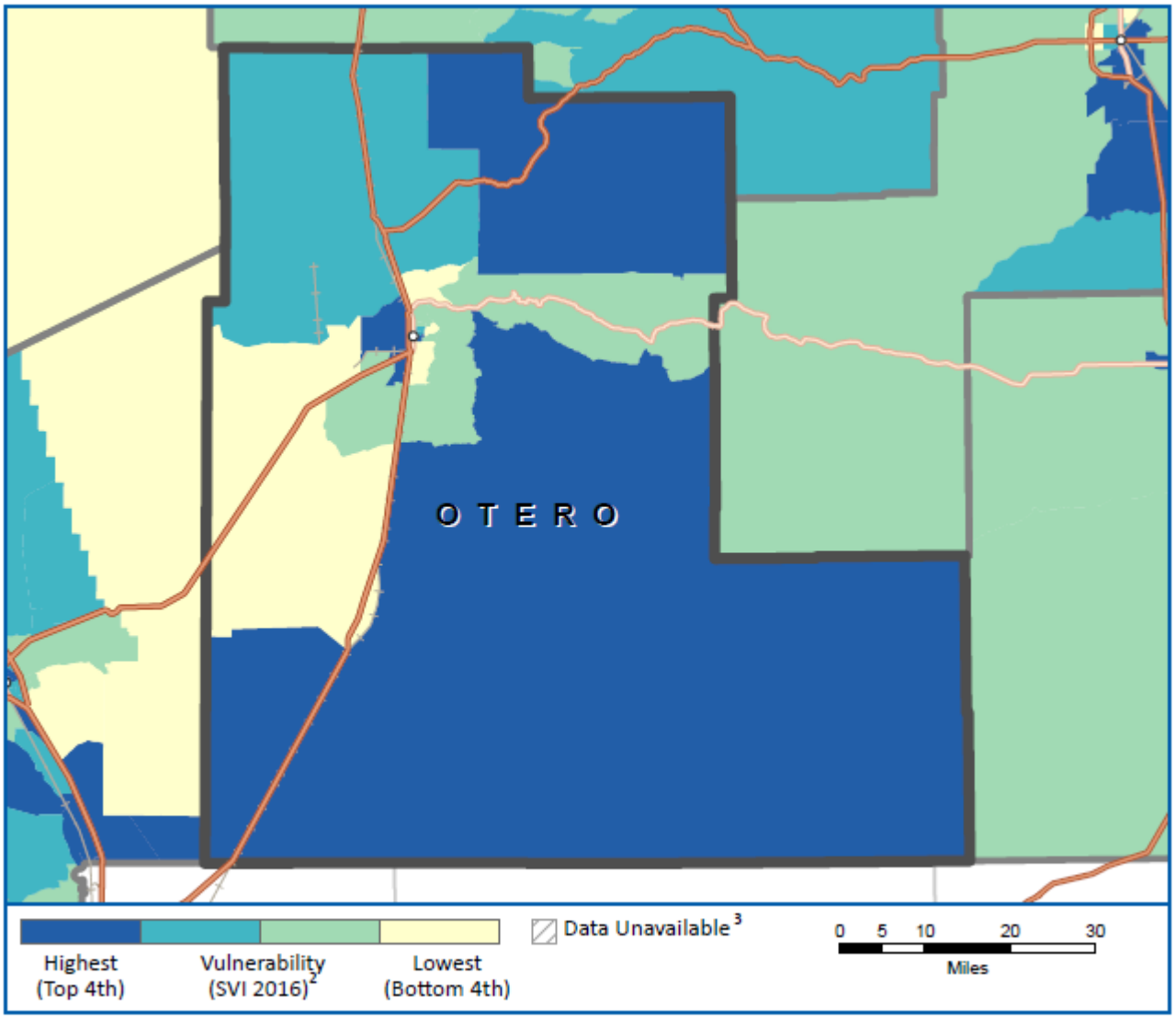
[25] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i
[26] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability[27]

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, such as natural or human-caused disasters, or disease outbreaks.

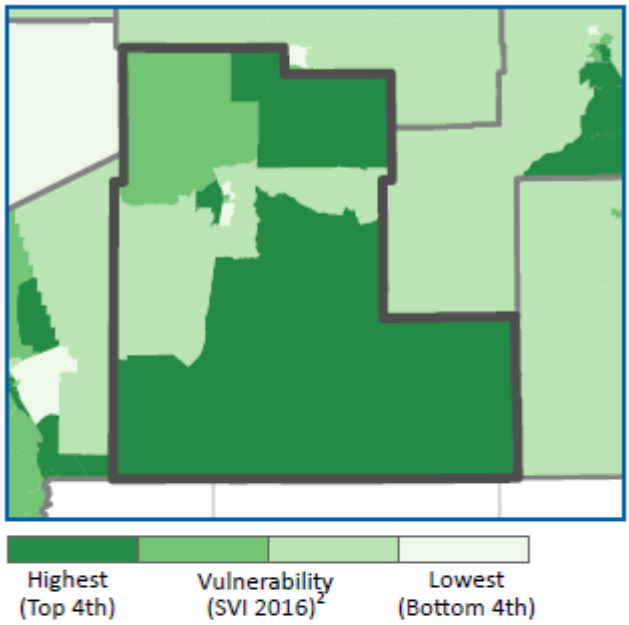
Overall, Otero County fall into all four quartiles:

- The southern and northeastern part of county are in the highest quartile of vulnerability (dark blue)
- Section in the mid-western part of the county are in the lowest quartile of vulnerability (yellow)
- The rest of the county are in the second lowest and second highest quartiles (light blue and light green)

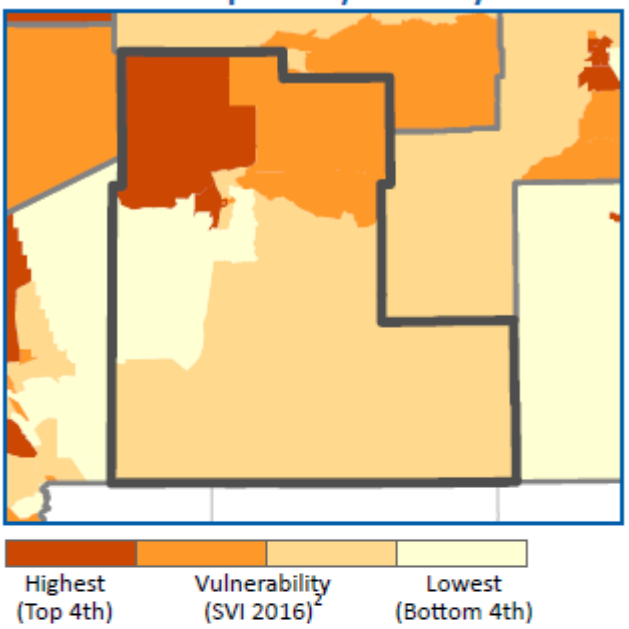


[27] http://svi.cdc.gov

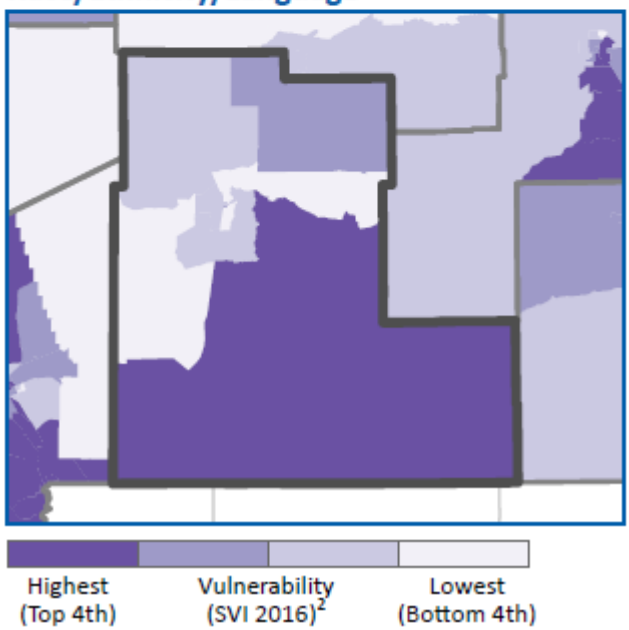
Socioeconomic Status



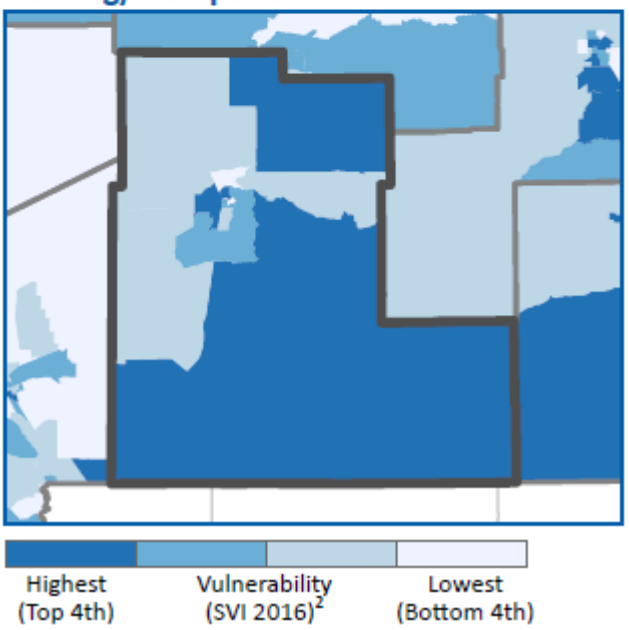
Household Composition/Disability



Race/Ethnicity/Language



Housing/Transportation



Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 60 individuals provided feedback on the 2015 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	11	44	55
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	8	48	56
3) **Priority Populations**	14	42	56
4) Representative/Member of **Chronic Disease Group** or Organization	13	42	55
5) Represents the **Broad Interest of the Community**	39	20	59
Other			4
Answered Question			59
Skipped Question			1

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

- Low-income groups
- Older adults
- Women

Gerald Champion received the following responses to the question: **"Should the hospital continue to consider the 2015 Significant Health Needs as the most important health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Access to Primary Care	30	3	1
Obesity	30	2	2
Insurance Affordability	30	3	1
Diabetes	29	4	1
Cancer	32	1	1
Behavioral Health	33	1	0
Heart Disease	30	2	2

Gerald Champion received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?"**

	Yes	No	No Opinion
Access to Primary Care	31	1	2
Obesity	27	4	3
Insurance Affordability	31	2	1
Diabetes	30	3	1
Cancer	32	1	1
Behavioral Health	32	1	2
Heart Disease	30	2	2

Comparison to Other State Counties[28]

To better understand the community, Otero County has been compared to all 32 counties in the state of New Mexico across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

In the chart below, the county's rank compared to all counties is listed along with any measures in each area that are ***worse than*** the state average and U.S. Best (90th percentile).

	Otero County	New Mexico	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	9/32		
Health Behaviors			
Overall Rank *(best being #1)*	25/32		
Physical Inactivity	21%	19%	19%
Access to Exercise Opportunities	64%	73%	91%
Excessive Drinking	15%	14%	12%
Alcohol-impaired Driving Deaths	15%	14%	12%
Teen Births *(per 1,000 females age 15-19)*	61	51	17
Clinical Care			
Overall Rank *(best being #1)*	8/32		
Uninsured Rate	18%	17%	8%
Population to Primary Care Physician	1,910:1	1,320:1	1,040:1
Population to Dentist	2,570:1	1,620:1	1,320:1
Population to Mental Health Provider	410:1	280:1	360:1
Social & Economic Factors			
Overall Rank *(best being #1)*	12/32		
Some College Attendance	54%	59%	72%
Children in Poverty	34%	27%	12%

[28] www.countyhealthrankings.org

	Otero County	New Mexico	U.S. Best
Physical Environment			
Overall Rank *(best being #1)*	15/32		
Air Pollution (PM2.5 concentration)	7.4 µg/m^3	9.1 µg/m^3	6.7 µg/m^3

Per 100,000

Comparison to Peer Counties[29]

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile).

In the below chart, Otero County is compared to its peer counties and the U.S. average, but only areas where the county is Better or Worse are listed. (The list and number of peer counties used in each ranking may differ.)

	Otero County	Peer Ranking	U.S. Median
Health Behaviors			
Better			
Adults Smoking	17%	5/30	14%
Adult Obesity	25%	5/25	26%
Physical Activity	21%	6/32	19%
Excessive Drinking	15%	3/33	12%
Worse			
Alcohol-Impaired Driving Deaths	44%	33/35	13%
Teen Births (per 1,00 population ages 15-19)	61	28/34	12
Clinical Care			
Better			
Preventable Hospital Stays	31	3/35	36
Worse			
Diabetes Monitoring	73%	34/34	91%
Social and Economic Factors			
Better			
None	--	--	--
Worse			
High School Graduation	72%	28/34	95%
Children in Poverty	34%	28/33	12%
Physical Environment			
Better			

[29] www.cdc.gov/communityhealth

	Otero County	Peer Ranking	U.S. Median
Driving Alone to Work	76%	8/33	72%
Worse			
None	--	--	--

Per 100,000

Conclusions from Demographic Analysis Compared to National Averages

The following areas were identified from a comparison of Otero county to national averages. **Adverse** metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- 14.0% more likely to have a **BMI of Morbid/Obese**, affecting 34.7%
- 10.5% less likely to **Vigorously Exercise**, affecting 51.1%
- 24.3% more likely to **Consume 3+ Drinks per Session**, affecting 35.0%
- 8.4% less likely to receive **Routine Cholesterol Screenings**, affecting 40.6%
- 14.6% less likely to receive **Cervical Cancer Screening every 2 years**, affecting 41.2%
- 12.4% more likely to have **Chronic Lower Back Pain**, affecting 34.7%
- 15.7% less likely to **Visit OB/Gyn Annually**, affecting 32.4%
- 9.4% more likely to use the **Emergency Room** (for non-emergent issues), affecting 38.0%

Beneficial metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- 19.8% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 43.1%

Conclusions from Other Statistical Data[30]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Otero County statistics to the U.S. average, and lists the change since the last date of measurement.

	Current Date of Data	Statistic	Change	Last Date of Data
Otero County measures that are **WORSE** than the U.S. average and **got worse**				
Female Diabetes, Urogenital, Blood and Endocrine Disease Deaths	2014	66.1* cases	54.10%	1980
Male Diabetes, Urogenital, Blood and Endocrine Disease Deaths	2014	75.1* cases	57.30%	1980
Female Self-Harm/Interpersonal Violence Deaths	2014	13.7* cases	5.20%	1980
Female Mental and Substance Use Disorder Deaths	2014	14.5* cases	322.80%	1980
Male Mental and Substance Use Disorder Deaths	2014	32.9* cases	87.80%	1980
Female Liver Disease Deaths	2014	27.0* cases	34.90%	1980
Male Liver Disease Deaths	2014	38.9* cases	6.60%	1980
Otero County measures that are **WORSE** than the U.S. average but **improved**				
Female Life Expectancy	2014	80.3 years	3.90%	1980
Male Life Expectancy	2014	75.6 years	7.30%	1980
Female Heart Disease	2014	124.1* cases	-38.80%	1980
Male Heart Disease	2014	207.3* cases	-49.20%	1980
Female Breast Cancer	2014	26.6* cases	-18.20%	1980
Female Malignant Skin Melanoma	2014	2.0* cases	-3.40%	1980
Male Self-Harm/Interpersonal Violence Deaths	2014	43.0* cases	-15.60%	1980
Female Transport Injury Deaths	2014	11.4* cases	-42.30%	1980
Male Transport Injury Deaths	2014	22.7* cases	-55.00%	1980
Female Smoking	2012	22.30%	-10.60%	1996
Male Smoking	2012	25.20%	-11.40%	1996

[30] http://www.healthdata.org/us-county-profiles

	Current Date of Data	Statistic	Change	Last Date of Data
Otero County measures that are **BETTER** than the U.S. average but **got worse**				
Female Tracheal, Bronchus, and Lung Cancer	2014	36.1* cases	7.30%	1980
Male Malignant Skin Melanoma	2014	4.1* cases	7.90%	1980
Female Heavy Drinking	2012	6.20%	36.90%	2005
Female Binge Drinking	2012	10.80%	11.20%	2002
Male Obesity	2011	33.40%	36.70%	2001
Otero County measures that are **BETTER** than the US average and **improved**				
Female Stroke	2014	40.1* cases	-58.00%	1980
Male Stroke	2014	39.6* cases	-54.60%	1980
Male Tracheal, Bronchus, and Lung Cancer	2014	55.4* cases	-30.50%	1980
Male Breast Cancer	2014	0.3* cases	-11.00%	1980
Male Heavy Drinking	2012	7.90%	-5.10%	2005
Male Binge Drinking	2012	21.50%	-10.60%	2002

**Per 100,000 population*

Significant Health Needs Identified During CHNA Process

1. **Access to Primary Care – 2015 Significant Health Need**
2. **Behavioral Health – 2015 Significant Health Need**
3. **Obesity – 2015 Significant Health Need**
4. **Cancer – 2015 Significant Health Need**
5. **Diabetes – 2015 Significant Health Need**

Other Needs Identified During CHNA Process

6. **Heart Disease – 2015 Significant Health Need**
7. **Insurance Affordability – 2015 Significant Health Need**
8. **Substance Use/Abuse**
9. **Alcohol Use**
10. **Prevention/Wellness Programs**
11. **Suicide**
12. **Women's Health**
13. **Tobacco Use**
14. **Alzheimer's**
15. **Stroke**
16. **Kidney Disease**
17. **Liver Disease**
18. **Lung Disease**
19. **Flu/Pneumonia**
20. **Accidents**

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Round 1)

Hospital solicited written comments about its 2015 CHNA.[31] 59 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.**

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	11	44	55
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	8	48	56
3) **Priority Populations**	14	42	56
4) Representative/Member of **Chronic Disease Group** or Organization	13	42	55
5) Represents the **Broad Interest of the Community**	39	20	59
Other			4
Answered Question			59
Skipped Question			1

Congress defines "Priority Populations" to include:

- Racial and ethnic minority groups
- Low-income groups
- Women
- Children
- Older Adults
- Residents of rural areas
- Individuals with special needs including those with disabilities, in need of chronic care, or in need of end-of-life care
- Lesbian Gay Bisexual Transsexual (LGBT)
- People with major comorbidity and complications

2. **Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed?**

- *Quality medical care to include mental health and pediatric specialties*
- *Facilities that offer support for adults in overcoming barriers that limit their ability to meet recommendations for daily activity and exercise. (i.e. wellness center, pool.)*

[31] Responds to IRS Schedule H (Form 990) Part V B 5

- *Patient education and specialty services for rural residents who have chronic conditions.*
- *More home care, better social facilities, better FB posts about health fairs.*
- *Rural maybe mobile clinics to visit the outlying areas regularly for common issues at the places some cannot get to town from.*
- *More transportation options. The Zia bus doesn't run often enough.*
- *I don't know of any unique needs other than readily available access to good care without worrying about cost.*
- *Women's health issues, specifically cancer and mammograms. Fibromyalgia and mental health issues.*
- *Health, particularly mental health, needs associated with (chronic) poverty. There's a limited continuum of care available to older adults - insufficient mid-level care available (too much to handle at home yet unqualified for skilled nursing care). Unknown prevalence of drug abuse in our communities/rural areas and co-morbid disorders - and how that impacts children living in those homes. Prevalence of diabetes and obesity with long-term effects on health.*
- *Need for mental health services, housing*

In the 2015 CHNA, there were seven health needs identified as "significant" or most important:

1. **Access to Primary Care**
2. **Obesity**
3. **Insurance Affordability**
4. **Diabetes**
5. **Cancer**
6. **Behavioral Health**
7. **Heart Disease**

3. **Should the hospital continue to consider the 2015 Significant Health Needs the most important health needs currently confronting residents in the county?**

	Yes	No	Response Count
Access to Primary Care	30	3	33
Obesity	30	2	32
Insurance Affordability	30	3	33
Diabetes	29	4	33
Cancer	32	1	33
Behavioral Health	33	1	34
Heart Disease	30	2	32

Comments:

- *Totally underserved in behavioral health, especially children's services and adult psychiatry.*
- *Neo natal, pregnancy and prevention, child care, STDs.*
- *I have seen to many cases where obese people only want surgery without putting in the effort to try and lose*

weight. It is irritating when Medicaid picks up the tab on my tax dollars. I overheard a woman talking about it in Wal-Mart as she was eating fries and a burger. I pay for health insurance and it seems covered but there are many steps that have to be taken prior to surgery.

- *Understanding current opioid addiction crisis and it's relation to current medical practices regarding treatment of chronic pain; learn how this has become an epidemic. Involve medical care providers and chronic pain management providers in understanding their roles in this crisis and work to identify available alternatives such as can be provided by alternative providers such as behavior health providers, chiropractors, etc. Currently, as a practicing chiropractor, I have seen decreasing numbers of PCP referrals for our services over the past 10 years while, at the same time, we've seen the opioid epidemic grow exponentially. West Virginia recently signed a bill making it law that MDs must include chiropractic services as part of the referral consideration for pain and chronic pain patients. One of the largest complaints I have from chronic pain VA patients is that their VA doctors hardly ever refer for chiropractic care while continuing to prescribe unwanted, ineffective, and potentially dangerous medications. I would like to see Gerald Campion spearhead a conversation with it's medical staff about its current policy regarding long-term management of chronic pain and to include in this conversation traditionally under-utilized practitioners, such as chiropractors, and how they may begin to battle opioid addiction while at the same time, offering their patients safe, and effective, alternatives.*
- *GCRMC has made incredible strides in meeting the above-mentioned needs in our communities: the addition of the urgent care clinic; hiring of more PAs and NPs; purchase of state-of-the-art radiology treatment equipment and a new focus on building a cancer center; recent opening of out-patient behavioral health clinic, and added assistance to Holloman personnel; the addition of the heart cath lab which has already saved an incredible number of lives and a lot of money!*
- *Awareness of Hemochromatosis*

4. Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?

	Yes	No	Response Count
Access to Primary Care	31	1	32
Obesity	27	4	31
Insurance Affordability	31	2	33
Diabetes	30	3	33
Cancer	32	1	33
Behavioral Health	32	1	33
Heart Disease	30	32	32

Comments:

- *Continued efforts intended to improve the culture of health of this community would benefit all. Patients who do choose to take a more active role in self-management of their health condition need our support. Optimizing the culture of health of the community may decrease the obstacles these patients face when intersecting with different aspects of community living: (i.e. restaurant menu options, places to be active that entice a participant, healthier convenient food options where people frequent)*

- *Pregnancy, child care, childhood nutritional needs, the importance of vaccination.*
- *Cancer and diabetes seem to be rampant here. It is important to educate and offer services so people know what to look out for and what actions to take. My mother in law was diagnosed with Stage 2 breast cancer that spread to two of her lymph nodes. She was unable to schedule in town within 30 days and had to see a provider in Las Cruces.*
- *Opportunities to partner with other community institutions (i.e., Alamogordo Public Schools and NMSU-Alamogordo) should be pursued. Working with the school system could provide much-needed support to APS with behavioral needs and provide early*

5. **Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.**
   - *Improve documentation and quality of care provided and across the board.*
   - *Emergency Room needs to be equipped with personal who listen to all the problems of a patient and not make decisions based on one part of patients complaint*
   - *ER visits are too long*
   - *Training of staff on procedures for handling patients and cleanliness of both.*
   - *Focus on childhood obesity.*
   - *Affordable allergy clinic for testing and medications.*
   - *Our highest need encountered is housing and homelessness.*
   - *Again, pregnancy, birth control, early childhood vaccination, childhood nutrition.*
   - *Fibromyalgia and mental health needs. I have to drive to El Paso and Las Cruces for services. A migraine clinic would be helpful.*
   - *Dermatology and Podiatry. With the sun have such serious effects on so many people (who travel to Las Cruces and El Paso for services), it would be beneficial to the community to have a full-time dermatologist on staff.*
   - *Pulmonary/Respiratory*
   - *Awareness of Hemochromatosis*

6. **Please share comments or observations about keeping <u>ACCESS TO PRIMARY CARE</u> among the most significant needs for the Hospital to address.**
   - *Healthy lifestyles are more expensive and make it difficult for much of the working class. Local statics show that we have high diabetes, high blood pressure, and obesity rates. Need to be more proactive in addressing these types of issues in the long-term. This is a cultural issue that will take time (decades) to address.*
   - *There are increasing civilians moving to Alamogordo to maintain the planes for the training mission at the 49th Wing therefore, there needs to be more Primary Care Managers and Pediatricians.*

- *GCRMC has made significant strides in improving all the above areas. I believe a challenge is 'getting the word out'.*
- *Physician recruitment seems to be a continuing process*
- *Additional clinics needed in surrounding rural communities.*
- *need more internal medicine physicians the new urgent care center is a great improvement*
- *GCRMC is all about our community! They are doing all they can to bring all health care needs to our front doors... so we don't have to travel*
- *Need for more Drs that will take poor people*
- *I believe a mobile clinic that travels to the outlying towns on a regular rotation would be an incredibly valuable tool in increasing access to primary care.*
- *Need more Primary care providers that accept Medicaid.*
- *Where else are we going to go?*
- *I believe that Gerald Champion has addressed this with its addition of the Urgent Care on 1st Street.*
- *I am/our family is thankful for the recent opening of the Urgent Care center and Family Care clinic. We live on the south side of town and appreciate having a facility closer to our home and employment. At least two family members have been to the clinic since it opened (flu). This summer I turn 65 and I am looking forward to (hopefully) having Jana McBurney as my primary care provider. She has been taking care of me for several years while assigned to Holloman. Thank you for bringing her on board.*

7. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>ACCESS TO PRIMARY CARE</u>.**
   - *Bringing in the pediatricians is good and we know that you do quite a bit of recruiting. We need another pediatrician in the community.*
   - *Gerald Champion has been successful in recruiting primary care physicians to this area*
   - *Urgent care, new mid level providers to augment physician shortages*
   - *We need more places to walk in a safe place. The hospital would be great for indoor walking*
   - *Other than ensuring that they are paid, nothing.*

8. **Please share comments or observations about keeping <u>OBESITY</u> among the most significant needs for the Hospital to address.**
   - *New Mexico does have a high incidence of obesity which affects healthcare and work force.*
   - *There are enough services provided to address this need*
   - *Keep nutritional guidance services and add further support for overcoming barriers to physical activity*

- *I do not rate obesity as a priority for the hospital*
- *Obesity is a national as well as a community problem. Anything we can do to help people learn how to manage their weight - and hopefully influence family members (especially children) - is a good thing.*

9. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>OBESITY</u>.**
   - *Am unaware of any actions taken other than standing up the Wellness Center.*
   - *Opened a health and wellness clinic - support local community initiatives*

10. **Please share comments or observations about keeping <u>INSURANCE AFFORDABILITY</u> among the most significant needs for the Hospital to address.**
    - *From my knowledge Gerald Champion accepts most insurances*
    - *Financial barriers remain an obstacle for many patients.*
    - *seeing an increase in patients with no insurance*
    - *Unless GCRMC is secretly lobbying the state insurance board to keep the ACA, nothing.*
    - *This is an area about which I do not know enough to offer comments.*

11. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>INSURANCE AFFORDABILITY</u>.**
    - *charity care program*
    - *People needs help*

12. **Please share comments or observations about keeping <u>DIABETES</u> among the most significant needs for the Hospital to address.**
    - *New Mexico does have a high incidence of diabetes which affects healthcare and local work force.*
    - *Excellent endocrinologist*
    - *This remains a major health concern that requires continued attention.*
    - *The need continues*
    - *We care... have classes*
    - *The wound care center was mentioned. This is a huge plus for our community. I have had several friends who would make innumerable trips to El Paso for bariatric treatments at a huge cost of time as well as money.*

13. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>DIABETES</u>.**

- *Am unaware of any actions taken specifically to address Diabetes. The sole endocrinologist is excellent however.*
- *Offers nutritional tips*
- *diabetes awareness promotion*

14. **Please share comments or observations about keeping <u>CANCER</u> among the most significant needs for the Hospital to address.**

- *It would be helpful for patients not to have to travel to Albuquerque or Las Cruces for state of the art cancer care. The travel adds addition stress to patients at a critical time in their lives.*
- *As a cancer patient at GCRMC, I believe too many people are unaware of the services available HERE and leave Alamogordo unnecessarily.*
- *This is a vital service provided to this community.*
- *need improvement in current clinic*
- *We will be building a bigger and better place*
- *So many friends and family members have been diagnosed with cancer. Not having to drive to El Paso or ABQ for treatment is a huge benefit to our community - and to know that the treatment they are receiving is state-of-the-art or just as effective as top hospitals is a huge relief.*

15. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>CANCER</u>.**

- *Not aware of specific actions being taken to address cancer or hire more oncologists.*
- *Expanding facility*
- *steps have been taken with the support of the hospital foundation.*

16. **Please share comments or observations about keeping <u>BEHAVORIAL HEALTH</u> among the most significant needs for the Hospital to address.**

- *New Mexico is chronically underserved for behavioral health, especially in southern New Mexico.*
- *Expanding facility.*
- *the need is great in southern new mexico especially for pediatrics*
- *GCRMC has stepped up to meet these needs also*
- *I worry about our society - the levels of stressors that increasingly impact everyone. Anything we can do to offer hope and intervention in our community is essential - to all ages.*

17. **Please share comments or observations about the implementation actions the Hospital has taken to address**

BEHAVORIAL HEALTH.

- *The new inpatient behavioral health unit is a step in the right direction. Need to recruit more psychiatrists and child behavioral health specialists.*
- *This is an absolute necessity in this community and should continue to be a focus*
- *increased inpatient beds opened new outpatient unit . continue to recruit for providers*

18. Please share comments or observations about keeping HEART DISEASE among the most significant needs for the Hospital to address.

- *One of the most significant health issues in the country.*
- *Have seen this service grow in this community*
- *continued need for education and prevention*
- *I believe GCRMC has the best heart doctors*
- *We need better cardiac drs so we don't have to gi to cruces or Elpaso for them*
- *Remove the current head of Cardiology and replace him with someone less reliant on God to do life saving.*
- *I would like to see more public education on various topics (obesity, diabetes, wound care, behavioral health) to include heart disease and prevention. I am so thankful that we have such an excellent facility in the community which can quickly address the needs of folks dealing with coronary issues.*

19. Please share comments or observations about the implementation actions the Hospital has taken to address HEART DISEASE.

- *Need to improve on documentation and staffing for the cardiac catheterization lab.*
- *recruitment of providers, opened heart cath lab, started cardiac rehab program*
- *So far, so good but a full cardiac treatment center is needed not just bits and pieces*

20. Finally, after thinking about our questions and the information we seek, is there anything else you think is important as we review and revise our thinking about significant health needs in the county?

- *There is not enough primary care or behavioral health care to support permanent population or to support the 49th Wing at Holloman AFB. Behavioral Health care is a great need for our wounded warrior community.*
- *I have been happy with the services provided by Gerald Champion and I feel that the services provided will continue to grow to meet the need of this community*
- *When attempting to meet the needs of the community, it should be recognized that each encounter role models or sends a message about health to the patient. What is the atmosphere? What foods are offered in cafeteria and vending machines. Is the personnel supported and encouraged to also have healthy behaviors? Do the*

personnel seem happy, healthy and active? In other words is the culture of health of the hospital in synch with what is desired for the community. Thinking about this aspect of the patient encounter and its potential power of suggestion may be considered an action step to meeting the health needs of the community.

- *Dermatologist Is what Otero County needs...I LOVE OUR HOSPITAL! THEY ARE ALWAYS IMPROVING...*
- *Shorten ER visit times*
- *Shut in health, preventative medicine, not just treating symptoms, treat the illness, and rural clinic/mobile clinic access for outlying areas.*
- *Access to healthcare includes having transportation to the appointment. Individuals don't like or are not able to wait for an hour after an appointment for transportation back to their home or to the pharmacy. For some individuals it is a 2 hour ride from the hospital to the Walker Road area.*
- *Review HIPPA compliance through out GCRMC starting at the reception desk. Change the head of cardiology, keep the dogs out of the hospital.*
- *As a community member, I feel a profound sense of thankfulness that we have such a diverse, top-notch, willing to grow and improve medical center in our midst. Please continue to move forward and lead the way for other rural hospitals!*

Appendix B – Identification & Prioritization of Community Needs (Round 2)

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
1. Access to Primary Care – 2015 Significant Need	321	16	17.83%	17.83%	Significant Needs
6. Behavioral Health - 2015 Significant Need	205	16	11.39%	29.22%	
2. Obesity – 2015 Significant Need	190	16	10.56%	39.78%	
5. Cancer - 2015 Significant Need	190	15	10.56%	50.33%	
4. Diabetes - 2015 Significant Need	157	14	8.72%	59.06%	
7. Heart Disease - 2015 Significant Need	156	15	8.67%	67.72%	Other Identified Needs
3. Insurance Affordability - 2015 Significant Need	151	13	8.39%	76.11%	
17. Substance Use/Abuse	93	11	5.17%	81.28%	
9. Alcohol Use	69	9	3.83%	85.11%	
15. Prevention/Wellness Programs	68	9	3.78%	88.89%	
18. Suicide	33	5	1.83%	90.72%	
20. Women's Health	28	5	1.56%	92.28%	
19. Tobacco Use	26	5	1.44%	93.72%	
10. Alzheimer's	24	6	1.33%	95.06%	
16. Stroke	23	6	1.28%	96.33%	
12. Kidney Disease	21	6	1.17%	97.50%	
13. Liver Disease	16	5	0.89%	98.39%	
14. Lung Disease	15	6	0.83%	99.22%	
11. Flu/Pneumonia	6	4	0.33%	99.56%	
8. Accidents	4	4	0.22%	99.78%	
21. Points reserved for NEW health needs listed in Question 11 below	4	2	0.22%	100.00%	
Total	1800		100.00%		

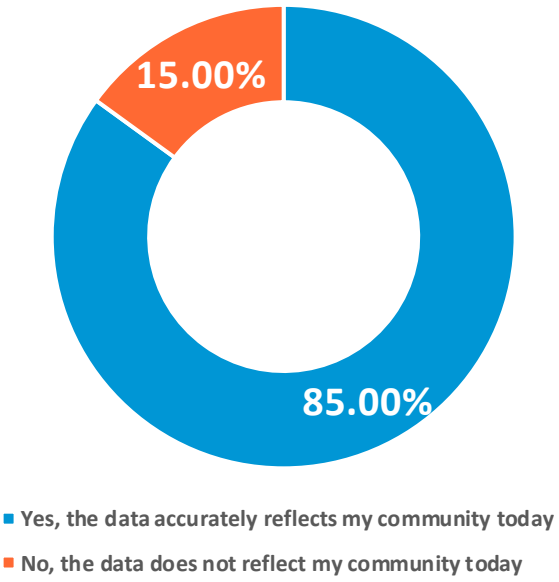
Individuals Participating as Local Expert Advisors[32]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	9	8	17
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	6	12	18
3) **Priority Populations**	6	12	18
4) Representative/Member of **Chronic Disease Group** or Organization	2	14	16
5) Represents the **Broad Interest of the Community**	22	10	22
Other			4
Answered Question			22
Skipped Question			0

[32] Responds to IRS Schedule H (Form 990) Part V B 3 g

Advice Received from Local Expert Advisors

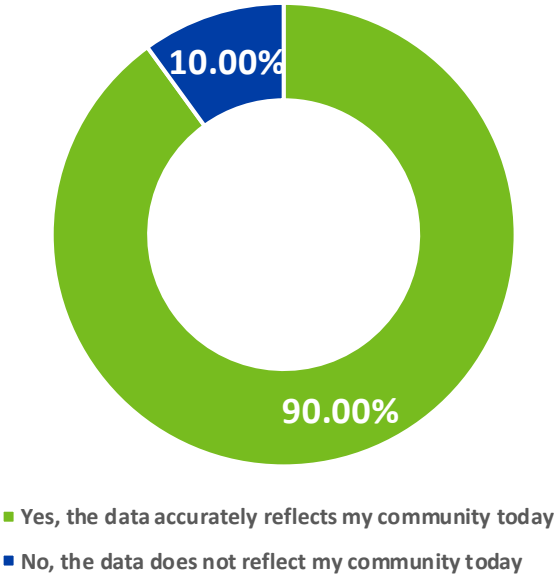
Question: Do you agree with the comparison of Otero County to all other New Mexico counties?



Comments:

- *Unfortunately despite efforts to improve health statistics, culture, lack of job opportunities, and a fledgling education system hold us back. Striving to improve the areas and large spread areas with limited resources impact all categories*
- *With the great weather we have and trails provided by the City, I do not believe Exercise Opportunities are lower than NM average. However, if people don't get out there and take advantage of it, that is on them. For the same reason (climate) I believe the Physical Environment should rank higher.*
- *Otero County remains medically underserved. Although some physicians communicate well with their patients and devise individual care plans the many do not ensure patient understanding and pay no attention to patient circumstances. I believe the military presence increases the education level.*
- *I have no doubt the data is accurate (as accurate as can be).*

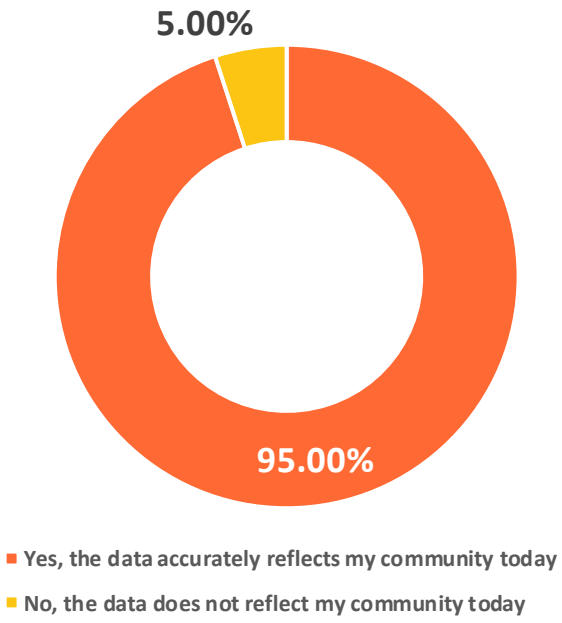
Question: Do you agree with the comparison of Otero County to its peer counties?



Comments:

- *There is no data listed. Hard to answer.*
- *Again, I have no doubt the data is as accurate as is possible. Very disturbed by trends and how poorly Otero County ranks in the various factors.*
- *Unfortunately, Teen Births is a big issue here in Otero County. Alamogordo, Tularosa, and Mescalero are all problem areas.*

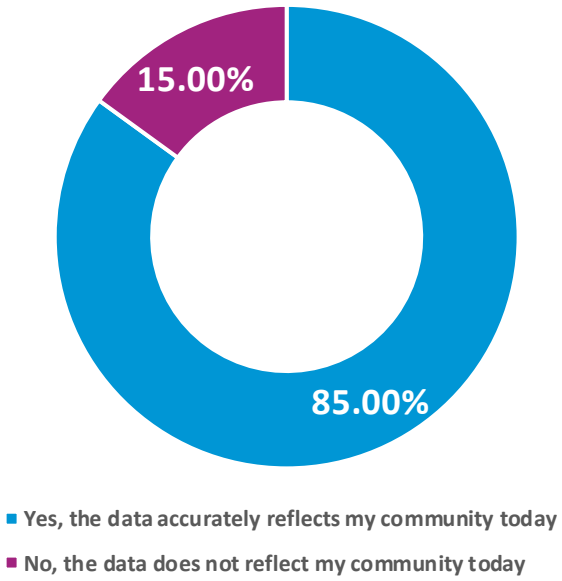
Question: Do you agree with the demographics and common health behaviors of Otero County?



Comments:

- *I am surprised by the population estimate. that is much higher than the last estimate I saw which I believe was from 2016.*

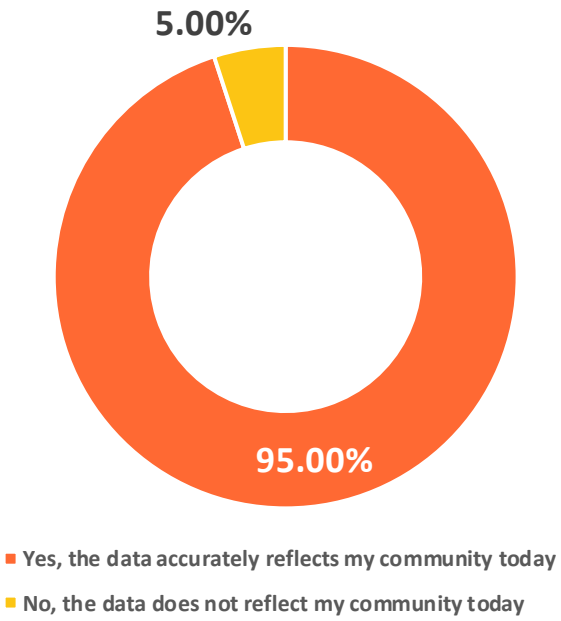
Question: Do you agree with the overall social vulnerability index for Otero County?



Comments:

- *These graphics do not make sense because you are showing household composition information in areas of the county where no one lives.*
- *Otero County encompasses an extremely large rural area to include considerable federal property (Ft. Bliss/MacGregor Range and the Lincoln National Forest). While there is no doubt that individuals and pockets of small communities do fall within the realms of vulnerability, I'm not sure that the above displays provide such far-ranging accuracy.*

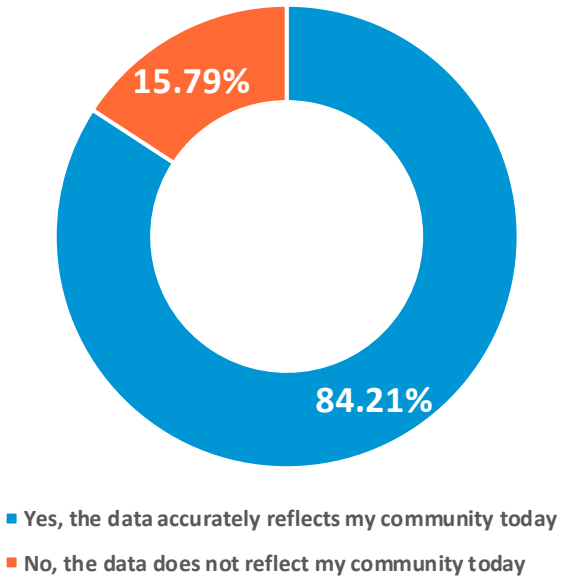
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *What exactly is meant by blood poisoning?*
- *Interesting! I can only assume the kidney rates are related to the diabetes rates*
- *Alcohol related death impact is something we are extremely high in as a state, and a county. It not listed here. It impacts accidental death, suicide, homicide, and liver disease*

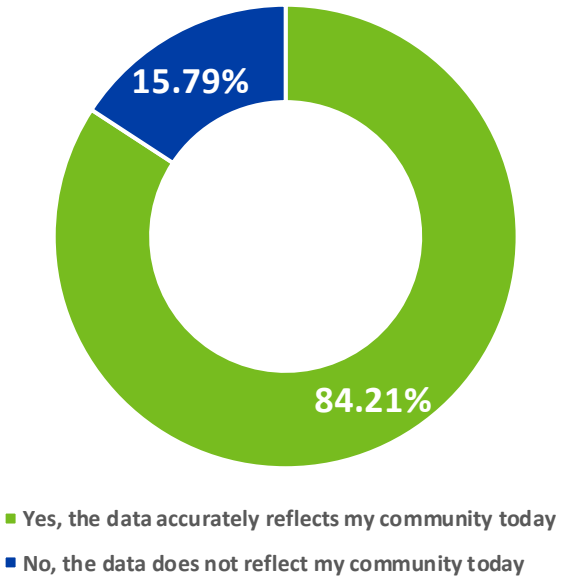
Question: Do you agree with the health trends in Otero County?



Comments:

- *Unfortunately, despite efforts to improve health statistics, culture, lack of job opportunities, and a fledgling education system hold us back. Striving to improve the areas and large spread areas with limited resources impact all categories*
- *With the great weather we have, and trails provided by the City, I do not believe Exercise Opportunities are lower than NM average. However, if people don't get out there and take advantage of it, that is on them. For the same reason (climate) I believe the Physical Environment should rank higher.*
- *Otero County remains medically underserved. Although some physicians communicate well with their patients and devise individual care plans the many do not ensure patient understanding and pay no attention to patient circumstances. I believe the military presence increases the education level.*
- *I have no doubt the data is accurate (as accurate as can be).*

Question: Do you agree with the written comments received on the 2015 CHNA?



Comments:

- *There are a few statements that I do not agree on.*
- *I feel our biggest need is appropriately trained & stable Primary Care Providers and a focus on drug & mental health education.*
- *I too suffer from Hemochromatosis. Dermatology locally would be good. Glad to see the local allergy clinic up and running.*
- *I have seen real improvements in the ER and in their willingness to partner with community. I agree that diabetes management and prevention needs to be a priority.*
- *Yes, and housing is a huge need. I also don't see anything about suicide prevention which needs to be addressed.*

Appendix C – National Healthcare Quality and Disparities Report[33]

The National Healthcare Quality and Disparities Reports (QDR) (annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

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

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

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

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

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

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[34] consistent with these trends.

[33] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i

[34] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.

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

Trends

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

Disparities

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

Trends

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

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

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[35]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[36]

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

Disparities

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).

---

[35] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

[36] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

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

Disparity Trends

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

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

Trends

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

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

Trends

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

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

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall

performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

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

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

Improving Quickly

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

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

time of surgery

Worsening

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

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

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

Disparities

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

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

Disparity Trends

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

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

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

Disparities Trends

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

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

Geographic Disparities

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

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

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

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[37]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

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

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

Trends

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

Disparities

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

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

Disparities Trends

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

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

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

Trends

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

Disparities

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

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

Trends

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

Disparities

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

Disparities Trends

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

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

Trends

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

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

Disparities

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

Disparities Trends

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

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

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

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[38]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or

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

prescription medicines who indicated a financial or insurance reason for the problem was:

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

CONCLUSION

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

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