Cibola General Hospital

Grants, New Mexico

CIBOLA
General Hospital, Inc.
"Healthcare with a hometown touch"

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution May 23, 2016[1]

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

Dear Community Member:

At Cibola General Hospital (CGH), we have spent almost 60 years providing high-quality compassionate healthcare to the greater Grants community. The "2016 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how CGH will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, CGH, are meeting our obligations to efficiently deliver medical services.

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

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

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

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

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

Thank You,

Tom Whelan
Chief Executive Officer
Cibola General Hospital

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EXECUTIVE SUMMARY

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

Data 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 Significant Health Needs for Cibola County are:

1. Substance Abuse
2. Obesity
3. Mental Health & Suicide
4. Affordability
5. Diabetes
6. Cancer and Cancer Testing

The Hospital has developed implementation strategies for all six needs including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

APPROACH

APPROACH

Cibola General Hospital ("CGH" or the "Hospital") is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA assures CGH identifies and responds to the primary health needs of its residents.

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

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

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

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

Project Objectives

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

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

Overview of Community Health Needs Assessment

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

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

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

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

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

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

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

the health needs of the community;

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

conducting the CHNA."[7]

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

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

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

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

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

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

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

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

Other (please specify)

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

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

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

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

county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Cibola County compared to all of State counties	October 22, 2015	2010 to 2012
www.communityhealth.hhs.gov	Assessment of health needs of Cibola County compared to its national set of "peer counties"	October 22, 2015	2005 to 2011
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	January 8, 2015	2012 to 2016
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	October 22, 2015	2015
www.caringinfo.org and www.nhpco.org	To identify the availability of hospice programs in the country	October 22, 2015	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	October 22, 2015	2000 to 2010
www.dataplace.org	To determine availability of specific health resources	October 22, 2015	2006

[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

Website or Data Source	Data Element	Date Accessed	Data Date
www.cdc.gov	To examine area trends for heart disease and stroke	October 22, 2015	2008 to 2010
http://svi.cdc.gov	To identify the Social Vulnerability Index value	October 22, 2015	2010
www.CHNA.org	To identify potential needs from a variety of resources and health need metrics	October 22, 2015	2003 to 2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	October 22, 2015	2015
www.worldlifeexpectancy.com	To determine relative importance among 15 top causes of death	October 22, 2015	2013

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

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 26 Local Expert Advisors. Survey responses started November 16, 2015 and ended with the last response on December 15, 2015. All written comments are presented verbatim in the Appendix to this report.
- Information analysis augmented by local opinions showed how Cibola 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
    - Drug and alcohol abuse is an issue
    - Hispanic and Native American populations face health related issues
    - Palliative care services are limited
    - Children of economically challenged families need help
    - High percentage of diabetics

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

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[14] Consultation with 55 Local Experts occurred again via an internet-based survey (explained below) beginning January 18, 2016 and ending February 16, 2016.

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

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

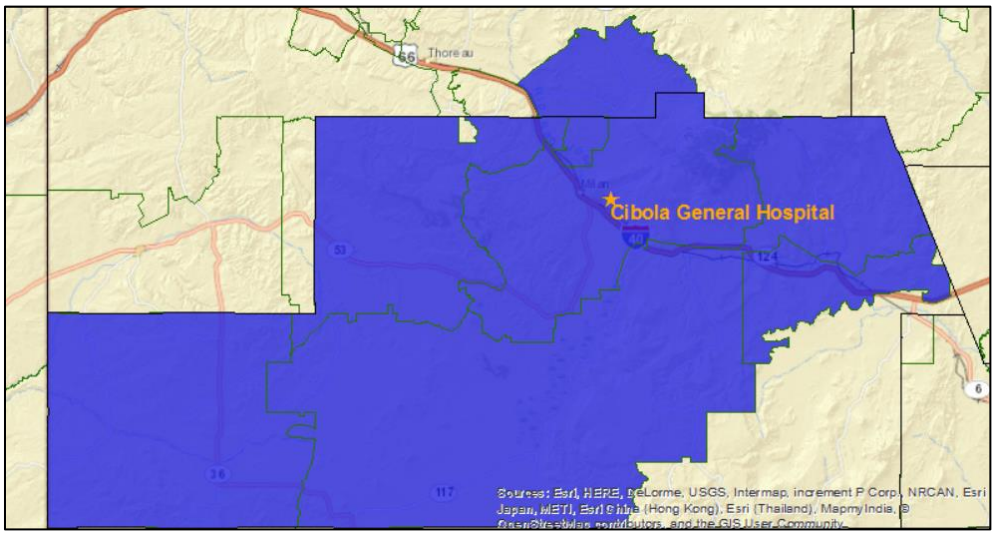
We dichotomized the rank order of prioritized needs into two groups: “Significant” and “Other Identified Needs.” Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked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

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

COMMUNITY CHARACTERISTICS

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



CGH, in conjunction with Quorum, defines its service area as Cibola County in New Mexico, which includes the following ZIP codes:[18]

87005 – Bluewater	87007 – Casa Blanca	87014 - Cubero
87020 – Grants	87021 – Milan	87315 – Fence Lake

In 2014, the Hospital received 84.0% 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] Truven MEDPAR patient origin data for the hospital; Responds to IRS Schedule h (Form 990) Part V B 3 a

Demographic of the Community[20] [21]

	County	State	U.S.
2016 Population[22]	**27,463**	**2,088,611**	**322,431,073**
% Increase/Decline	**0.3%**	**1.1%**	**3.7%**
Estimated Population in 2021	**27,538**	**2,111,991**	**334,341,965**
% White, non-Hispanic	**20.0%**	**38.1%**	**61.3%**
% Hispanic	**37.7%**	**48.2%**	**17.8%**
Median Age	**36.3**	**37.2**	**38.0**
Median Household Income	**$36,064**	**$45,057**	**$55,072**
Unemployment Rate	**4.9%**	**3.9%**	**5.0%**
% Population >65	**14.6%**	**15.6%**	**15.1%**
% Women of Childbearing Age	**18.6%**	**19.1%**	**19.6%**

Demographics Expert 2.7
2016 Demographic Snapshot
Area: Cibola County
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	27,426	308,745,538
2016 Total Population	27,463	322,431,073
2021 Total Population	27,538	334,341,965
% Change 2016 - 2021	0.3%	3.7%
Average Household Income	$46,564	$77,135

	2016	2021	% Change
Total Male Population	13,982	14,029	0.3%
Total Female Population	13,481	13,509	0.2%
Females, Child Bearing Age (15-44)	5,100	5,178	1.5%

POPULATION DISTRIBUTION

Age Distribution

Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	5,642	20.5%	5,626	20.4%	19.0%
15-17	1,120	4.1%	1,130	4.1%	4.0%
18-24	2,683	9.8%	2,706	9.8%	9.8%
25-34	3,827	13.9%	3,984	14.5%	13.3%
35-54	6,675	24.3%	6,318	22.9%	26.0%
55-64	3,505	12.8%	3,218	11.7%	12.8%
65+	4,011	14.6%	4,556	16.5%	15.1%
Total	27,463	100.0%	27,538	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

Income Distribution

2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	1,856	20.5%	12.3%
$15-25K	1,546	17.0%	10.4%
$25-50K	2,486	27.4%	23.4%
$50-75K	1,522	16.8%	17.6%
$75-100K	778	8.6%	12.0%
Over $100K	884	9.7%	24.3%
Total	9,072	100.0%	100.0%

EDUCATION LEVEL

Education Level Distribution

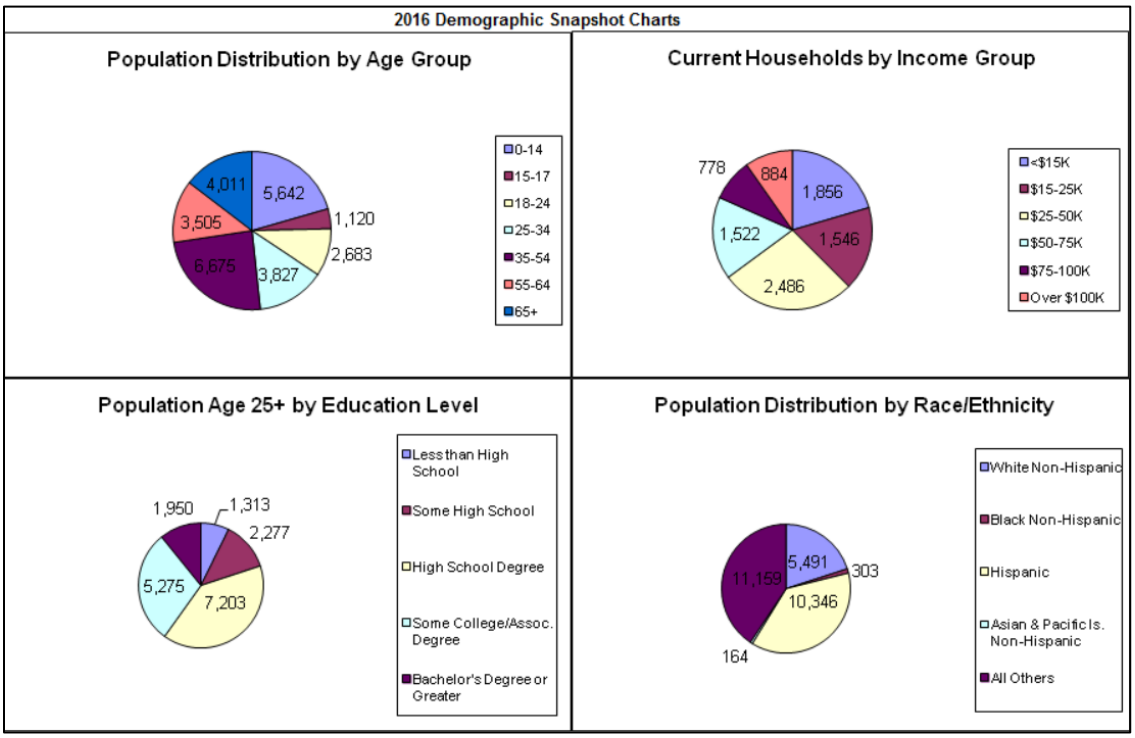
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	1,313	7.3%	5.8%
Some High School	2,277	12.6%	7.8%
High School Degree	7,203	40.0%	27.9%
Some College/Assoc. Degree	5,275	29.3%	29.2%
Bachelor's Degree or Greater	1,950	10.8%	29.4%
Total	18,018	100.0%	100.0%

RACE/ETHNICITY

Race/Ethnicity Distribution

Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	5,491	20.0%	61.3%
Black Non-Hispanic	303	1.1%	12.3%
Hispanic	10,346	37.7%	17.8%
Asian & Pacific Is. Non-Hispanic	164	0.6%	5.4%
All Others	11,159	40.6%	3.1%
Total	27,463	100.0%	100.0%

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



2016 Benchmarks
Area: Cibola County
Level of Geography: ZIP Code

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
New Mexico	1.1%	37.2	15.6%	13.4%	19.1%	0.8%	$45,057	$48,980	$167,523
Selected Area	0.3%	36.3	14.6%	13.6%	18.6%	1.5%	$36,064	$46,548	$102,708

Demographics Expert 2.7
DEMO0003.SQP

The population was also examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors.

The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to determine probable lifestyle and medical conditions present in the population. The national average, or norm, is represented as 100%. Where Cibola County varies more than 5% above or below that norm (that is, less than 95% or greater than 105%), it is considered significant.

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

Health Service Topic	Demand as % of National	% of Population Effected	Health Service Topic	Demand as % of National	% of Population Effected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	112.6%	34.3%	Mammography in Past Yr	95.8%	43.7%
Vigorous Exercise	96.4%	55.0%	Cancer Screen: Colorectal 2 yr	92.7%	23.7%
Chronic Diabetes	124.5%	15.4%	Cancer Screen: Pap/Cerv Test 2 yr	93.1%	55.9%
Healthy Eating Habits	87.9%	26.1%	Routine Screen: Prostate 2 yr	95.3%	30.6%
Ate Breakfast Yesterday	98.5%	72.4%	**Orthopedic**		
Slept Less Than 6 Hours	116.8%	17.0%	Chronic Lower Back Pain	123.9%	29.1%
Consumed Alcohol in the Past 30 Days	76.2%	41.3%	Chronic Osteoporosis	114.9%	11.3%
Consumed 3+ Drinks Per Session	108.9%	30.4%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.8%	91.6%
I Will Travel to Obtain Medical Care	94.6%	21.8%	Used Midlevel in last 6 Months	102.5%	42.4%
I am Responsible for My Health	94.9%	62.0%	OB/Gyn 1+ Visit	86.9%	40.2%
I Follow Treatment Recommendations	93.6%	48.6%	Medication: Received Prescription	99.1%	57.9%
Pulmonary			**Internet Usage**		
Chronic COPD	139.6%	5.5%	Use Internet to Talk to MD	68.3%	8.4%
Tobacco Use: Cigarettes	123.2%	31.3%	Facebook Opinions	93.7%	9.6%
Heart			Looked for Provider Rating	83.4%	11.9%
Chronic High Cholesterol	116.2%	25.5%	**Emergency Service**		
Routine Cholesterol Screening	91.9%	46.7%	Emergency Room Use	106.7%	36.1%
Chronic Heart Failure	144.4%	6.0%	Urgent Care Use	96.3%	22.4%

Leading Causes of Death

Cause of Death			Rank among all counties in NM (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
Cibola Rank	NM Rank	Condition		NM	Cibola	
1	2	Heart Disease	26 of 32	147.1	160.4	Lower than expected
2	1	Cancer	17 of 32	145.4	158.8	Lower than expected
3	3	Accidents	9 of 32	59.0	79.7	Higher than expected
4	6	Diabetes	1 of 32	27.6	60.2	Higher than expected
5	4	Lung	20 of 32	44.7	45.1	As expected
6	7	Liver	3 of 32	19.7	37.8	Higher than expected
7	5	Stroke	25 of 32	30.0	34.8	Lower than expected
8	10	Flu - Pneumonia	7 of 32	14.8	22.1	As expected
9	8	Suicide	21 of 32	20.3	19.7	Higher than expected
10	11	Kidney	3 of 32	13.2	17.2	Higher than expected
11	9	Alzheimer's	21 of 32	14.9	13.5	Lower than expected
12	12	Blood Poisoning	5 of 32	9.1	12.2	As expected
13	14	Hypertension	1 of 32	7.4	10.4	Higher than expected
14	12	Parkinson's	4 of 32	7.9	9.3	Higher than expected
15	15	Homicide	13 of 32	6.7	8.9	Higher than expected

National Healthcare Disparities Report – Priority Populations[23]

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

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

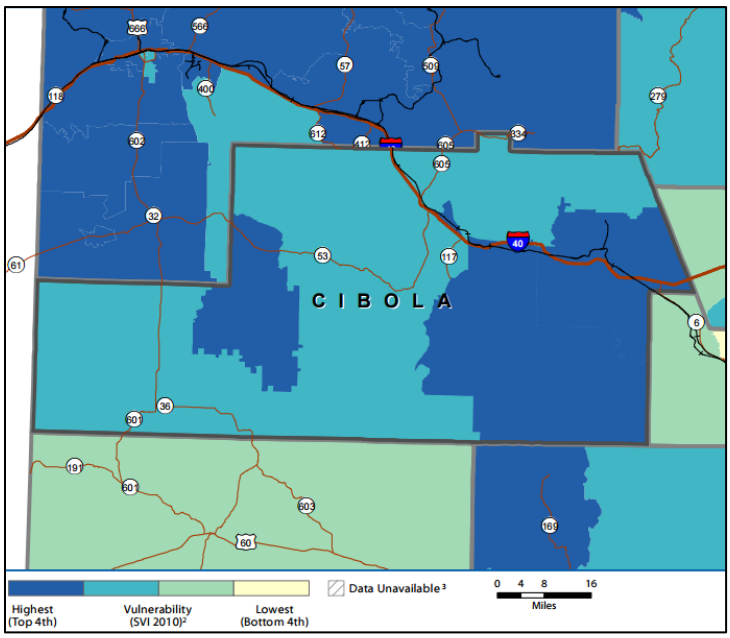
We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to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

- Drug and alcohol abuse is an issue
- Hispanic and Native American populations face health related issues
- Palliative care services are limited
- Children of economically challenged families need help
- High percentage of diabetics

[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

Cibola County zip codes primarily fall into the second highest quartile of social vulnerability. The southeastern portion is noted as being in the highest quartile of vulnerability. Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks.



Consideration of Written Comments from Prior CHNA

A group of 26 individuals provided written comment in regard to the 2013 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	2	22	24
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	8	17	25
3) Priority Populations	4	20	24
4) Representative/Member of Chronic Disease Group or Organization	1	22	23
5) Represents the Broad Interest of the Community	16	8	24
Other			
Answered Question			25
Skipped Question			1

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

- Affordability
- Diabetes
- Cancer and Cancer Testing
- Obesity
- Substance Abuse
- Mental Health and Suicide

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

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

	Yes	No	No Opinion
Affordability	17	3	1
Diabetes	19	1	1
Cancer and Cancer Testing	18	1	2
Obesity	19	1	1
Substance Abuse	19	2	0
Mental Health and Suicide	18	2	1

- Specific comments or observations about Affordability as being among the most significant needs for the Hospital to work on to seek improvements?

- Provide more information regarding preventive medicine and good health habits. Provide illustrations of results of healthy life style.
- Some individuals have such a high copay that they forego picking up prescriptions or seeing specialists. Another issue related to affordability is the need to travel to Albuquerque or Gallup to see an expert. Many individuals in our service community cannot afford transportation outside of their geographic region.
- Affordability should not be an issue with the Affordable Heath Care for America Act. If it is, the issue should be addressed at the federal government level.
- Hospital membership similar to PHI Cares, patient education on funding opportunites
- hospital has to be accessible .
- Prices are extremely high. When we go to the hospital, we are offered a discount if we pay our portion up front. WE STILL RECEIVE A BILL FOR THE DIFFERENCE EVERY TIME. THE HOSPITAL SHOULD KNOW WHAT THE GENERAL CHARGE SHOULD BE. IT IS VERY INCONVENIENT.
- People I have spoken with indicate that they will seek treatment elsewhere due to the fees charged by the hospital. I personally have experienced inconsistencies with billings I have received.
- Many programs now make it affordable for children at this time.
- Need to keep the affordability affordable for the residents of the area some of them just seem way to high compared to other areas.
- Need to resolve payment issues with Native American payment sources. Takes too long to receive payment. County is stating that they are reimbursing hospital for indigent care but no money flows to the hospital. It is a paper transfer only. Citizens are paying a tax for indigent care but the money remains in the county accounts. Could be being used for paving roads for all we know. Amounts to hundreds of thousands of dollars a year.
- Difficult to comment on this one . ECONOMY / OBAMA-CARE . Remain optimistic with 2016 elections.

- Specific comments or observations about Diabetes as being among the most significant needs for the Hospital to work on to seek improvements?
  - Agree. Explore possibility of additional funding to provide services to native Americans.
  - Working to reduce diabetes could also be tied to classes on proper nutrition, obesity and sugar reduction. For our area this has become epidemic.
  - Research has shown a correlation between Type-2 diabetes and Alzheimer's and dementia. Diabetes should continue to be among the most significant needs for the Hospital to work on to seek improvements.
  - Classes and seminars for the county not just Grants area
  - diabetic ed and group therapy
  - It is unfortunate that we have such a high level of diabetes in this area. Most people only see a general

practitioner and the following is not as specialized.No

- Education is the key.
- Unknown
- Our staff at all levels are not knowledgeable enough about diabetes to serve as resources for our patients. Have seen multiple instances where patients were not adequately managed for their diabetes. If the majority of our patients are diabetic then our staff should become much more knowledgeable about the entire disease process.
- This area will continue to grow along with childhood obesity. Needs in these two fields will continue to grow faster than support teams. (epidemic)

- Specific comments or observations about Cancer and Cancer Screening as being among the most significant needs for the Hospital to work on to seek improvements?
  - Explore joint efforts with hospitals in Albuquerque and Gallup.
  - Cibola General Hospital's health fairs have been a great resource in cancer screening, particularly breast cancer.
  - Possible community events tailored around education and screening options.
  - list screening tests, and their potential success
  - We need someone locally to read our tests. It is very costly to have to pay an outside provider.
  - Education against factors leading to cancer is key: smoking, drug abuse, alcohol abuse and diet.
  - Hospital could consider offering chemotherapy treatments here for those patients who have a plan developed by an oncologist. Would save them from having to travel to Albuquerque.
- Specific comments or observations about Obesity as being among the most significant needs for the Hospital to work on to seek improvements?
  - Continue education to area residents.
  - It may be helpful to enter into a joint agreement with Future Foundations on weight management programs targeting youth. However, if youth are to succeed, parents must also be educated and be provided opportunities to reduce obesity. We also need to go into the rural areas of the county with these programs.
  - Most obesity, as described in the description of percentages presented above, should be controllable and a responsibility at the individual household level.
  - Education, cooking classes, exercise clubs, etc.
  - affordable fun groups
  - No
  - Obese patients have more complications and longer patient stays which can impact our financial status. As a nation our obesity rate is outrageous. It is decreasing our life expectancy. Everyone needs to be

working on the problem. Our county has a higher rate than normal due to our Native American population.

- Specific comments or observations about Substance Abuse as being among the most significant needs for the Hospital to work on to seek improvements?
  - Get social agencies more involved.
  - Substance Abuse continues to be a major health issue in our area and should continue to be among the most significant needs for the Hospital to work on to seek improvements.
  - Treatment center
  - No
  - it is not working if in place.
  - We have a high rate of substance abuse in our county and virtually no treatment and referral sources. Difficult to find in-patient beds for evaluation and treatment. Could look into recruiting substance abuse counsellors.
- Specific comments or observations about Mental Health and Suicide as being among the most significant needs for the Hospital to work on to seek improvements?
  - This is an expanding area of need. It should be addressed constantly.
  - Mental Health and Suicide are, to me, the most underserved needs in our community. We have extremely limited services. Mental Health is an issue in my home. We have traveled back and forth to Albuquerque up to 4 times per week for appointments due to the lack of services in Cibola County. Could we not explore the option of connecting with the service providers from the many prison systems in this community? I understand that those not employed by the state, are outsourced to a private enterprise.
  - Mental Health, particularly among the area's aging and transient populations is very significant, considering the increasing population of both groups.
  - Education, more options for seeking professional help, treatment center
  - We need to find some therapists locally.
  - This is also and area that seems not to be working.
  - The county has very limited mental health resources. Could look into recruiting mental health providers. Could look into establishing inpatient mental health beds.

Conclusions from Public Input

Our group of 26 Local Expert Advisors participated in an online survey to offer opinions about their perceptions of community health needs and the potential needs of unique populations. Complete verbatim written comments appear in the Appendix to this report.

CGH received the following responses to the question: "*Should the Hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronting residents in the county? Please add any additional information you would like us to understand."*

- Education efforts are most efficient method of hospital involvement for diabetes and obesity issues regarding prevention. Regarding cancer and mental health, cooperation and joint efforts with out of town organizations who already have facilities in place addressing these needs locally.
- Most obesity, as described in the description of percentages presented above, should be controllable and a responsibility at the individual household level Affordability should not be an issue with the Affordable Heath Care for America Act. If it is, the issue should be addressed at the federal government level.
- I think of the above needs, affordability is very important in this area. Susbantace Abuse and Suicide are very big issues here and we need more behavioral health providers in the county. There is a long wait list now to meet with behavioral health provide and many go untreated because they do not want to wait or before they are seen the issues escalate to a higher level. There are many in this community that can not afford cancer treatments or testing and need financial assistance.

Summary of Observations: Comparison to Other Counties

Health Outcomes

In a health status classification termed "Health Outcomes," Cibola ranks number 22 among the 32 ranked New Mexico counties (best being #1). Premature Death (deaths prior to age 75) presents worse values (shorter survivability) than on average for the US and New Mexico.

Health Factors

In another health status classification "Health Factors," Cibola County ranks number 29 among the 32 ranked New Mexico counties. The following indicators compared to the NM average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Adult Obesity – Cibola 33% compared to NM 24% and US best of 25%
- Physical Inactivity – Cibola 25% compared to NM 20% and US best of 20%
- Access to Exercise Opportunities – Cibola 58% which is considerably lower than the NM avg. of 75% and US best of 92%
- Sexually Transmitted Infections – Cibola 673 cases compared to NM 571 and US best of 138
- Teen Births – Cibola 80 births compared to NM 57 and US best of 20 births

Clinical Care

In the "Clinical Care" classification, Cibola County ranks number 29 among the 32 ranked New Mexico counties. The following indicators compared to the NM average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Uninsured – Cibola 24% of residents compared to NM 22% and US best of 11%
- Population to Primary Care Physician – Cibola 1,708:1 which is more than the NM 1,388:1 and US best of 1,045:1
- Population to Dentist – Cibola 2,278:1 which is considerably above the NM average of 1,741:1 and US best of 1,377:1
- Population to Mental Health Provider – Cibola 497:1 compared to NM 295:1 and US best of 386:1
- Preventable Hospital Stays (a measure of potential physician shortage) – Cibola 58 admissions per 1,000 compared to NM 50 and US best of 41
- Diabetic Monitoring – Cibola 45% which is considerably lower than NM average 74% and US best of 90%
- Mammography Screening – Cibola 41.8% of women age 67 to 69 compared to NM avg. of 56.4% and US best of 70.7%

Social and Economic Factors

In the "Social and Economic Factors" classification, Cibola County ranks number 29 among the 32 ranked New Mexico counties. The following indicators compared to the NM average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Some College – Cibola 41.8% which is less than the NM avg. of 58.6% and US best of 71.0%
- Children in Poverty – Cibola 43% which is above the NM avg. of 30% and US best of 1%
- Children in Single-Parent Households – Cibola 55% compared to NM 40% and US best of 20%
- Number of Social Associations – Cibola 7.3 per 10,000 residents less than the NM avg. of 8.1 and US best of 22 per 10,000
- Violent Crime – Cibola 718 offenses per 100,000 compared to NM 571 and US best of 22
- Injury Deaths – Cibola 111 deaths compared to NM 94 and US best of 50

Summary of Observations: Peer Comparisons

The Federal Government administers a process to allocate all counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. Health and wellness observations when Cibola County is compared to its national set of Peer Counties and compared to national rates result in the following:

Mortality

- *Better*
  - Alzheimer's Disease Deaths; Cancer Deaths; Chronic Kidney Disease Deaths; Coronary Heart Disease Deaths; Female Life Expectancy; Male Life Expectancy; Stroke Deaths
- *Worse*
  - Diabetes Deaths – 54.5 deaths per 100,000; 6th worst among 56 peer counties; US avg. 24.7
  - Unintentional Injury (including motor vehicle) – 82.5 deaths per 100,000; 6th worst among peer counties; US avg. 50.8

Morbidity

- *Better*
  - Alzheimer's Diseases/Dementia; Cancer; Gonorrhea
- *Worse*
  - Nothing

Healthcare Access and Quality

- *Better*
  - Cost Barrier to Care; Older Adult Preventable Hospitalizations
- *Worse*
  - Uninsured – 25.7% of the population; 8th worst among peers; US avg. 17.7%

Health Behaviors

- *Better*
  - Adult Physical Inactivity; Adult Smoking
- *Worse*
  - Adult Female Routine Pap Tests – 71.0% of adult women; 8th worst among peer counties; US avg. 77.3%
  - Teen Births – 79.6 births per 1,000 teens; 10th worst among peer counties; US avg. 42.1

Social Factors

- *Better*
  - High Housing Costs; Unemployment

- *Worse*
    - Violent Crime – 719.4 per 100,000 population; 7th worst among peer counties; US avg. 199.2

Physical Environment

- *Better*
    - Air Quality; Housing Stress
- *Worse*
    - Limited Access to Healthy Food – 19.0% of individuals who are low-income and do not live close to a grocery store; 8th worst among peer counties; US avg. 6.2%

Conclusions from Demographic Analysis Compared to National Averages

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

The 2016 population for Cibola County is estimated to be 27,463 and expected to increase at a rate of 0.3% through 2021. This is lower than the 3.7% national rate of growth, while New Mexico's population is expected to increase by 1.1%. In 2020, Cibola County anticipates a population of 27,538.

Population estimates indicate the 2016 median age for the county is 36.3 years, younger than the New Mexico median age (37.2 years) and the national median age of 38.0 years. The 2016 Median Household Income for the area is $36,064, lower than the New Mexico median income of $45,057 and the national income of $55,072. Median Household Wealth value is lower than both the national and New Mexico value. Median Home Value for Cibola ($102,708) is significantly lower than both the New Mexico median of $167,523 and the national median of $192,364. Cibola's unemployment rate as of November 2015 was 4.9%, which is higher than the 3.9% statewide but lower than the 5.0% national civilian unemployment rate.

The portion of the population in the county over 65 is 14.6%, compared to New Mexico (15.6%) and the national average (15.1%). The portion of the population of women of childbearing age is 18.6%, slightly lower than the New Mexico average of 19.1% and the national rate of 19.6%. 20.0% of the population is White non-Hispanic. The largest minority is the Hispanic population which comprises 37.7% of the total.

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

- BMI: Morbid/Obese is 12.6% above average impacting 34.3% of the population
- Consumed 3+ Drinks per Session is 8.9% above average impacting 30.4% of the population
- I Am Responsible for My Health is 5.1% below average impacting 62.0% of the population
- I Follow Treatment Recommendations is 6.4% below average impacting 48.6% of the population
- Tobacco Use: Cigarettes is 23.2% above average impacting 31.3% of the population
- Routine Cholesterol Screening is 8.1% below average impacting 46.7% of the population
- Cervical Cancer Screening in last two years is 6.9% below average impacting 55.9% of the population
- Had an OB/GYN Visit is 13.1% below average impacting 40.2% of the population
- Emergency Room Use is 6.7% above average impacting 36.1% of the population

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

- Consumed Alcohol in the Past 30 Days is 23.8% below average impacting 41.3% of the population

Conclusions from Other Statistical Data

Among the Top 15 Causes of Death in the U.S., 3 of 15 occurred at expected rates in Cibola County. Accidents, Diabetes, Liver, Suicide, Kidney, Hypertension, Parkinson's, and Homicide occurred at higher rates than expected. Heart Disease, Cancer, Stroke, and Alzheimer's occurred at lower rates than expected. The Top 10 Causes of Death in Cibola County are:

1. Heart Disease with Cibola ranking #26 among 32 NM counties (where #1 is worst in state)
2. Cancer ranking #17 in NM
3. Accidents ranking #9 in NM
4. Diabetes ranking #1 in NM
5. Lung Disease ranking #20 in NM
6. Liver Disease ranking #3 in NM
7. Stroke ranking #25 in NM
8. Flu/Pneumonia ranking #7 in NM
9. Suicide ranking #21 in NM
10. Kidney Disease ranking #3 in NM

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

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

- **Male Binge Drinking** - As of 2012, 26.0% of males engage in binge drinking; value increased 1.1 pct points since 2002
- **Male Obesity** - As of 2011, 35.4% of males are obese; value increased 6.8 pct points since 2001
- **Female Obesity** - As of 2011, 44.0% of females are obese; value increased 11.8 pct points since 2001
- **Male Physical Activity** - As of 2011, physical activity prevalence for males is at 54.3%; value decreased 2.2 pct points since 2001

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

- **Male Life Expectancy** - As of 2013, male life expectancy is at 74.5 years; value increased 5.5 years since 1985
- **Female Life Expectancy** - As of 2013, female life expectancy is at 78.9 years; value increased 1.4 years since 1985
- **Male Smoking** - As of 2012, male smoking is at 28.0%; value decreased 2.4 pct points since 1996
- **Female Smoking** - As of 2012, female smoking is at 44.0%; value decreased 2.0 pct points since 1996

- **Female Physical Activity** - As of 2011, recommended physical activity for females is at 50.4%; value increased 5.1 pct points since 2001

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

- **Male Heavy Drinking** - As of 2012, 8.5% of males are heavy drinkers; value increased 0.6 pct points since 2005
- **Female Heavy Drinking** - As of 2012, 5.8% of females are heavy drinkers; value increased 1.9 pct points since 2005

Desirable Cibola County measures *better than* the US avg. *and* had a *favorable change*:

- **Female Binge Drinking** - As of 2012, 9.4% of females engage in binge drinking; value decreased 0.3 pct points since 2002

Conclusions from Prior CHNA Implementation Activities

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

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

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

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

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

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

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

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

- $4,545,170

EXISTING HEALTHCARE FACILITIES, RESOURCES, & IMPLEMENTATION STRATEGY

SIGNIFICANT HEALTH NEEDS

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by CGH.[25] The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies CGH current efforts responding to the need including any written comments received regarding prior CGH implementation actions
- Establishes the Implementation Strategy programs and resources CGH will devote to attempt to achieve improvements
- Documents the Leading Indicators CGH will use to measure progress
- Presents the Lagging Indicators CGH believes the Leading Indicators will influence in a positive fashion, and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, CGH is the major hospital in the service area. Cibola General Hospital (CGH) is a 25-bed, general medical and surgical hospital located in Grants, NM. The next closest facilities are outside the service area and include (* indicates open to Native American population only):

- *Crownpoint Healthcare Facility in Crownpoint, NM, 57 miles (60 minutes)**
- Rehoboth McKinley Christian Hospital in Gallup, NM, 64 miles (64 minutes)
- *Gallup Indian Medical Center, Gallup, NM, 67 miles (64 minutes)**
- *Acoma-Canoncito-Laguna, Canoncito, NM, 20.0 miles (24 minutes)**
- Lovelace Health System, Albuquerque, NM, 83 miles (1 hour, 24 minutes)
- Presbyterian Health System, Albuquerque, NM, 81 miles (1 hour, 16 minutes)
- UNM Hospital, Albuquerque, NM, 81 miles (1 hour, 16 minutes)

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

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

New Mexico Community Benefit Requirements

Significant Needs

1. **SUBSTANCE ABUSE** – 2013 Significant Need, 2016 – Local Experts Support; male binge drinking worse than US average; 'Consumed 3+ Drinks Per Session' behavior is 8.9% above average

Public comments received on previously adopted implementation strategy:

- See item14 above. [*Get social agencies more involved*].
- I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Substance Abuse.
- Have not observed any actions besides acute ED treatment and release.
- No
- Inpatient substance abuse treatment Detox facility
- ??

CGH services, programs, and resources available to respond to this need include:[26]

- Hospital employs licensed mental health professional who counsels on and sets up referrals
- Provide limited detox care/services and organize placement at other facilities
- Inpatient assessments and evaluations as appropriate
- Provide 24-hour emergency services to assess, evaluate, and transfer as necessary
- Provide in-house detoxification using CIWA protocol

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

- Investigate partnering with schools to provide education
- Potentially provide meeting space for recovery services (e.g., AA, NA, AlAnon)
- Investigate sponsorship of Scared Straight program (to show school-age children the dangers of substance abuse and incarceration)

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

- Utilization of contract employee who is a licensed mental health professional to assist in counseling

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

Anticipated results from CGH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization		X
7. Increases knowledge; then benefits the public	X	

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

- Number of Emergency Room visits ETOH and Substance abuse-related in 2015: 259

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

- Estimated percentage of Cibola County population age 18+ drinking excessively = 14.2% in 2015 (chna.org)

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

Organization	Contact Name	Contact Information
Cibola County Public Health Office		505-285-4601
Grants-Cibola County School District		505-285-2600

Other local resources identified during the CHNA process that are believed available to respond to this need:[27]

Organization	Contact Name	Contact Information
AA (Grants)		505-287-3773 or 505-287-6337
AA (Gallup)		505-722-4818
New Mexico Rehab (Roswell)		575-347-3400

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

Organization	Contact Name	Contact Information
Turquoise Lodge		505-841-8978
Peak Behavioral Health Services		575-589-3000
Alcohol and Narcotics Help Line		888-206-7272 or 24 Hour Help Line, 877-479-9777
Alcohol and Drug Treatment Referral		800-454-8966
Mesilla Valley (Las Cruces, NM)		505-382-3500
University of New Mexico Hospital (Albuquerque, NM)		505-925-2300
Anna Kaseman Hospital (Albuquerque, NM)		505-291-2000
Pueblo of Laguna Service Center (Alcohol Treatment)		505-552-5720
Hogares		505-285-3672
ACL Hospital		505-552-5300

2. OBESITY – 2013 Significant Need, 2016 – Local Experts Support; male and female obesity worse than the US average

Public comments received on previously adopted implementation strategy:

- See item 8 above. [*Continue education to area residents*].
- I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Obesity.
- Have not observed any actions.
- No

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

- Provided 'What the Health' program to employees and families – challenge to lose % fat over 3 months
- Three mini health fairs performed this year including BMI screening, community fitness options (e.g., gyms), nutrition classes including healthy samples and recipes, and education on cholesterol
- Annual, community-wide health fair
- Provided nutrition, exercise, and dental education within schools
- Sponsor 5K run/walk in collaboration with Grants Recreation Department
- Nutritionist visits inpatients weekly for consultation and education; also available for outpatient visits
- Provide free blood pressure checks and free use of scale; also provide educational materials
- Visit employers and provide education on health and wellness
- Perform minimal-cost sports physicals and refer to primary care physicians any students with abnormal findings

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

- Provide educational flyers regarding obesity within patient discharge materials
- Promote community education to website on health and wellness and exercise
- Patient Care Coordinator focused on chronic conditions, including obesity, and readmissions reduction in the Medicare population through mutual goal-setting and encouraging personal ownership of health and care
- Potentially partner with local food pantry to promote healthy food/eating

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

- Added Patient Care Coordinator
- Visit employers and provide education on health and wellness
- Provided nutrition, exercise, and dental education within schools
- Quarterly mini health fairs

Anticipated results from CGH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization		X
7. Increases knowledge; then benefits the public	X	

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

- Number of programs offered that promote healthy behaviors in 2015: 30

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

- Percent of population age 20+ with BMI greater than 30 = 34.3%

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

Organization	Contact Name	Contact Information
Grants-Cibola School District		505-285-2600
Continental Divide Electric (annual county health fair)		505-285-6656
Future Foundations Family Center/ Grants Recreation		505-285-3542

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

Organization	Contact Name	Contact Information
Cibola Family Health Center		505-287-6500
Presbyterian Medical Services		505-285-3542

Organization	Contact Name	Contact Information
Snap Fitness		505-240-6009
JHM Action Plaza		505-287-2462
Cibola County Public Health Office		505-285-4601
Acoma Fitness Center		505-552-2134
Cibola Senior Citizens Center		505-285-3922
The Dance Center		505-290-7892
T-Bones Gym		505-285-6758
Acoma Elderly Nutrition Program		505-552-6316
Pueblo of Zuni Wellness Center		505-782-2665
Navajo Nation Health Education		928-871-6562
ACL Hospital		505-552-5300

3. **MENTAL HEALTH AND SUICIDE** – 2013 Significant Need, 2016 – Local Experts Support; suicide is #9 leading cause of death; 19.65 deaths per 100,000

Public comments received on previously adopted implementation strategy:

- More expert input is needed. A plan of action should be implemented and followed.
- I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Mental Health.
- Only have observed acute ED treatment and release or transfer.
- No
- ??

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

- Licensed mental health counselor
- Suicide risk assessment is completed on all patients who present with suicidal ideations
- 24-hour emergency services
- Provide discharge plans and referrals to local mental health facilities
- Ongoing education and awareness and suicide prevention through community health fairs
- Employee assistance program available to employees and families, including suicide prevention counseling

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

- Increase annual depression screenings in physician offices
- Investigate ways to work with other local organizations to educate on mental health and suicide prevention
- Post/promote suicide hotline services

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

- Licensed mental health counselor

Anticipated results from CGH Implementation Strategy

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

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

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

- Number of counseling sessions performed for patients with suicide risk assessment greater than 5 in 2015: 89

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

- Suicide death rate – 19.7 deaths/100,000 residents adjusted

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

Organization	Contact Name	Contact Information
Presbyterian Medical Services		505-285-3542
Cibola Family Health Center		505-287-6500
Mesilla Valley (Las Cruces, NM)		505-382-3500
Hotline Suicide Prevention		800-273-8255
University of New Mexico Hospital (Albuquerque, NM)		505-925-2300
Anna Kaseman Hospital (Albuquerque, NM)		505-291-2000
Pueblo of Acoma Social Services		505-552-9712
Pueblo of Zuni Social Services		505-782-7166
Pueblo of Laguna Community Health and Wellness		505-552-6652
Navajo Nation Behavioral Health Services		928-871-6235
ACL Hospital		505-552-5300

4. **AFFORDABILITY** – 2013 Significant Need, 2016 – Local Experts Support; 25.7% of population without health insurance; uninsured rate above the NM and US average

Public comments received on previously adopted implementation strategy:

- See its. 6 above. [*Provide more information regarding preventive medicine and good health habits. Provide illustrations of results of healthy life style*]. Examine fees for same procedures at hospitals within easy driving distance. Adjust fees if necessary to be competitive.
- I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Affordability.
- Have not observed any.
- get off your butt an go
- BETTER TRAINING UP FRONT.
- Reduce hospital fees.
- Why do you get bills for service from so many differeent places when you make co payments at the time of service ??
- Need to somehow change the mind set of our community that the hospital ER is a free clinic.

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

- Financial counselors available
- Financial assistance policy available for all services
- Breast cancer/mammography fund – sponsor 5K run/walk to help provide these services at low cost
- The Sister Pam Account – available to help patients afford prescriptions
- Provide reduced-cost labs (e.g., A1C, lipid panel) at annual health fair
- Participate in grant program to provide Accucheck devices and test strips for free
- Participate in 340B program to provide low-cost prescriptions
- Provide free immunizations for employees and families
- Community-wide Flu Pod – provide supplies (bags, gloves, etc.) and staff
- $1 sports physicals
- Provide staff, booths, educational materials/seminars at quarterly mini health fairs
- Clinic offers sliding-scale fee schedule
- Offer 25% discount on services paid for same-day
- Free diabetic services/counseling (with physician referral)

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

- Provide additional services and materials for chronic care patients through Patient Care Coordinator

- Continue above listed services

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

- Free diabetic services/counseling (with physician referral)
- The Sister Pam Account – available to help patients afford prescriptions
- Participate in 340B program to provide low-cost prescriptions
- Breast cancer/mammography fund – sponsor 5K run/walk to help provide these services at low cost
- Clinic offers sliding-scale fee schedule
- Provide staff, booths, educational materials/seminars at quarterly mini health fairs

Anticipated results from CGH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

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

- Amount of charity care provided in FY2015: $4,545,170

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

- Population in Cibola County receiving Medicaid in 2015 = 42.15%

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

Organization	Contact Name	Contact Information
Be Well New Mexico		505-989-1600
Future Foundations Family Center/ Grants Recreation		505-285-3542

Organization	Contact Name	Contact Information
Continental Divide Electric		505-285-6656

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

Organization	Contact Name	Contact Information
Local Medicaid Office		505-287-8836
Cibola County Public Health Office		505-285-4601
Presbyterian Medical Services (Clinic)		505-285-3542
Cibola Family Health Center		505-287-6500
ACL Hospital		505-552-5300

5. **DIABETES** – 2013 Significant Need, 2016 – Local Experts Support; 6th worst among peer counties; diabetic monitoring considerably lower than the NM and US average; #4 leading cause of death; 60.16 deaths per 100,000

Public comments received on previously adopted implementation strategy:

- See item 8 above. [*Continue education to area residents*]. Provide more education on diet and preventive measures.
- I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Diabetes prevention, diagnosis and treatment.
- Bimonthly Diabetes cooking classes are the only action I've observed.
- as above. explain advantages of control
- No
- Unknown
- Hospital use to provide free lab tests during the health fair. It was easy to have the tests done at the health fair. Now you have to pre register and come in on a different day. The number of tests offered is much less than before. HgA1C is an important part of these screening tests.

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

- Free diabetic services/counseling (with physician referral)
- Provide reduced-cost labs (e.g., A1C, lipid panel) at annual health fair
- Participate in grant program to provide Accucheck devices and test strips for free
- Provided 'What the Health' program to employees and families – challenge to lose % fat over 3 months
- Three mini health fairs performed this year including BMI screening, community fitness options (e.g., gyms), nutrition classes including healthy samples and recipes, and education on cholesterol
- Annual, community-wide health fair
- Provided nutrition, exercise, and dental education within schools
- Sponsor 5K run/walk in collaboration with Grants Recreation Department
- Nutritionist visits inpatients weekly for consultation and education; also available for outpatient visits
- Provide free blood pressure checks and free use of scale; also provide educational materials
- Visit employers and provide education on health and wellness
- Perform minimal-cost sports physicals and refer to primary care physicians any students with abnormal findings

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

- Investigate providing diabetic training through the clinic
- Investigate nutrition support/education at local grocery store
- If NMSU grant isn't renewed, look at partnering with Futures Foundations to provide cooking classes

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

- Free diabetic services/counseling (with physician referral)

Anticipated results from CGH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

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

- Number of A1C tests with results less than 9 (start tracking in 2016)

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

- Cibola County Diabetic Death Rate = 60.2 per 100,000 adjusted

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

Organization	Contact Name	Contact Information
Future Foundations Family Center/ Grants Recreation		505-285-3542
Grants-Cibola County School District		505-285-2600

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

Organization	Contact Name	Contact Information
American Diabetes Association		www.diabetes.org
Children with Diabetes		www.childrenwithdiabetes.com

Organization	Contact Name	Contact Information
New Mexico Department of Health		505-476-2600
Pueblo of Acoma Health and Wellness/Special Diabetes Program		505-552-5145
Presbyterian Medical Services		505-285-3542
Cibola Family Health Center		505-287-6500
Global Nutrition Services		505-332-8070
ACL Hospital		505-552-5300

6. **CANCER AND CANCER TESTING** – 2013 Significant Need, 2016 – Local Experts Support; #2 leading cause of death; mammography screening considerably lower than the NM and US average; 158.77 deaths per 100,000

Public comments received on previously adopted implementation strategy:

- See item 10 above. [*Explore joint efforts with hospitals in Albuquerque and Gallup*].
- I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Cancer and Cancer Screening. Cibola General Hospital should continue its community outreach through health fairs and other opportunities.
- Community events and staff events in support of awareness.
- pt implamentation . can lead them to h2o
- No

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

- In-house mammography provided and promoted, and mammography fund
- Breast & Cervical Cancer policy (through state)
- Colo-rectal screening
- Can provide Porta-cath placement so people can receive chemotherapy
- Provide follow-up lab work and limited supportive treatments for chemotherapy patients
- Gave away sunscreen and sun hats, provided skin cancer screenings at mini health fairs
- Educated and signed up for mammography appointments at health fairs

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

- Explore specialty breast surgery services, including stereotactic surgery
- Increase education at health fairs
- Explore possibility of adding 3D mammography
- Make available materials from the American Cancer Society
- Consider opening up smoking cessation training to families of employees and possibly community
- Widen advertising and promotion of mammography cancer screening to other types of cancers

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

- Mammography fund
- Gave away sunscreen and sun hats, provided skin cancer screenings at mini health fairs
- Educated and signed up for mammography appointments at health fairs

Anticipated results from CGH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

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

- Number of mammograms performed in 2015 = 1,212

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

- Cancer death rate in Cibola County = 158.8 per 100,000 adjusted

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

Organization	Contact Name	Contact Information
American Cancer Society		www.cancer.org, 800-227-2345
New Mexico Department of Health		505-476-2600
Pueblo of Acoma Community Health and Wellness		505-552-6652
Presbyterian Medical Services		505-285-3542
Cibola Family Health Center		505-287-6500
ACL Hospital		505-552-5300

Other Needs Identified During CHNA Process

7. **PHYSICIAN**
8. **EDUCATION/PREVENTION**
9. **SMOKING**
10. **UNHEALTHY FOOD CHOICES**
11. **HEART DISEASE**
12. **TEEN BIRTHS**
13. **STROKE**
14. **PALLIATIVE CARE AND HOSPICE**
15. **LUNG DISEASE**
16. **COMPLIANCE BEHAVIOR**
17. **DENTAL**
18. **LIVER DISEASE**
19. **HOUSING CONCERNS**
20. **SOCIAL VULNERABILITY**
21. **KIDNEY DISEASE**
22. **ACCESS TO EXERCISE OPPORTUNITIES**
23. **ACCIDENTS**
24. **FLU/PNEUMONIA**
25. **SEXUALLY TRANSMITTED INFECTION**
26. **PRIORITY POPULATIONS**
27. **CHRONIC PAIN MANAGEMENT**
28. **SOCIAL SUPPORT**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[28]

1. Substance Abuse
2. Obesity
3. Mental Health & Suicide
4. Affordability
5. Diabetes
6. Cancer and Cancer Testing

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

None

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

7. PHYSICIAN
8. EDUCATION/PREVENTION
9. SMOKING
10. UNHEALTHY FOOD CHOICES
11. HEART DISEASE
12. TEEN BIRTHS
13. STROKE
14. PALLIATIVE CARE AND HOSPICE
15. LUNG DISEASE
16. COMPLIANCE BEHAVIOR
17. DENTAL
18. LIVER DISEASE
19. HOUSING CONCERNS
20. SOCIAL VULNERABILITY
21. KIDNEY DISEASE

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

22. ACCESS TO EXERCISE OPPORTUNITIES
23. ACCIDENTS
24. FLU/PNEUMONIA
25. SEXUALLY TRANSMITTED INFECTION
26. PRIORITY POPULATIONS
27. CHRONIC PAIN MANAGEMENT
28. SOCIAL SUPPORT

APPENDIX

Appendix A – Written Commentary on Prior CHNA

Hospital solicited written comments about its 2013 CHNA.[30] 26 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	2	22	24
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	8	17	25
3) Priority Populations	4	20	24
4) Representative/Member of Chronic Disease Group or Organization	1	22	23
5) Represents the Broad Interest of the Community	16	8	24
Other			
Answered Question			25
Skipped Question			1

- **Within the county do you perceive the local Priority Populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.**
  - Homeless native Americans with possible mental health issues need services to address their problems. Cooperation between local law enforcement agencies and local health organizations could help solve these problems.
  - Outreach to outside rural communities
  - Diabetes. Domestic violence, drug and alcohol abuse
  - Yes. For seniors we need specialists in the field of Geriatrics, Cardiovascular, etc. For persons with disabilities and behavioral issues, we need more mental health experts and psychiatric services. We need medical experts who take a true interest in the populations they serve.
  - Yes, the local Priority Populations have unique needs; in addition potential unique health issues needing attention include chronic alcoholism and drug abuse, as well as medical problems associated with our area's transient population.
  - Education about their medical illnesses along with possible home visits by designated medical personnel.

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

- etoh,drug addiction. children having children. family dissolution=elders caring for children ,and no one caring for elders. responsibility of community,and authority s
- Yes, there are many factors the major being low income elderly populations in are area plus the cultural diversity.
- Minority populations as well as individuals with chronic care need face specific health related issues that can not necessarily receive the health care they need in this area or up to date health care.
- We have a great need for diabetes care.
- I do not.
- I believe the specific ethnic minority groups of Hispanics and Native American have significant challenges with obesity and diabetes. Diet, health and physical education need to be a critical component of education beginning in early childhood and continued on through secondary education.
- The residents of the county , whoever they are and wherever they reside, need to work on issues themselves
- children of economically challenged families need help providing the best care possible when children become ill; either by means of getting them to the proper care facility through providing transportation to the care facility; albeit via ambulance, private vehicle or public transportation.
- The community has a high rate of cancer and diabetes among it's population
- yes I believe that there is need for better care to be given to the abuse of substance abuse. Who that is the question i do not have the answer.
- All have their own unique needs. To define and care for those individual needs is certainly a long drawn out process. It requires a team of experts in their own professional fields. TIME / RESOURSES which we all know can and will be difficult to accomplish. I strongly believe that these "priority populations" will grow faster than we can perceive.
- High percentage of diabetics. Need more community diabetes education. High percentage of renal failure patients. Do not have any providers in our community who can manage them. Need a provider who can insert vas caths and fistulas and declot fistulas.
- There are many people in this community that fall under this category. I believe the hospital needs to get medicaid and medicare information from county caseworkers to determine which families fall under this initiative and if their needs are being met by the hospital.

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

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

   - Affordability
   - Diabetes

- Cancer and Cancer Testing
- Obesity
- Substance Abuse
- Mental Health and Suicide

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

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

	Yes	No	No Opinion
Affordability	17	3	1
Diabetes	19	1	1
Cancer and Cancer Testing	18	1	2
Obesity	19	1	1
Substance Abuse	19	2	0
Mental Health and Suicide	18	2	1

- Specific comments or observations about Affordability as being among the most significant needs for the Hospital to work on to seek improvements?
  - Provide more information regarding preventive medicine and good health habits. Provide illustrations of results of healthy life style.
  - Some individuals have such a high copay that they forego picking up prescriptions or seeing specialists. Another issue related to affordability is the need to travel to Albuquerque or Gallup to see an expert. Many individuals in our service community cannot afford transportation outside of their geographic region.
  - Affordability should not be an issue with the Affordable Heath Care for America Act. If it is, the issue should be addressed at the federal government level.
  - Hospital membership similar to PHI Cares, patient education on funding opportunites
  - hospital has to be accessible .
  - Prices are extremely high. When we go to the hospital, we are offered a discount if we pay our portion up front. WE STILL RECEIVE A BILL FOR THE DIFFERENCE EVERY TIME. THE HOSPITAL SHOULD KNOW WHAT THE GENERAL CHARGE SHOULD BE. IT IS VERY INCONVENIENT.
  - People I have spoken with indicate that they will seek treatment elsewhere due to the fees charged by the hospital. I personally have experienced inconsistencies with billings I have received.
  - Many programs now make it affordable for children at this time.
  - Need to keep the affordability affordable for the residents of the area some of them just seem way to high compared to other areas.

- Need to resolve payment issues with Native American payment sources. Takes too long to receive payment. County is stating that they are reimbursing hospital for indigent care but no money flows to the hospital. It is a paper transfer only. Citizens are paying a tax for indigent care but the money remains in the county accounts. Could be being used for paving roads for all we know. Amounts to hundreds of thousands of dollars a year.
- Difficult to comment on this one . ECONOMY / OBAMA-CARE . Remain optimistic with 2016 elections.

- Specific comments or observations about Diabetes as being among the most significant needs for the Hospital to work on to seek improvements?
  - Agree. Explore possibility of additional funding to provide services to native Americans.
  - Working to reduce diabetes could also be tied to classes on proper nutrition, obesity and sugar reduction. For our area this has become epidemic.
  - Research has shown a correlation between Type-2 diabetes and Alzheimer's and dementia. Diabetes should continue to be among the most significant needs for the Hospital to work on to seek improvements.
  - Classes and seminars for the county not just Grants area
  - diabetic ed and group therapy
  - It is unfortunate that we have such a high level of diabetes in this area. Most people only see a general practitioner and the following is not as specialized.No
  - Education is the key.
  - Unknown
  - Our staff at all levels are not knowledgeable enough about diabetes to serve as resources for our patients. Have seen multiple instances where patients were not adequately managed for their diabetes. If the majority of our patients are diabetic then our staff should become much more knowledgeable about the entire disease process.
  - This area will continue to grow along with childhood obesity. Needs in these two fields will continue to grow faster than support teams. (epidemic)
- Specific comments or observations about Cancer and Cancer Screening as being among the most significant needs for the Hospital to work on to seek improvements?
  - Explore joint efforts with hospitals in Albuquerque and Gallup.
  - Cibola General Hospital's health fairs have been a great resource in cancer screening, particularly breast cancer.
  - Possible community events tailored around education and screening options.
  - list screening tests, and their potential success
  - We need someone locally to read our tests. It is very costly to have to pay an outside provider.
  - Education against factors leading to cancer is key: smoking, drug abuse, alcohol abuse and diet.

- Hospital could consider offering chemotherapy treatments here for those patients who have a plan developed by an oncologist. Would save them from having to travel to Albuquerque.

- Specific comments or observations about Obesity as being among the most significant needs for the Hospital to work on to seek improvements?
  - Continue education to area residents.
  - It may be helpful to enter into a joint agreement with Future Foundations on weight management programs targeting youth. However, if youth are to succeed, parents must also be educated and be provided opportunities to reduce obesity. We also need to go into the rural areas of the county with these programs.
  - Most obesity, as described in the description of percentages presented above, should be controllable and a responsibility at the individual household level.
  - Education, cooking classes, exercise clubs, etc.
  - affordable fun groups
  - No
  - Obese patients have more complications and longer patient stays which can impact our financial status. As a nation our obesity rate is outrageous. It is decreasing our life expectancy. Everyone needs to be working on the problem. Our county has a higher rate than normal due to our Native American population.
- Specific comments or observations about Substance Abuse as being among the most significant needs for the Hospital to work on to seek improvements?
  - Get social agencies more involved.
  - Substance Abuse continues to be a major health issue in our area and should continue to be among the most significant needs for the Hospital to work on to seek improvements.
  - Treatment center
  - No
  - it is not working if in place.
  - We have a high rate of substance abuse in our county and virtually no treatment and referral sources. Difficult to find in-patient beds for evaluation and treatment. Could look into recruiting substance abuse counsellors.
- Specific comments or observations about Mental Health and Suicide as being among the most significant needs for the Hospital to work on to seek improvements?
  - This is an expanding area of need. It should be addressed constantly.
  - Mental Health and Suicide are, to me, the most underserved needs in our community. We have extremely limited services. Mental Health is an issue in my home. We have traveled back and forth to Albuquerque up to 4 times per week for appointments due to the lack of services in Cibola County.

Could we not explore the option of connecting with the service providers from the many prison systems in this community? I understand that those not employed by the state, are outsourced to a private enterprise.

- Mental Health, particularly among the area's aging and transient populations is very significant, considering the increasing population of both groups.
- Education, more options for seeking professional help, treatment center
- We need to find some therapists locally.
- This is also and area that seems not to be working.
- The county has very limited mental health resources. Could look into recruiting mental health providers. Could look into establishing inpatient mental health beds.

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

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

	Yes	No	No Opinion
Affordability	16	3	1
Diabetes	18	1	1
Cancer and Cancer Testing	16	1	3
Obesity	15	3	2
Substance Abuse	17	3	0
Mental Health and Suicide	17	2	1

- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Affordability?
  - See its. 6 above. Examine fees for same procedures at hospitals within easy driving distance. Adjust fees if necessary to be competitive.
  - I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Affordability.
  - Have not observed any.
  - get off your butt an go
  - BETTER TRAINING UP FRONT.
  - Reduce hospital fees.
  - Why do you get bills for service from so many differeent places when you make co payments at the time of service ??
  - Need to somehow change the mind set of our community that the hospital ER is a free clinic.

- Q8

- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Diabetes?
  - See item 8 above. Provide more education on diet and preventive measures.
  - I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Diabetes prevention, diagnosis and treatment.
  - Bimonthly Diabetes cooking classes are the only action I've observed.
  - as above. explain advantages of control
  - No
  - Unknown
  - Hospital use to provide free lab tests during the health fair. It was easy to have the tests done at the health fair. Now you have to pre register and come in on a different day. The number of tests offered is much less than before. HgA1C is an important part of these screening tests.
- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Cancer and Cancer Screening?
  - See item 10 above.
  - I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Cancer and Cancer Screening. Cibola General Hospital should continue its community outreach through health fairs and other opportunities.
  - Community events and staff events in support of awareness.
  - pt implamentation . can lead them to h2o
  - No
- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Obesity?
  - See item 8 above.
  - I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Obesity.
  - Have not observed any actions.
  - No
- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Substance Abuse?
  - See item14 above.
  - I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement

in Substance Abuse.

- Have not observed any actions besides acute ED treatment and release.
- No
- Inpatient substance abuse treatment Detox facility
- ??

- Specific comments and observations about the implementation actions of the Hospital seeking improvement in Mental Health and Suicide?
  - More expert input is needed. A plan of action should be implemented and followed.
  - I applaud the efforts made toward the implementation actions of the Hospital in seeking improvement in Mental Health.
  - Only have observed acute ED treatment and release or transfer.
  - No
  - ??
- Do you have opinions about new or additional implementation efforts or community needs the Hospital should pursue?
  - Yes. Public should be more informed about services available locally for which local residences are going out of town secure. Cost comparisons should also be provided.
  - Not at this time.
  - No.
  - Numerous disease seminars or workshops for the community for patients and families to attend and learn how to deal/live/address the disease.
  - shelter with structure for addicts . education for underaged parents i.e.. obesity , dental hygiene,addiction, self image. home or work shop [non threatening] with easy access and worked by the people it is serving
  - no
  - Voucher System for Substance Abuse treatment for uninsured adults
  - The community needs to work on retention of health professionals
  - No
  - Mobile medical units for surrounding rural communities and intercity screening for client that have no transportation / homebound. Target the very old / the very young.
  - Could develop the medical campus adjacent to MOB. Physical therapy, retail pharmacy, durable medical, oxygen therapy, home health, hospice.
- Finally, after thinking about our questions and the information we seek, is there anything else you think

important as we review and revise our thinking about significant health needs within the county?

- FOLLOW UP!!
- Initially, I left out the aging population as one of the "potential unique health issues" need attention. I included the aging population on the previous page, along with the transient population. That is all. Thank you for everything Cibola General Hospital does for our area.
- Possibly having a quarterly health fairs to aid community members with vital sign checks, blood work, education, etc.
- This survey was difficult to understand.
- No
- Yes to have a better review on what does and what does not work.
- The hospital has been placed in the role of determining how best to meet the community's health needs. No other agency is going to take on this role.

Appendix B – Identification & Prioritization of Community Needs

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
1. Substance Abuse - 2013 Significant Need	350	26	12.55%	12.55%	Significant Need
2. Obesity - 2013 Significant Need	277	23	9.94%	22.49%	
3. Mental Health and Suicide - 2013 Significant Need	275	22	9.86%	32.35%	
4. Affordability - 2013 Significant Need	262	19	9.40%	41.75%	
5. Diabetes - 2013 Significant Need	254	23	9.11%	50.86%	
6. Cancer and Cancer Testing - 2013 Significant Need	212	20	7.60%	58.46%	
7. Physician	157	14	5.63%	64.10%	Other Identified Needs
8. Education/Prevention	137	15	4.91%	69.01%	
9. Smoking	97	10	3.48%	72.49%	
10. Unhealthy Food Choices	96	15	3.44%	75.93%	
11. Heart Disease	83	14	2.98%	78.91%	
12. Teen Births	75	14	2.69%	81.60%	
13. Stroke	67	9	2.40%	84.00%	
14. Palliative Care and Hospice	56	10	2.01%	86.01%	
15. Lung Disease	46	11	1.65%	87.66%	
16. Compliance Behavior	45	10	1.61%	89.28%	
17. Dental	43	9	1.54%	90.82%	
18. Liver Disease	41	10	1.47%	92.29%	
19. Housing Concerns	36	3	1.29%	93.58%	
20. Social Vulnerability	36	10	1.29%	94.87%	
21. Kidney Disease	35	10	1.26%	96.13%	
22. Access to Exercise Opportunities	29	8	1.04%	97.17%	
23. Accidents	25	8	0.90%	98.06%	
24. Flu/Pneumonia	20	8	0.72%	98.78%	
25. Sexually Transmitted Infection	16	7	0.57%	99.35%	
26. Priority Populations	12	7	0.43%	99.78%	
27. Chronic Pain Management	4	1	0.14%	99.93%	
28. Social Support	2	1	0.07%	100.00%	
Total	2788		100.00%		

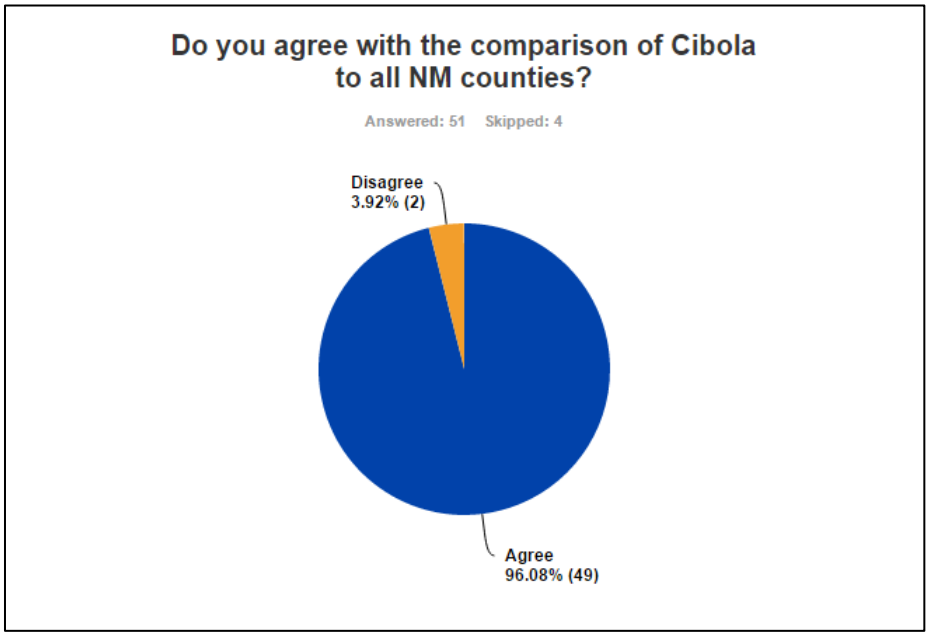
Individuals Participating as Local Expert Advisors[31]

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	21	28	49
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	16	31	47
3) Priority Populations	19	30	49
4) Representative/Member of Chronic Disease Group or Organization	12	34	46
5) Represents the Broad Interest of the Community	26	24	50
Other			
Answered Question			55
Skipped Question			0

Advice Received from Local Expert Advisors

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

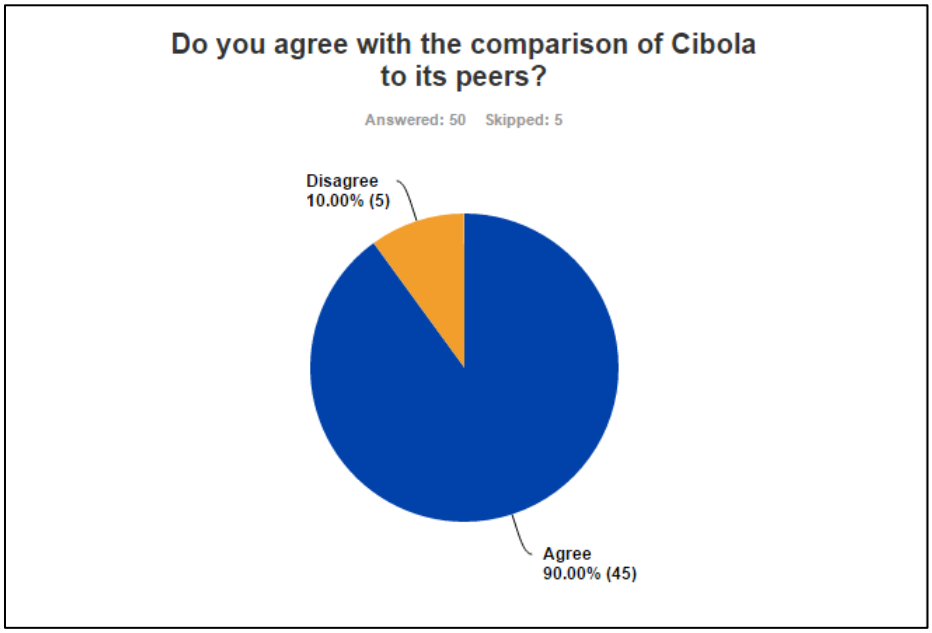
Question: *Do you agree with the observations formed about the comparison of Cibola County to all other New Mexico counties?*



Comments:

- Being a rural region, Cibola County faces many challenges regarding the health of the community. The health status reflects the income and the opportunities within the county and are often directly related to outcomes. However, Cibola County has implemented several avenues for resources to help the community improve the overall health status through prevention. I believe the physician shortage will continue to be a problem as stronger incentives are needed for retention.
- Small rural communities with a lack of good education and family values create the above issues.
- violent death (i'm sure we are a leader) - try OMI data, alcohol involved vehicle fatality (alcohol and non-alcohol) use TSB data, intentional harm/suicide (im sure we are a national leader
- Substance abuse is not mentioned but is definitely a contributing factor to the above statistic for this community.
- These seem inline with what I've observed in our community/area.
- Poverty / indigence / lack of education / large population of Hispanic and native American. Slow economic growth.

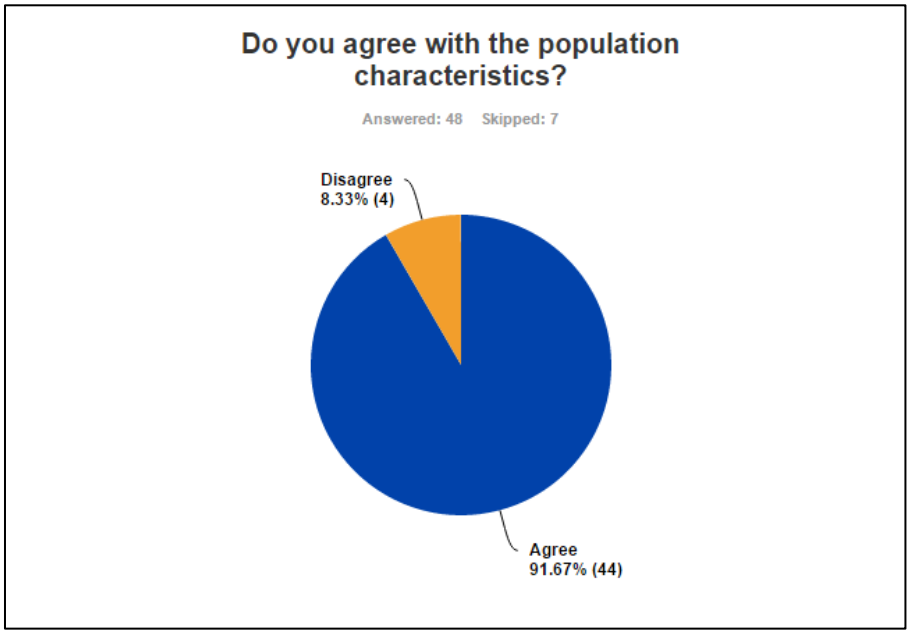
Question: *Do you agree with the observations formed about the comparison of Cibola County to its peer counties?*



Comments:

- I do not believe social factors have improved, particularly unemployment. Many members of the community need help in obtaining employment and often need to settle for much less pay than other areas.The cost of housing in Cibola County is substantially high when looking at the income of the population. Other categories in this section appear to be fairly accurate.
- Job opportunities are low in this county. There is virtually no mental health facilities or self-help groups offered to the community to assist alcohol and drug abuse.
- food expense is greater than average local income. Health care cost are greater than average local income.
- Again, no consideration of substance abuse as a contributing factor.
- Working in the hospital it doesn't seem that we see "alot" of people vicims of violent crime.
- More data is needed for this correlation. Many can say that the values shown are slanted towards the negative as opposed to placing all negative and positive values in the base.
- comments in the previous observation will apply to ALL. We can add Cibola counties geographic location.

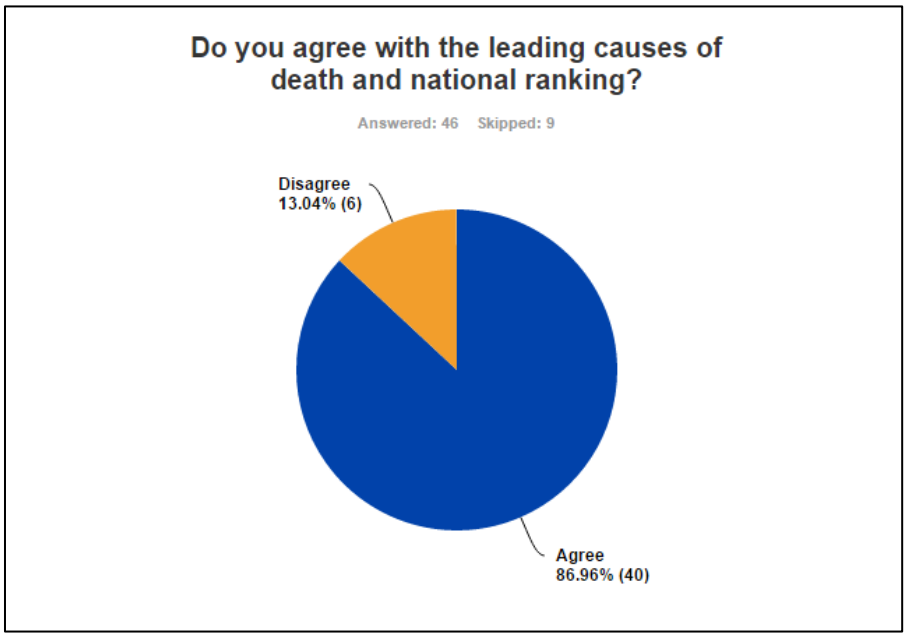
Question: *Do you agree with the observations formed about the population characteristics of Cibola County?*



Comments:

- I would tend to think the lack of mental and behavioral resources in the Cibola County area greatly effects these statistics.
- Because of the lack of education of eating healthy and lack of education of the importance of routine doctor visits, the community does not see these issues as an important issue.
- No urgent care is available and the population does not utilize walk in appointments during normal business hours. Emergency room is used for situations normally treated by PCPs, and incurs a long wait and back log of patients who would be better served in the urgent care setting with increase cost effectiveness. Would reduce the wait time at the emergency room and allow improved treatment for true emergencies.
- What about other drugs? Alcohol is important, but there is a high use of methamphetamine and Heroin as well.
- I would be surprised if the actual unemployment rate and alcohol consumption were not much higher. Transient and homeless populations in Cibola are high, hard to obtain census information for, and often addicted to alcohol.
- Disagree with consumed alcohol in past 30 days as being below average.
- Although I question the accuracy of the percentages stated for unemployment and alcohol usage.

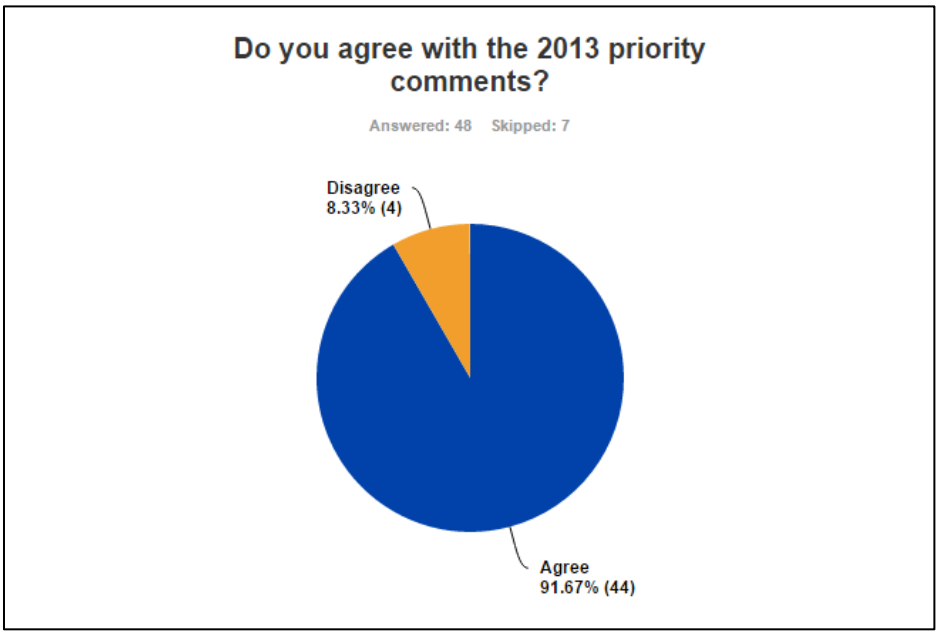
Question: *Do you agree with the observations formed from the leading causes of death and national ranking?*



Comments:

- I sure have seen an increase in the number of cancers at work
- Again, the lack of resources leads to many of the outcomes in these statistics. Chronic disease is often treated at the surface with patients turning to larger organizations for specialty services to get to the underlying problems. Health education is an important aspect that does not reach many members of the community so prevention is a challenge.
- If this is done with self reporting, I suspect the true numbers for binge drinking are higher.
- I think the cancer deaths are probably artificially low as we lose these people to other states. I can't imagine a community with higher rates of thyroid disease and thyroid cancer (not by death but by incidence per capita). Otherwise, this is describing our service population and strongly correlates with poverty. This is not a 'Cibola County' thing, its a poor thing...
- Again, I would question alcohol consumption statistics and weather they include the transient/homeless population.
- It is curious that the section under "Unfavorable Cibola County measures which are worse than the US avg. but had a favorable change" uses a data comparison from the mid-1980s rather than 2000 or greater as with other sections. I do not believe this shows an accurate comparison with the other sections.
- past occupational industry (uranium)

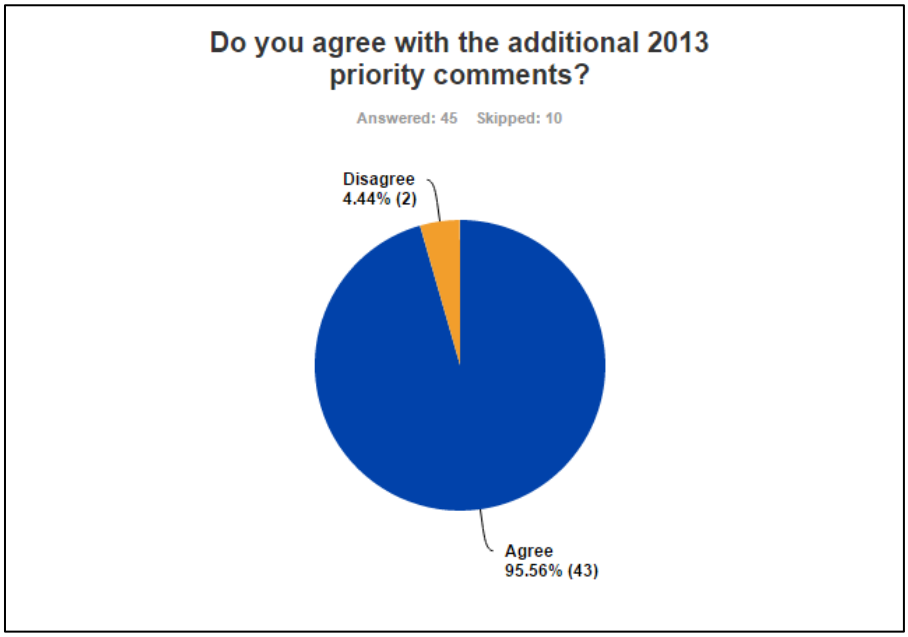
Question: *Do you agree with the written comments received on the 2013 CHNA?*



Comments:

- I think that mental illness and substance abuse is a major problem in our community. Also, people as for workshops or seminars on needed education/support but then no one shows up. I am not sure what the answer is but definitely need major help w mental illness and drug abuse.
- I agree entirely with these observations. Mental and behavioral resources are greatly needed along with education and outreach programs.
- young adults are the most likely to fall through the cracks of healthcare and insurance
- Health care at Cibola General Hospital is higher than the same services at other hospitals. The bills are not itemized, but generally grouped (Emergency room billing and in patient billing), which allows for multiple items group and it is impossible to determine if the services charged are actually the services rendered.
- Utilize more midlevel providers. Urgent care services.
- Cost to the patient should be brought in line with those of the surrounding areas.
- County needs to hire a full time public relations person to continually communicate with our community through media about what is or is not available in preventive health especially (out-reach) rural communities.

Question: *Do you agree with the additional written comments received on the 2013 CHNA?*



Comments:

- All of the above are very important in my opinion.
- Education is always the key to a healthy quality of life. I see the need for county wide education to develop better public transportation, healthy eating habits, and especially self-help groups for potential recovering alcoholics/drug abusers.
- More focus on social determinants of health -- given that Grants is a minority, rural, and poor county in NM.
- Cancer Prevention/Detection doesn't seem as important as the other issues. Perhaps Healthy Homes Initiative would encompass cancer screening but focus on other issues like indoor air quality, exposure to chemicals, etc which can cause cancer...
- Obesity, substance abuse, mental health should be top priorities. Also recruitment of skilled health professionals to our area should be top priority.

Appendix C – National Healthcare Quality and Disparities Reports

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

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

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

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

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

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

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

Trends

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

- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[32] consistent with these trends.

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

Trends

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

Disparities

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

Trends

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

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

Trends

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

Disparities

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

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

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

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

Disparity Trends

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

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

Trends

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

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

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities:
  - Median change in quality was 3.6% per year among measures of Patient Safety.
  - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
  - Median improvement in quality was 1.7% per year among measures of Effective Treatment.

- Median improvement in quality was 1.1% per year among measures of Healthy Living.
- There were insufficient data to assess Care Coordination and Care Affordability.

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

Achieved Success

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

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

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

Improving Quickly

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

- *Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*

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

Worsening

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

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

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

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).

- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems.

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

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

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

Disparities Trends

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

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

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality while states in the South census region tended to have lower quality.

- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities.
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

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

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

Trends

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

Disparities Trends

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

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

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial/ethnic and income groups.

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

- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

Disparities

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

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

Disparities Trends

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

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

Trends

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

Disparities

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

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

Trends

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

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often

disappeared as measures achieved high levels of performance.

Disparities Trends

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

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

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.
- About half of all Healthy Living measures tracked in the QDR improved.
- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

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

Disparities Trends

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

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

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

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.

- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[36]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

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

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

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

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

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnotes 17 and 19 on page 12

   b. **Demographics of the community**

      See footnote 20 on page 13

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

      See footnotes 26 and 27 on pages 36 and 37

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 26 on page 36

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

      See footnote 12 on page 9

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

      See footnote 31 on page 65

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

      See footnotes 8 and 9 on page 7

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

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

See footnote 10 on page 8; 13 and 14 on page 10, and 23 on page 17

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

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

2013

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

See footnote 15 on page 10 and 39 on page 62

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

See footnote 4 on page 4, and footnote 7 on page 7

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

No

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

Yes

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

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

www.cibolahospital.com

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

No other website

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

Yes

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

No other efforts

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

See footnote 26 on page 36, and footnote 27 on page 37

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

   2013

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

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

       Yes; www.cibolahospital.com

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

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

    See footnote 26 on page 36

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

    None incurred

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

    Nothing to report

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

    Nothing to report