Gerald Champion Regional Medical Center

Alamogordo, NM

Community Health Needs Assessment

Adopted by Board Resolution June 29, 2021[1]

Gerald Champion Regional Medical Center
Our Family Caring for Yours

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

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EXECUTIVE SUMMARY

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Gerald Champion Regional Medical Center ("GCRMC" 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. Additionally, the group reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The 2021 Significant Health Needs identified for Otero County are:

- Behavioral Health
- Substance Abuse
- Access to Primary Care
- Education/Prevention
- Diabetes
- Heart Disease
- Cancer
- Obesity

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

APPROACH

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Gerald Champion Regional Medical Center ("GCRMC" 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designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent Schedule H (Form 990) filings made by the hospital.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

GCRMC 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 for 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:

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

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

[3] As of the date of this report all tax questions and suggested answers relate to 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

- 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:*
>
> *(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*

[5] Section 6652

community, or individuals or organizations serving or representing the interests of such populations; and

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

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

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

To complete a CHNA:

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

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

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

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

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

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

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."[7]

Additionally, all CHNAs developed after the very first CHNA received written commentary on the prior

[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

[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

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. Input was obtained from the required three minimum sources and expanded input to include other representative groups. The Hospital asked all those 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 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]

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[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
[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

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	April 2021	2013-2019
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	April 2021	2019
http://svi.cdc.gov	To identify the Social Vulnerability Index value	April 2021	2018
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	April 2021	2019

A standard process of gathering community input was developed. In addition to gathering data from the above sources:

- A CHNA survey was deployed to the Hospital's Local Expert Advisors and offered to the community, through the Hospital social media and website, 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 27 Local Expert Advisors was received. Survey responses started April 19, 2021 and ended on May 11, 2021.
- 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

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

conditions of these groups. .[12] [13]

- 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:
    - The top three priority populations identified by the Local Experts were low-income groups, older adults, and racial and ethnic minority groups
    - Summary of unique or pressing needs of the priority groups:
        - Access to affordable healthcare
        - Education on services and health programs
        - Mental health education and services

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. [14]

In the GCRMC process, the Local Experts 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 ranked each health needs importance from not at all (1 rating) to extremely significant (5 rating). The Hospital analyzed the health issues that received the most responses and established a plan for addressing them.

The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation where a reasonable break point in rank order occurred. [15]

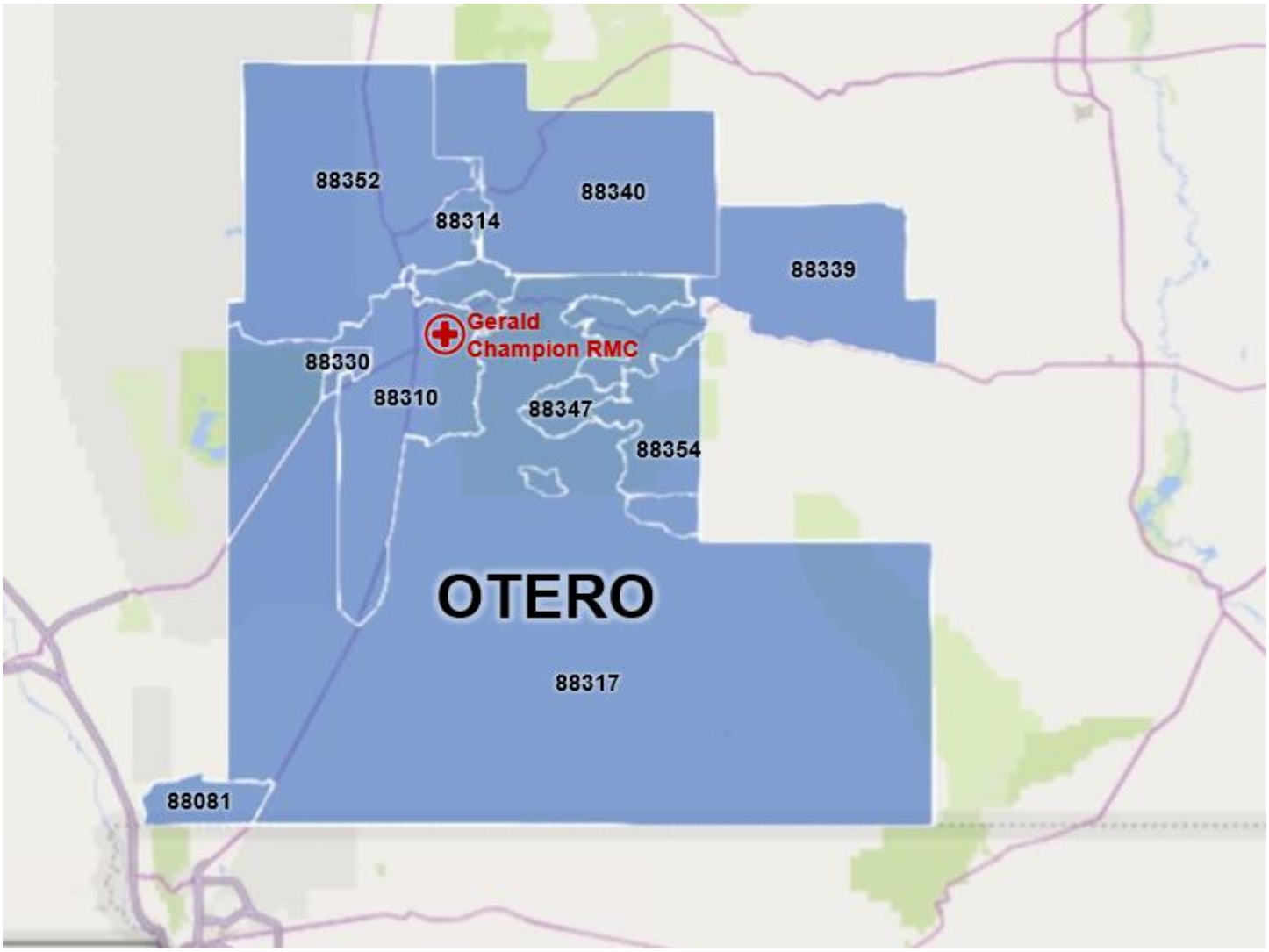
[12] Response to Schedule H (Form 990) Part V B 3 f
[13] Response to Schedule H (Form 990) Part V B 3 h
[14] Response to Schedule H (Form 990) Part V B 5
[15] Response to Schedule H (Form 990) Part V B 3 g

Overview of COVID-19 Survey Results:

- As an addition to the survey, GCRMC gathered input from Local Experts on the impacts COVID-19 has had on their community. Below you will find and overview of their feedback; See the appendix for full survey responses:
    - **Overall impact of COVID-19:** It is clear from the survey results that the community was impacted by COVID-19 personally or in their household; 45% of the surveyors reported being noticeably impacted by the pandemic and 45% reported significant daily disruption with reduced access to healthcare services or severe daily disruption, immediate needs unmet
    - **Social Determinants of Health:** Social determinants of health have been shown to have a considerable effect on COVID-19 outcomes. The top areas respondents reported as negatively impacted by the pandemic include education, employment, social support systems, childcare, and access to healthcare services. As a result of this, mental health issues have increased throughout the community.
    - **Delay in Healthcare Services:** As a result of COVID-19, 40% of surveyors reported delaying specialty care, 35% reported delaying primary care and 25% elective care.
    - **Community Support:** There are several ways that healthcare providers, like GCRMC, can support the community through these pressing times. Examples include serving as a trusted source of information and education, offering alternatives to in-person healthcare visits, connecting with patients through digital communication channels, and posting enhanced safety measures and process changes to prepare for upcoming appointments.
    - **Pressing Healthcare Services/Programs:** The healthcare services/programs identified by respondents as being most important to supporting community health throughout the pandemic are primary care, mental health, primary specialty care, elder/senior care and substance abuse services.
    - **Alternative Care Options:** Establishing alternative options to in-person care will continue to be a critical piece of the COVID response. Survey respondents believe video and telephone, smartphone apps, and remote monitoring technologies to manage chronic diseases would be most beneficial to the local community

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[16]



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:[17]

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

During 2018, the Hospital received 87.3% of its Medicare inpatients from this area. [18]

[16] Responds to IRS Schedule H (Form 990) Part V B 3 a
[17] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[18] 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 [19] [20]

Variable	Otero County	New Mexico	United States
DEMOGRAPHIC SUMMARY			
2020 Population	**68,853**	**2,158,077**	**333,793,107**
2025 Population	**70,785**	**2,216,618**	**346,021,282**
2020-2025 % Change	**2.8%**	**2.7%**	**3.7%**
2020 Median Household Income	**$42,509**	**$47,016**	**$62,203**
2025 Median Household Income	**$44,045**	**$49,693**	**$67,325**
2020 Median Age	**37.6**	**38.0**	**38.5**
2025 Median Age	**38.5**	**38.8**	**39.3**

	Otero County					*United States*
Age Group	**2020**	**2020 %Total**	**2025**	**2025 %Total**	**%Change**	**US % Change**
0-4	4,787	7.0%	4,903	6.9%	2.4%	3.7%
5-9	4,526	6.6%	4,656	6.6%	2.9%	0.9%
10-14	4,379	6.4%	4,575	6.5%	4.5%	1.8%
15-17	2,398	3.5%	2,601	3.7%	8.5%	3.2%
18-20	2,642	3.8%	2,738	3.9%	3.6%	0.8%
21-24	3,811	5.5%	3,659	5.2%	-4.0%	-3.3%
25-29	5,156	7.5%	4,415	6.2%	-14.4%	-6.6%
30-34	4,493	6.5%	4,688	6.6%	4.3%	7.7%
35-39	4,308	6.3%	4,492	6.3%	4.3%	7.5%
40-44	3,682	5.3%	4,348	6.1%	18.1%	10.6%
45-49	3,602	5.2%	3,747	5.3%	4.0%	-1.1%
50-54	3,854	5.6%	3,623	5.1%	-6.0%	-3.2%
55-59	4,541	6.6%	3,821	5.4%	-15.9%	-8.1%
60-64	4,401	6.4%	4,670	6.6%	6.1%	2.2%
65-69	3,861	5.6%	4,246	6.0%	10.0%	10.7%
70-74	3,430	5.0%	3,750	5.3%	9.3%	15.6%
75-79	2,229	3.2%	2,792	3.9%	25.3%	31.7%
80-84	1,486	2.2%	1,655	2.3%	11.4%	24.1%
85+	1,267	1.8%	1,406	2.0%	11.0%	7.3%
Total	68,853	100.0%	70,785	100.0%	2.8%	3.7%

[19] Responds to IRS Schedule H (Form 990) Part V B 3 b
[20] Claritas (accessed through IBM Watson Health)

	Otero County				
Gender	**2020**	**2020 %Total**	**2025**	**2025 %Total**	**%Change**
Male Population	34,726	50.4%	35,753	50.5%	3.0%
Female Population	34,127	49.6%	35,032	49.5%	2.7%
Total	**68,853**	**100.0%**	**70,785**	**100.0%**	**2.8%**
Females, Child Bearing Age (15-44)	12,542	18.2%	12,742	18.0%	1.6%
Race	**2020**	**2020 %Total**	**2025**	**2025 %Total**	**%Change**
White	47,444	68.9%	47,648	67.3%	0.4%
Black	2,530	3.7%	2,607	3.7%	3.0%
American Indian	5,477	8.0%	6,060	8.6%	10.6%
Asian	964	1.4%	1,057	1.5%	9.6%
Pacific Islander	131	0.2%	130	0.2%	-0.8%
Other Race	9,137	13.3%	9,863	13.9%	7.9%
Two or More Races	3,170	4.6%	3,420	4.8%	7.9%
Total	68,853	100.0%	70,785	100.0%	2.8%
Hispanic*	*27,500*	*39.9%*	*29,956*	*42.3%*	*8.9%*

Ethnicity is calculated separately from Race

Household Income	**2020**	**2020 %Total**	**2025**	**2025 %Total**	**%Change**
<$15,000	5,219	19.6%	5,204	18.9%	-0.3%
$15,000-24,999	2,740	10.3%	2,714	9.9%	-0.9%
$25,000-34,999	2,870	10.8%	2,928	10.7%	2.0%
$35,000-49,999	4,270	16.0%	4,264	15.5%	-0.1%
$50,000-74,999	5,047	18.9%	5,412	19.7%	7.2%
$75,000-99,999	3,047	11.4%	3,146	11.5%	3.2%
$100,000-149,999	2,027	7.6%	2,121	7.7%	4.6%
$150,000-199,999	958	3.6%	1,149	4.2%	19.9%
$200,000+	465	1.7%	535	1.9%	15.1%
Total	**26,643**	**100.0%**	**27,473**	**100.0%**	**3.1%**

Education	**2020 Pop. 25+**	**2020 %Total**
< 9th Grade	3,006	6.5%
High School/No Diploma	4,545	9.8%
GED	2,684	5.8%
High School Diploma	9,715	21.0%
Some College/No Degree	12,483	27.0%
Associates Degree	4,725	10.2%
Bachelor's Degree	5,410	11.7%
Grad/Professional Degree	3,742	8.1%
Total	**46,310**	**100.0%**

Consumer Health Service Behavior[21]

Key health services topics for the service area population are presented in the table below. In the second column of the chart, 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 the GCRMC Service Area 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	112.8%	34.4%	Cancer Screen: Skin 2 yr	83.7%	9.0%
Vigorous Exercise	91.8%	52.4%	Cancer Screen: Colorectal 2 yr	90.9%	18.7%
Chronic Diabetes	109.7%	17.2%	Cancer Screen: Pap/Cerv Test 2 yr	82.7%	39.8%
Healthy Eating Habits	99.2%	23.1%	Routine Screen: Prostate 2 yr	89.2%	25.4%
Ate Breakfast Yesterday	95.7%	75.7%	**Orthopedic**		
Slept Less Than 6 Hours	117.8%	16.1%	Chronic Lower Back Pain	107.2%	33.1%
Consumed Alcohol in the Past 30 Days	78.7%	42.3%	Chronic Osteoporosis	134.1%	13.6%
Consumed 3+ Drinks Per Session	118.4%	33.3%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	101.0%	82.1%
Search for Pricing Info	82.7%	22.3%	NP/PA Last 6 Months	103.0%	42.7%
I am Responsible for My Health	99.4%	90.0%	OB/Gyn 1+ Visit	79.4%	30.5%
I Follow Treatment Recommendations	100.7%	77.6%	Medication: Received Prescription	105.2%	62.6%
Pulmonary			**Internet Usage**		
Chronic COPD	132.4%	7.1%	Use Internet to Look for Provider Info	78.5%	31.4%
Chronic Asthma	102.8%	12.1%	Facebook Opinions	93.9%	9.5%
Heart			Looked for Provider Rating	74.5%	17.5%
Chronic High Cholesterol	109.7%	26.8%	**Emergency Services**		
Routine Cholesterol Screening	90.3%	40.0%	Emergency Room Use	105.0%	36.5%
Chronic Heart Failure	151.4%	6.1%	Urgent Care Use	88.0%	29.0%

Conclusions from Demographic Analysis Compared to National Averages

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

- 8% less likely to **Vigorously Exercise**, affecting 52%
- 10% less likely to receive **Routine Cholesterol Screenings**, affecting 40%
- 17% less likely to receive **Cervical Cancer Screenings Every 2 Years**, affecting 40%

[21] Claritas (accessed through IBM Watson Health)

- 5% more likely to **Visit Emergency Room for Non-Emergent Needs**, affecting 37%
- 13% more likely to have a **BMI: Morbid/Obese**, affecting 34%
- 7% more likely to have **Chronic Lower Back Pain**, affecting 33%
- 18% more likely to **Consume 3+ Drinks per Session**, affecting 33%
- 21% less likely to have **Routine OB/Gyn Visit**, affecting 31%

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

- 21% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 42%

Leading Causes of Death[22]

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 tables below in GCRMC'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 (Otero County Compared to U.S.)
NM Rank	Otero Rank	Condition		NM	Otero	
1	1	Heart Disease	10 of 32	158.2	198.0	***Higher than expected***
2	2	Cancer	9 of 32	131.9	166.3	***Higher than expected***
4	3	Lung	12 of 32	40.1	51.8	***Higher than expected***
3	4	Accidents	30 of 32	77.7	51.4	***As expected***
5	5	Stroke	22 of 32	33.2	34.9	***As expected***
6	6	Diabetes	14 of 32	25.4	33.6	***Higher than expected***
9	7	Suicide	11 of 32	24.0	25.3	***Higher than expected***
7	8	Liver	19 of 32	26.2	17.6	***Higher than expected***
10	9	Flu - Pneumonia	27 of 32	13.2	13.6	***As expected***
8	10	Alzheimer's	24 of 32	21.3	13.4	***Lower than expected***
11	11	Kidney	16 of 32	12.9	13.1	***As expected***
15	12	Hypertension	4 of 32	5.2	8.5	***As expected***
12	13	Blood Poisoning	21 of 32	9.2	7.9	***As expected***
14	14	Parkinson's	20 of 32	8.1	6.4	***As expected***
13	15	Homicide	23 of 32	11.7	6.3	***As expected***

**County Death Rate Observation: Higher than expected = 5 or more deaths per 100,000 compared to the US; Lower than expect = 5 or more less deaths per 100,000 compared to the US*

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

Priority Populations[23]

Information about Priority Populations in the service area of the Hospital is difficult to access, 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)**.

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 trends in the service area. Accordingly, the Hospital places great importance on the commentary received from the Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[24]

- The top three priority populations identified by the Local Experts were low-income groups, older adults, and racial and ethnic minority groups
- Summary of unique or pressing needs of the priority groups:
    - Access to affordable healthcare
    - Education on services and health programs
    - Mental health education and services

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

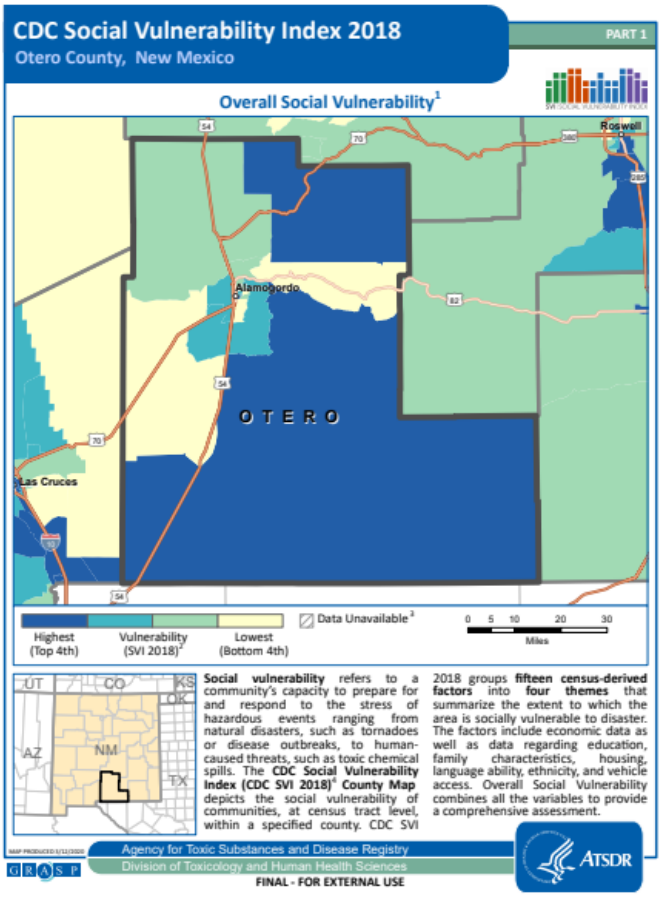
Social Vulnerability[25]

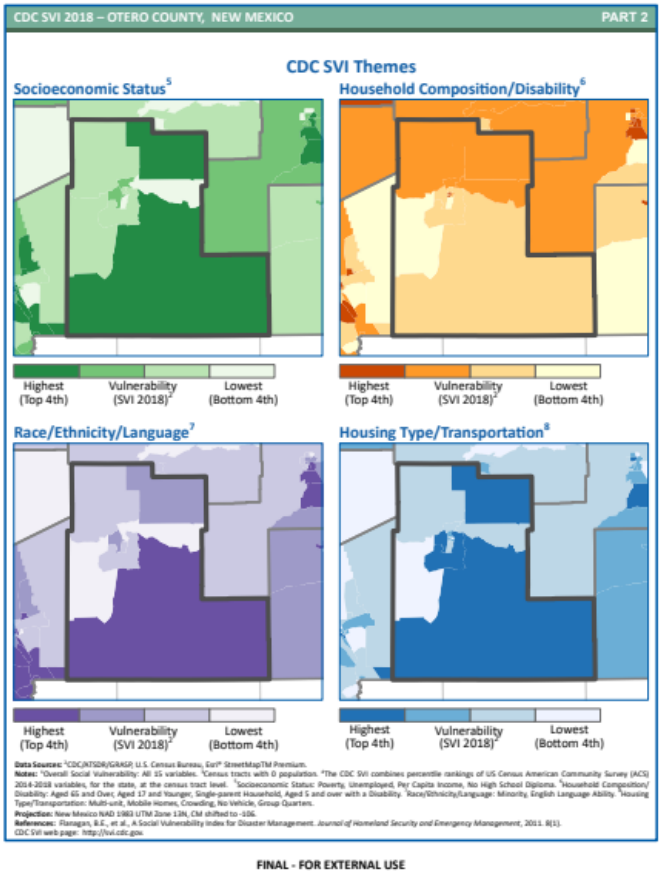
Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss. The Social Vulnerability Index uses U.S. census variables at tract level to help local officials identify communities that may need support in preparing for hazards, or recovering from disaster.

Social Vulnerability ranks an area's ability to prepare for and respond to disasters. Measures of socioeconomic status, household composition, race/ethnicity/language, and housing/transportation are layered to determine an area's overall vulnerability.

Based on the overall social vulnerability, Otero County falls into all four quartiles of social vulnerability. The lower half and upper right region of the county has the highest vulnerability, which makes up the majority of the county. The Alamogordo area is a mix of the first, second, and third quartiles (lowest – second highest), meaning there is a variety of social vulnerability in this area.

Link to Otero, NM SVI Map





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

Comparison to Other State Counties[26]

To better understand the community, Otero County has been compared to all 33 counties in the state of New Mexico across six areas: Length of Life, Quality of Life, 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, each county's rank compared to all counties is listed along with any measures in each area compared to state average and U.S. median.

	Otero County	New Mexico	U.S. Median	Top U.S. Performers
Length of Life				
Overall Rank *(best being #1)*	***8/33***			
- Premature Death*	**8,600**	9,100	8,200	5,400
Quality of Life				
Overall Rank *(best being #1)*	***16/33***			
- Poor or Fair Health	**22%**	20%	17%	14%
- Poor Physical Health Days	**4.9**	4.3	3.9	3.4
- Poor Mental Health Days	**4.8**	4.5	4.2	3.8
- Low Birthweight	**8%**	9%	8%	6%
Health Behaviors				
Overall Rank *(best being #1)*	***22/33***			
- Adult Smoking	**20%**	16%	17%	16%
- Adult Obesity	**31%**	27%	33%	26%
- Physical Inactivity	**23%**	19%	27%	19%
- Access to Exercise Opportunities	**55%**	77%	66%	91%
- Excessive Drinking	**16%**	17%	18%	15%
- Alcohol-Impaired Driving Deaths	**26%**	30%	28%	15%
- Sexually Transmitted Infections*	**560.6**	670.5	327.4	161.2
- Teen Births *(per 1,000 female population ages 15-19)*	**46**	32	28	12
Clinical Care				
Overall Rank *(best being #1)*	***13/33***			
- Uninsured	**12%**	12%	11%	6%
- Population to Primary Care Provider Ratio	**2,390:1**	1,340:1	2,070:1	1,030:1
- Population to Dentist Ratio	**1,870:1**	1,440:1	2,410:1	1,210:1
- Population to Mental Health Provider Ratio	**360:1**	250:1	890:1	270:1
- Preventable Hospital Stays	**2,790**	2,894	4,710	2,565
- Mammography Screening	**41%**	35%	41%	51%
- Flu vaccinations	**34%**	40%	43%	55%
Social & Economic Factors				
Overall Rank *(best being #1)*	***10/33***			
- High school graduation	**83%**	86%	90%	94%
- Unemployment	**4.9%**	4.9%	3.9%	2.6%
- Children in Poverty	**28%**	24%	20%	10%
- Income inequality**	**4.4**	5.1	4.4	3.7
- Children in Single-Parent Households	**23%**	30%	32%	14%
- Violent Crime*	**355**	650	205	63
- Injury Deaths*	**102**	108	84	59
- Median household income	**$43,100**	$52,000	$50,600	$72,900
- Suicides	**29**	24	17	11
Physical Environment				
Overall Rank *(best being #1)*	***17/33***			
- Air Pollution - Particulate Matter	**6.4 µg/m³**	5.6 µg/m³	9.4 µg/m³	5.2 µg/m³
- Severe Housing Problems***	**12%**	17%	14%	9%
- Driving to work alone	**80%**	80%	81%	72%
- Long commute - driving alone	**18%**	27%	31%	16%

Key (Legend)
- Better than Average
- Average
- Worse than Average

Per 100,000 Population
****Ratio of household income at the 80th percentile to income at the 20th percentile***
*****Overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities***

[26] www.countyhealthrankings.org

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Local Expert Survey)

Hospital solicited written comments about its 2018 CHNA.[27] 27 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.[28]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	3	16	19
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	4	18	22
3) **Priority Populations**	8	12	20
4) Representative/Member of **Chronic Disease Group** or Organization	4	17	21
5) Represents the **Broad Interest of the Community**	25	0	25
Other	9		9

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?

- *Not enough help to keep patients in their homes due to finances. New Mexico is low income, especially the elderly. Very few can afford private caregivers. Need more funding to allow personal care to increase to care for the growing elderly population.*
- *Access to information about health care; available resources.*

[27] Responds to IRS Schedule H (Form 990) Part V B 5
[28] Responds to IRS Schedule H (Form 990) Part V B 3 g

- *Lack of access to services. Being stigmatized and marginalized*
- *100% vaccinated against Covid-19. I am sure that racial and ethnic and low-income groups are under served with regard to medical and dental care. I do not mean to indicate that is the fault of the providers. There are many social and economic issues to be addressed. I think GCRMC does and outstanding job of providing care to all groups.*
- *I believe all of these groups are represented in our community. In almost all cases, they are lacking in information regarding: how to access to healthcare, how insurance works and what alternatives are available to traditional office visits (such as telehealth).*
- *Domestic Violence affects all*
- *A significant swath of the community has behavioral medicine needs*
- *Mental Health and Educational Health Services*
- *Mental Health Education and service*

In the 2018 CHNA, there were five health needs identified as "significant" or most important:

1. Access to Primary Care
2. Behavioral Health
3. Obesity
4. Cancer
5. Diabetes

3. Please share comments or observations about the actions GCRMC has taken to address Access to Primary Care.

- *Teaming with Family Medicine Residency program helps to grow providers in Primary Care.*
- *Initiated telehealth services*
- *We have lots of Primary Care providers. We also make sure patients have a primary care connection with discharge.*
- *Does appear to be growing. Many in the community complain that there are too many CNP's and not enough physicians for primary care.*
- *I believe GCRMC has worked very hard to secure Audi primary Health however because of poor leadership at a state level It can be difficult to obtain high-level medical professionals it can be difficult to obtain high-level medical professionals*
- *Urgent Care / Family Medicine clinics now available (apart from main hospital).*
- *1) I still hear negative things about the Emergency Department. 2) Dr's offices do not follow through with patients. There needs to be a patient advocate to help navigate all of the things that drop through the cracks*
- *GCRMC has acquired all Primary Care Physician in the area to serve the citizens.*

- *That is an issue. There are a limited number of primary care physicians.*
- *GCRMC has increased its primary care providers as well as added telehealth to its service delivery methods.*
- *I know GCRMC has been working hard to increase the access to primary care and we have seen several new physician practices open.*
- *Continued outreach in reaching the community including CEO's Newsletter, The Community Advisory Committee, Web Site, Recruitment & placement of CPN's & LPN's, Tele Med. In the past health fairs and community in person events. (Pre-COVID) before social distance and contact rules. Note: On a personnel level my PC. My wife and I would not trade her or her staff for anyone else including doctors. I think the use of CPN as a PCP is the way to go in health care. My wife and I both have COVID in November and her staff/nurses treatment and Rx regiment (in our home) got us both through COVID without hospitalization. Credit to use of tele med included.*
- *GCRMC has established a Family Medicine Residency Program which will address the current limited opportunities for patients to be seen as we have few of these types of providers.*
- *GCRMC has added primary care providers and supports other providers in the community*
- *New & updated facilities. Continued efforts is providing medical professionals in diverse areas of expertise.*
- *Growing primary care providers and offices.*
- *Having access to physicians in the community and having a choice is very helpful.*

4. **Please share comments or observations about the actions GCRMC has taken to address Behavioral Health.**

- *Continue to work to grow an Inpatient and Outpatient Behavioral Health programs.*
- *Inpatient Behavioral Health unit w/ outpatient unit*
- *We have Inpatient and Outpatient Behavioral Health. There still need to be growth with demand vs supply in this field.*
- *I believe great strides have been made here!*
- *Outpatient/Inpatient facilities; increased staff. But still a problem (accessing? Awareness of?) care. Consistent staffing concerns.*
- *There had been much growth in the Behavioral medicine services, but that group doesn't seem active in the MH provider community now. Haven't heard from them.*
- *From the information I have received from the community, GCRMC has done an excellent job with the Behavioral Health.*
- *Behavioral health is an issue in this community. It is an issue for the Courts. However, I think GCRMC has recently done an admirable job in provision of that.*
- *GCRMC has added behavioral health services and providers since 2018 but still lacks accessibility for*

the community. Wait times are too long to get appointments and providers are hesitant to refer to this department.

- *Behavioral Health services are much more prominent in our community.*
- *GCRMC continues to recruit behavioral health providers to manage inpatient and outpatient service lines. Staff leave after a short time and permanent staff is difficult to find. New and critical service lines have been added as stepdown or bridging from inpatient to outpatient but again, lack of providers to manage.*
- *GCRMC has grown it BH program*
- *GCRMC has increased services such as Partial Hospitalization Unit.*
- *Growing services at different locations both inpatient and outpatient.*
- *Expanding behavioral health in our community has been very beneficial as these problems will never go away.*

5. **Please share comments or observations about the actions GCRMC has taken to address Obesity.**

- *Diabetes Education and CNP program for weight management*
- *Offer healthy choices for patients and staff. Also, to the public.*
- *Needs more community knowledge and programs. Sadly, too many fast food restaurants.*
- *Community "lectures" on healthy weight, available program*
- *Potentially hired an outpatient nutritionist*
- *GCRMC has added/expanded the Weight Clinic utilization but could perhaps advertise it more.*
- *Classes are available as much as possible in spite of the challenges of COVID.*
- *GCRMC has increased its focus on Wellness and now has a dedicated Nurse Practitioner.*
- *GCRMC has supported community education*
- *Employed nutritionists.*
- *Increase education in primary care and growing outpatient services to provide individualized education on nutrition.*

6. **Please share comments or observations about the actions GCRMC has taken to address Cancer.**

- *Support current Cancer Center*
- *Cancer center and renovations coming specific to cancer services*
- *GCRMC doctor and her team that do an amazing job.*

- *Center is growing. Great to have the services in our community as many cannot travel out of town.*
- *Local residents continue to receive good care at GCRMC Cancer Center. Building of new Center underway.*
- *Hearing a lack of referrals or follow through for patients from PCPs. Some are just sent home with a cancer diagnosis, and not assisted in finding a specialist. Services here are very limited. Are you affiliated with UNM Comp Cancer Program?*
- *I have received information from the community about the Cancer Center and everyone is appreciative.*
- *The community is very fortunate that GCRMC has built and provides oncology services at the local level. I am sure we are very fortunate for a community of our size.*
- *The Cancer Center continues to serve the community but is resistant to telehealth follow up appointments and counseling.*
- *Community outreach presentations.*
- *GCRMC is currently working to expand Cancer Center and improve ambiance for patients.*
- *Cancer center opened with knowledgeable professionals*
- *GCRMC has updated the services and equipment to treat cancer.*
- *Growing services and providers. Networking with large cancer center networks to expand access to treatment and options.*

7. Please share comments or observations about the actions GCRMC has taken to address Cancer.

- *Diabetes program and Nurse Educator*
- *We have diabetic education and endocrinologist.*
- *Another major NM issue (as obesity.) Not enough education or intervention. Education is dependent on the provider and many only understand the meds (i.e. not cooking, other habits, etc.) There is an outpatient dietician but not very involved in community.*
- *Clear progress has been made in this area*
- *So thankful to have GCRMC doctors and CNPs to care for community.*
- *Diabetes education was an accredited program, now vacant and hasn't been active*
- *This is an excellent program with the Diabetes. Many people are better as a result of GCRMC doctor's help.*
- *The diabetes providers are seeing patients via telehealth, which is great! Can expand further.*
- *As stated above, GCRMC has increased it's focus on Wellness. Recruiting a Diabetic Educator as the one we had move up to become a Nurse Practitioner.*
- *You have many Physicians knowledgeable in the field of Diabetes.*
- *GCRMC has employed registered dietitians to help with dietetic counseling.*

- *Growing outpatient services and education*

Appendix B – Identification & Prioritization of Community Needs (Local Expert Survey)

Survey question: Please rate each item's importance on a scale of 1 (Not at all) to 5 (Extremely) = 2018 Identified Significant Health Needs*

Health Need	Significant *4 Rating*	Extremely Significant *5 Rating*	Combined *4+5 Rating*
Access to Primary Healthcare*	37%	63%	100%
Behavioral Health (depression, anxiety, suicide)*	11%	84%	95%
Affordable Healthcare	28%	67%	94%
Diabetes*	44%	50%	94%
Physical Activity	42%	47%	89%
Youth Health Education	26%	63%	89%
Drug/Substance Abuse	32%	58%	89%
Obesity/Overweight*	37%	53%	89%
Heart Disease	50%	39%	89%
Hypertension	56%	33%	89%
Education/Prevention (Healthy Lifestyle Promotion)	21%	63%	84%
Stroke	44%	39%	83%
Smoking/Tobacco Use	33%	50%	83%
Lung (asthma, COPD)	44%	33%	78%
Social Factors	44%	33%	78%
Women's Health	44%	33%	78%
Cancer*	32%	42%	74%
Dental	58%	16%	74%
Infectious/contagious disease (flu, pneumonia, food poisoning)	39%	22%	61%
Alzheimer's	47%	12%	59%
Accidents	28%	11%	39%

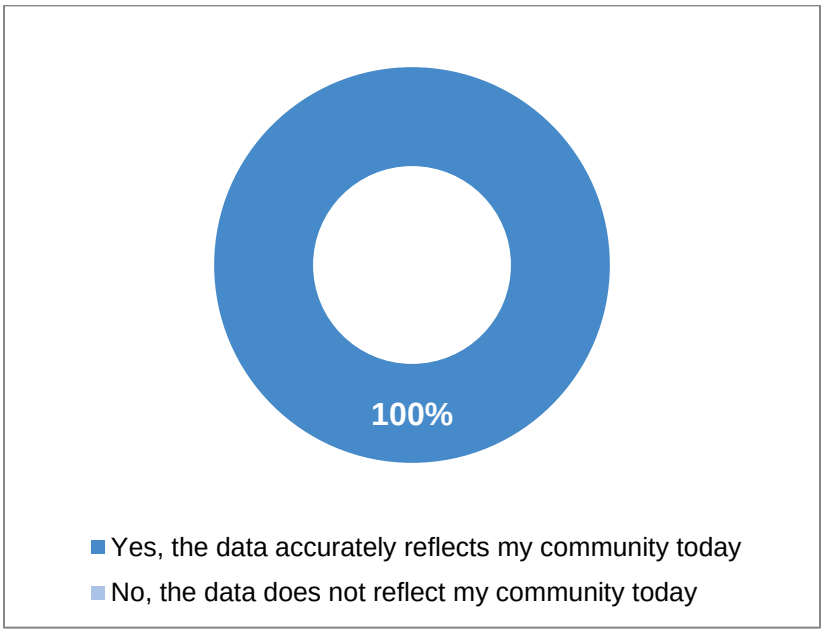
* = 2018 Significant Need

Survey question: Of the issues listed above for Otero County, which 3 do you think are most important within the community?

Health Need	1	2	3	4	Total
Behavioral Health	45%	15%	0%	13%	73%
Substance Abuse	0%	15%	15%	38%	68%
Access to Primary Care	20%	15%	5%	13%	53%
Education/Prevention	5%	10%	15%	0%	30%
Diabetes	5%	0%	10%	13%	28%
Heart Disease	0%	10%	0%	13%	23%
Cancer	5%	5%	10%	0%	20%
Obesity	10%	0%	10%	0%	20%
Information about healthcare services	0%	5%	0%	13%	18%
Affordable Healthcare	5%	5%	5%	0%	15%
Lung Disease	0%	5%	5%	0%	10%
Youth Health Education	0%	0%	10%	0%	10%
Access to Healthcare	0%	5%	0%	0%	5%
Dental	0%	5%	0%	0%	5%
Hypertension	0%	0%	5%	0%	5%
Infectious Disease	0%	5%	0%	0%	5%
Physical Activity	0%	0%	5%	0%	5%
Primary care	5%	0%	0%	0%	5%
Social Factors	0%	0%	5%	0%	5%

Advice Received from Local Expert Advisors

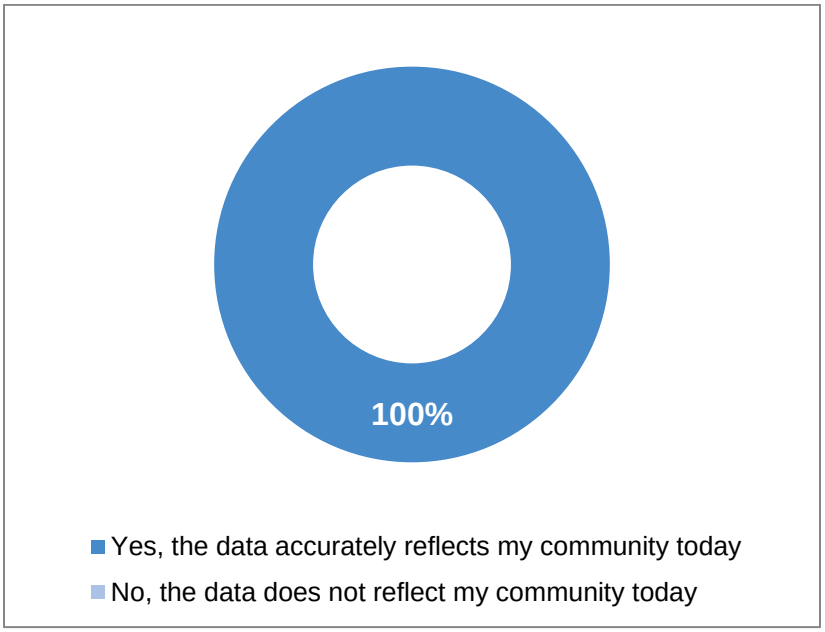
Question: Do you agree with the comparison of Otero County compared to New Mexico and the US?



Comments:

- *I am not informed well enough to make an accurate choice. I wouldn't be surprised if actual percentages of negative health habits/behaviors aren't higher.*
- *Data not reflected here which should be: low birth weights; suicide death rate; alcohol-related harm; eating 5 or more fruits & vegetable servings per day.*
- *Continue to work on getting Otero numbers that are above average down.*
- *I feel the % that Visit Emergency Room for Non-Emergent Needs should be higher as well as the Morbid/Obese BMI.*

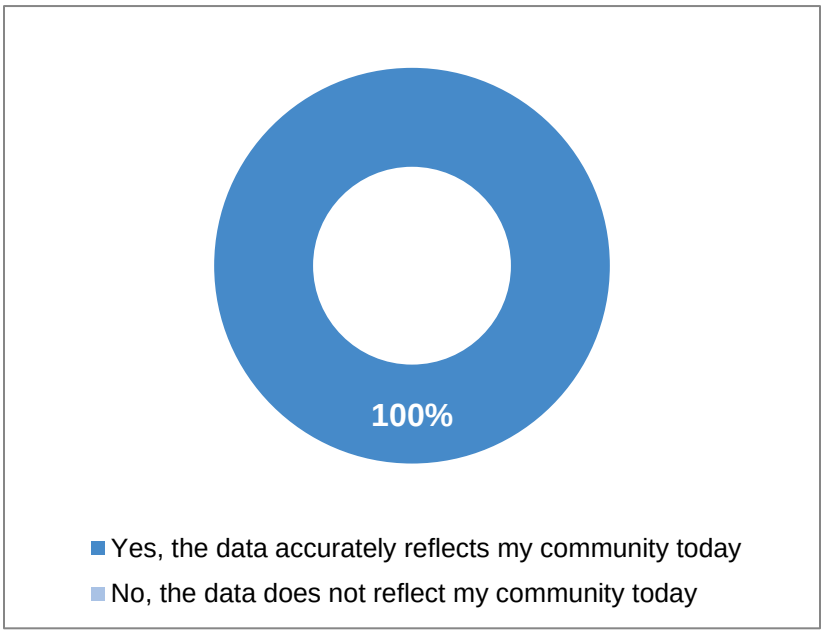
Question: Do you agree with the demographics and common health behaviors of GCRMC's Service Area?



Comments:

- *I do believe that alcohol isn't much more serious problem then we recognize. In my industry also seeing effects of drugs in our community is just horrific. Clearly we need drug treatment center options and more intervention there as well.*
- *No reason to doubt accuracy of data.*
- *Yes because I believe in data, but I am surprised we are ranked 8 out of 33 given all the other factors on which we rank poorly.*
- *I believe this information is correct.*
- *I have no idea really but hope the data sources are validating their data!*
- *As sad as it makes me. I am afraid it does.*
- *Continue to work on getting Otero numbers that are above average down. Find ways to do outreach under COVID restriction..*
- *I think part of the air pollution is caused by dirt and sand in the air.*
- *As a somewhat rural community there will be a continuing issue of the lack of primary care and dental providers. Adult obesity is a continuing national problem.*

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

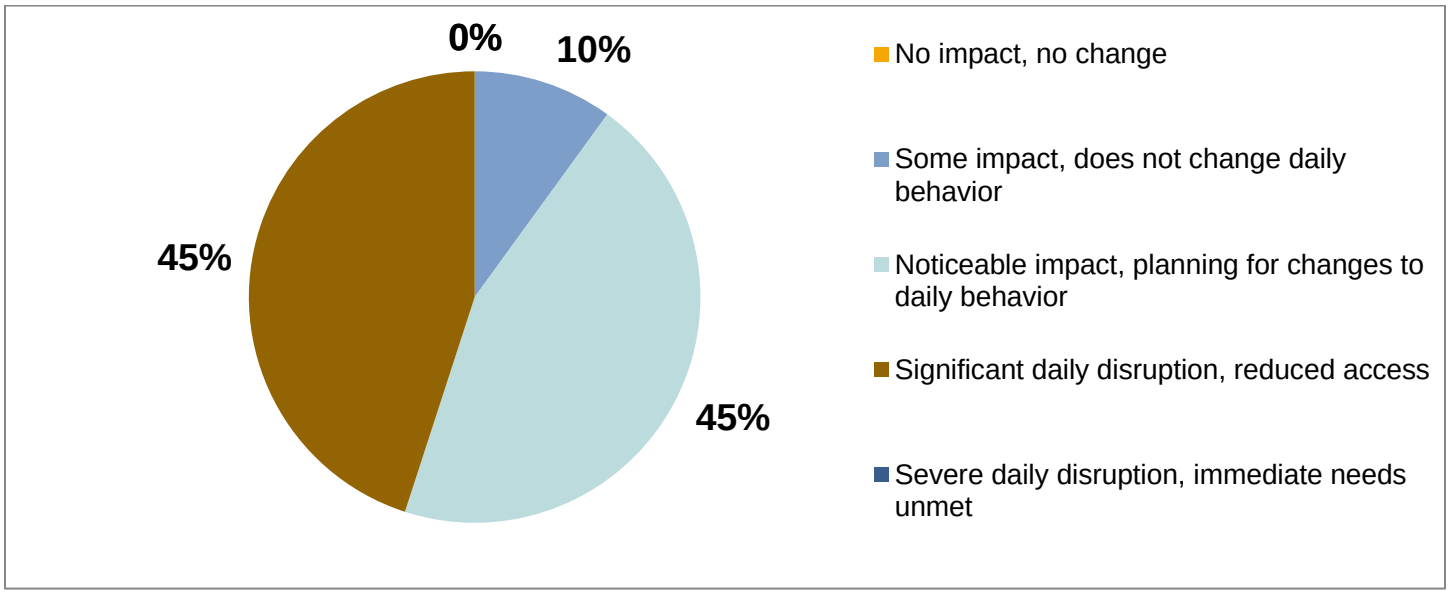


Comments:

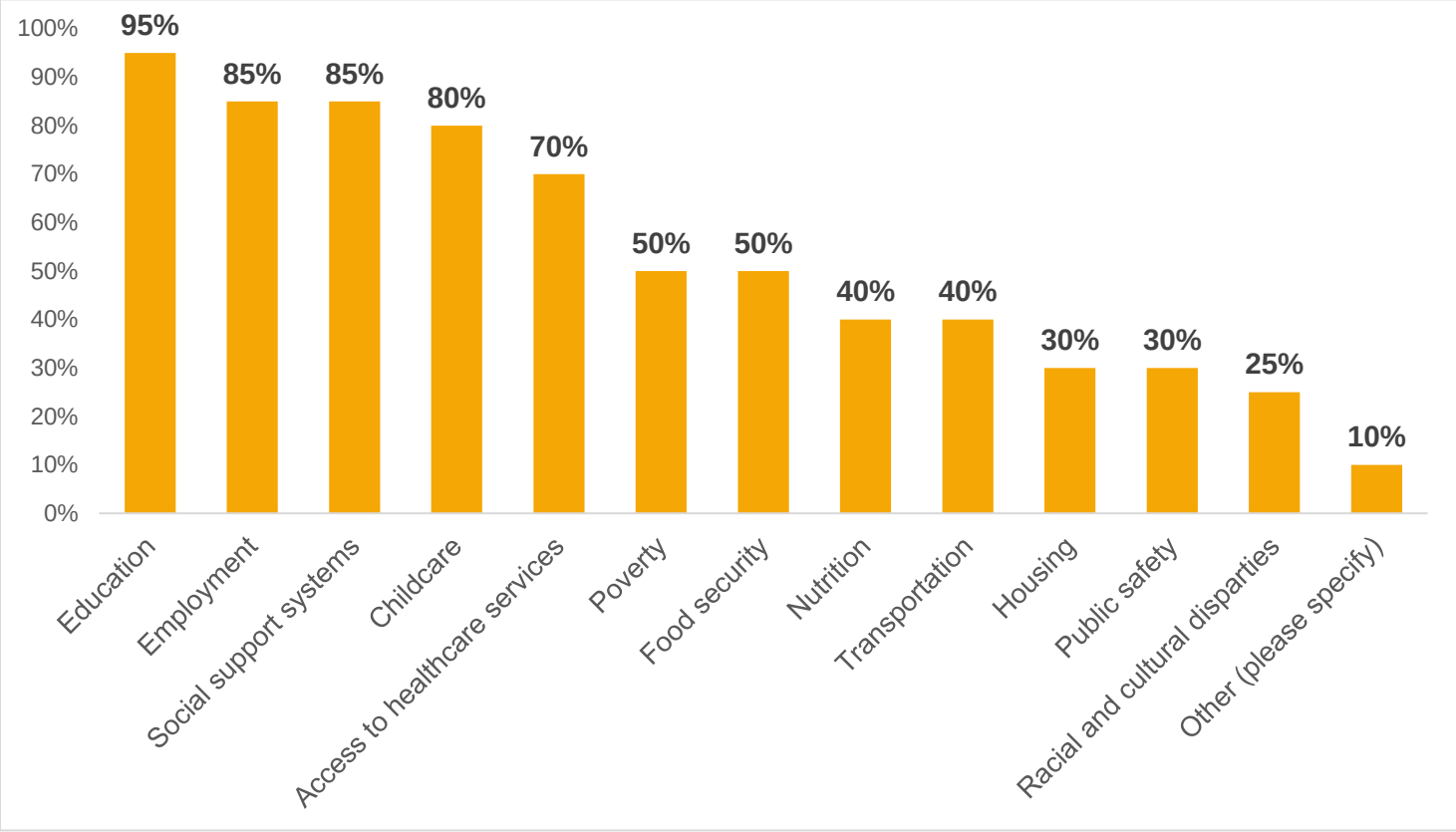
- *No reason to doubt the accuracy of the data.*
- *The diseases listed as "Higher than expected" are the ones we see most in Hospice (except suicide of course).*
- *Continue to work on getting Otero numbers that are above average down. Education & Outreach*
- *We definitely need more resources on suicide prevention.*

Local Expert COVID-19 Impacts

Question: Overall, how much has the COVID-19 pandemic affected you and your household?



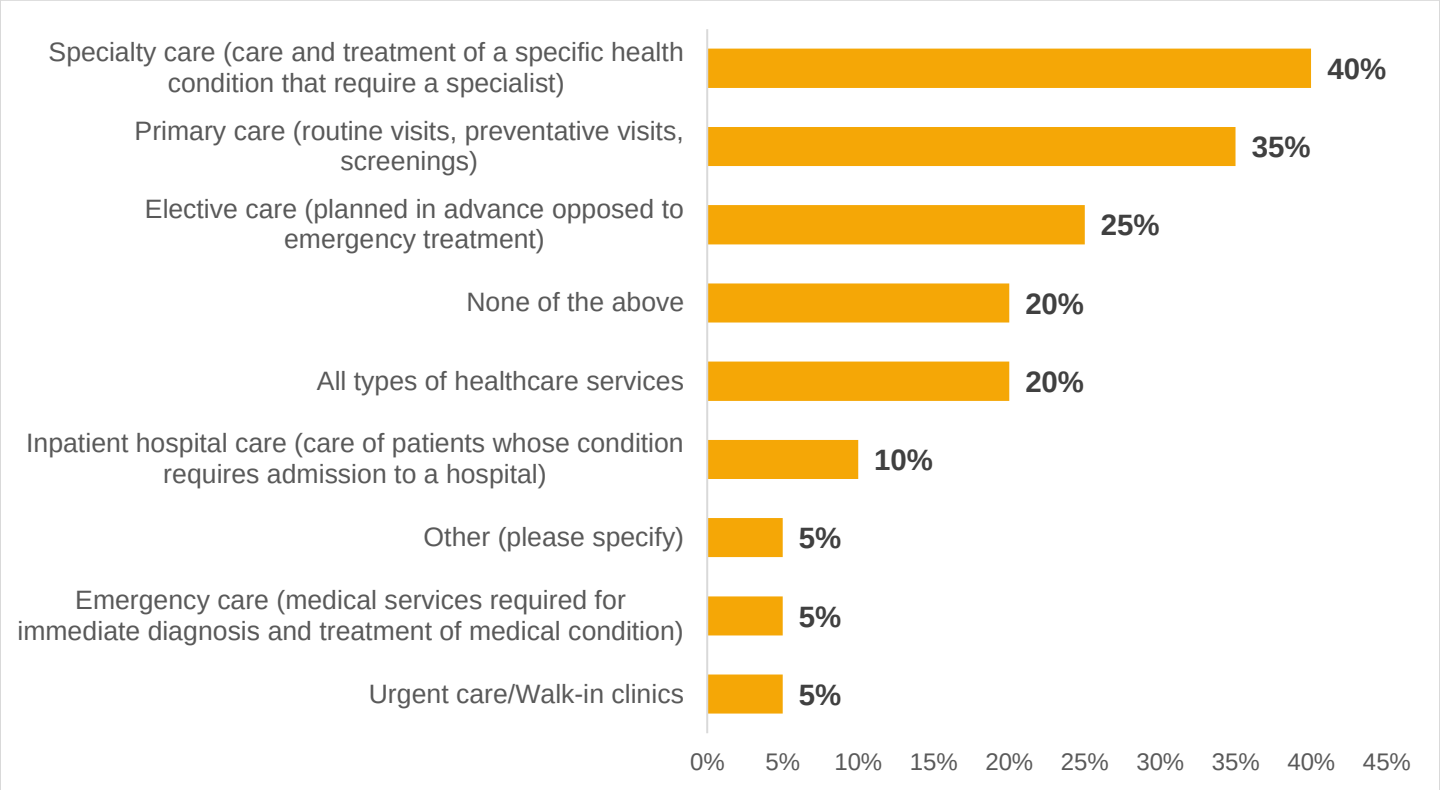
Question: Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. Please select the key social determinants that have been negatively impacted by the COVID-19 pandemic in your community (please select all that apply):



Comments:

- *Different people (groups) impacted in different ways.*
- *Depression, Fear, Uncertainty*

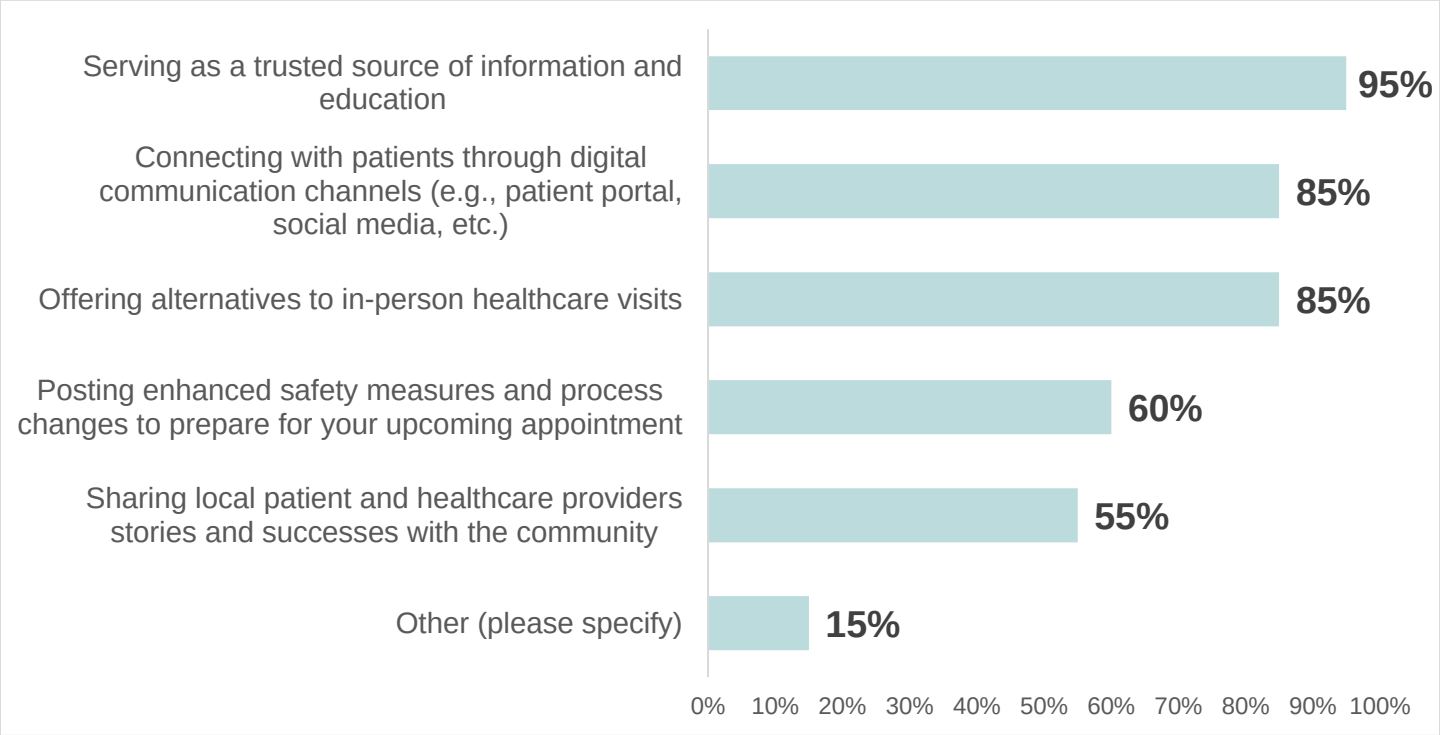
Question: During the COVID-19 pandemic, what healthcare services, if any, have you or your family delayed accessing? (please select all that apply)



Comments:

- *We are a family involved in health care, but not high consumers*

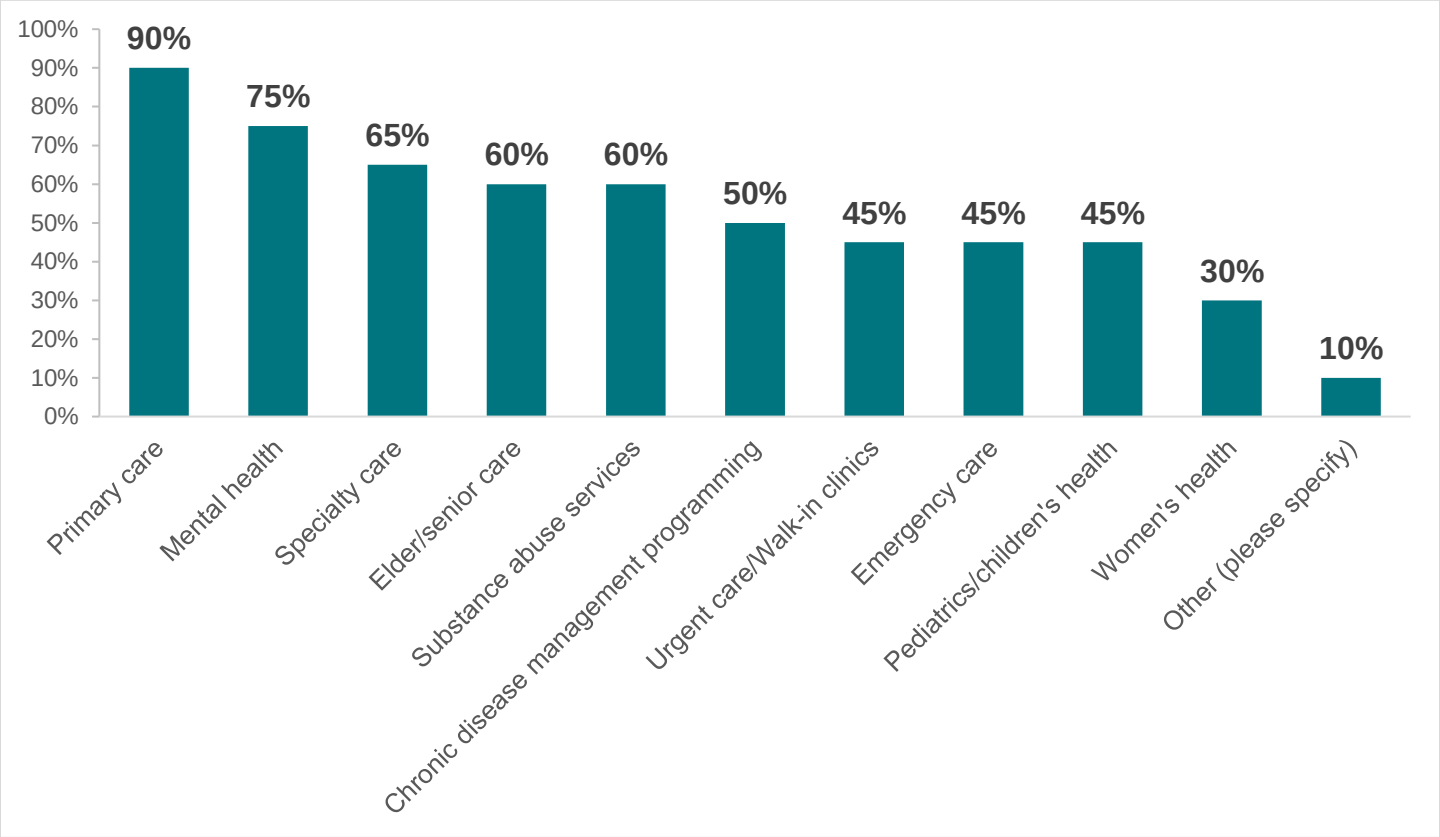
Question: How can healthcare providers, including Gerald Champion Regional Medical Center, continue to support the community through the challenges of COVID-19? (please select all that apply)



Comments:

- *One very positive thing Covid has brought to us is digital meeting.*
- *Vaccine Clinic*
- *I feel GCRMC does all of the above*

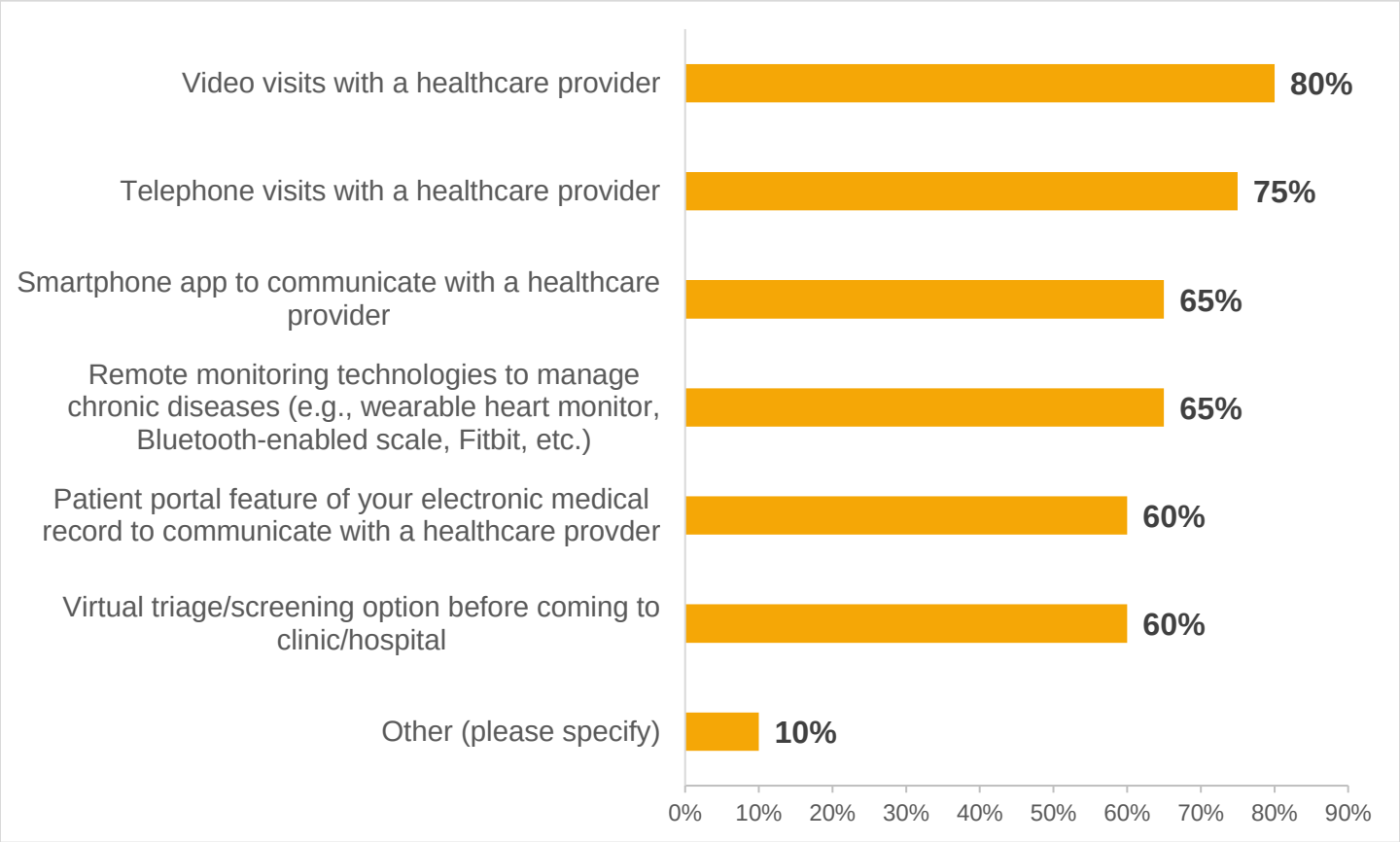
Question: What healthcare services/programs will be most important to supporting community health as the pandemic continues to unfold? (please select all that apply)



Comments:

- *ALL of the above!*
- *Telehealth*

Question: COVID-19 has led to an increase in virtual and at-home healthcare options, including telemedicine, telephone visits, remote monitoring, etc. What alternative care options do you believe would benefit the community most? (please select all that apply)



Comments:

- *All telemedicine*
- *In person visits, video or telephone visits are not the best way to identify issues with children, older or economically disadvantaged persons*

Question: Please share resources and solutions that would help you and community get through the COVID-19 crisis.

Comments:

- *Community updates of what is going on. Not everyone is getting the same message. Need to have at least monthly community updates.*
- *1. Collaboration with all health-providing sources. 2. Active support of and participation with 100% Community*
- *I think GCRMC has done well with it's COVID19 response.*
- *I think that GCRMC has done an excellent job of getting the vaccine out to everyone.*
- *Getting healthcare back to a new normal, but more toward normal. We cannot survive in a vacuum.*
- *More recreational opportunities keeping CDC guidelines in mind.*
- *More in-person visits.*
- *Thank you for providing such a convenient and efficient vaccination process.*
- *Telemedicine*