Cibola General Hospital

Grants, NM

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution June, 2019[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 more than 60 years providing high-quality compassionate healthcare to the greater Cibola County community. The “2019 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how CGH will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

In compliance with the Affordable Care Act, all not-for-profit hospitals are 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.

Because this 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, and together, we can make our community healthier for every one of us.

Thank You,

Thomas Whelan
Chief Executive Officer
Cibola General Hospital

TABLE OF CONTENTS

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.

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

The 2019 Significant Health Needs identified for Cibola County are:

1. Substance Abuse – 2016 Significant Need
2. Mental Health & Suicide – 2016 Significant Need
3. Obesity – 2016 Significant Need
4. Diabetes – 2016 Significant Need
5. Affordability – 2016 Significant Need

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

APPROACH

APPROACH

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 helps the hospital identify and respond to the primary health needs of its residents.

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designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent Schedule H (Form 990) filings made by the hospital.

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

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

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

Project Objectives

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 – Schedule H (Form 990)
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

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

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

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

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

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

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

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

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other (please specify)

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

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

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

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

existed in their portion of the county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Cibola County compared to all New Mexico counties	February 22, 2019	2012-2014
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	February 25, 2019	2019
http://svi.cdc.gov	To identify the Social Vulnerability Index value	February 25, 2019	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	February 25, 2019	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	February 25, 2019	2016

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

[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

- A CHNA survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 38 Local Expert Advisors was received. Survey responses started March 8, 2019 and ended on April 5, 2019.
- 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] [13]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
    - The top three priority populations identified in the area are low-income groups, racial and ethnic minority groups, and residents of rural areas
    - There should be a focus on behavioral health and substance abuse
    - There should be a focus on affordable healthcare and accessibility

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.[14]

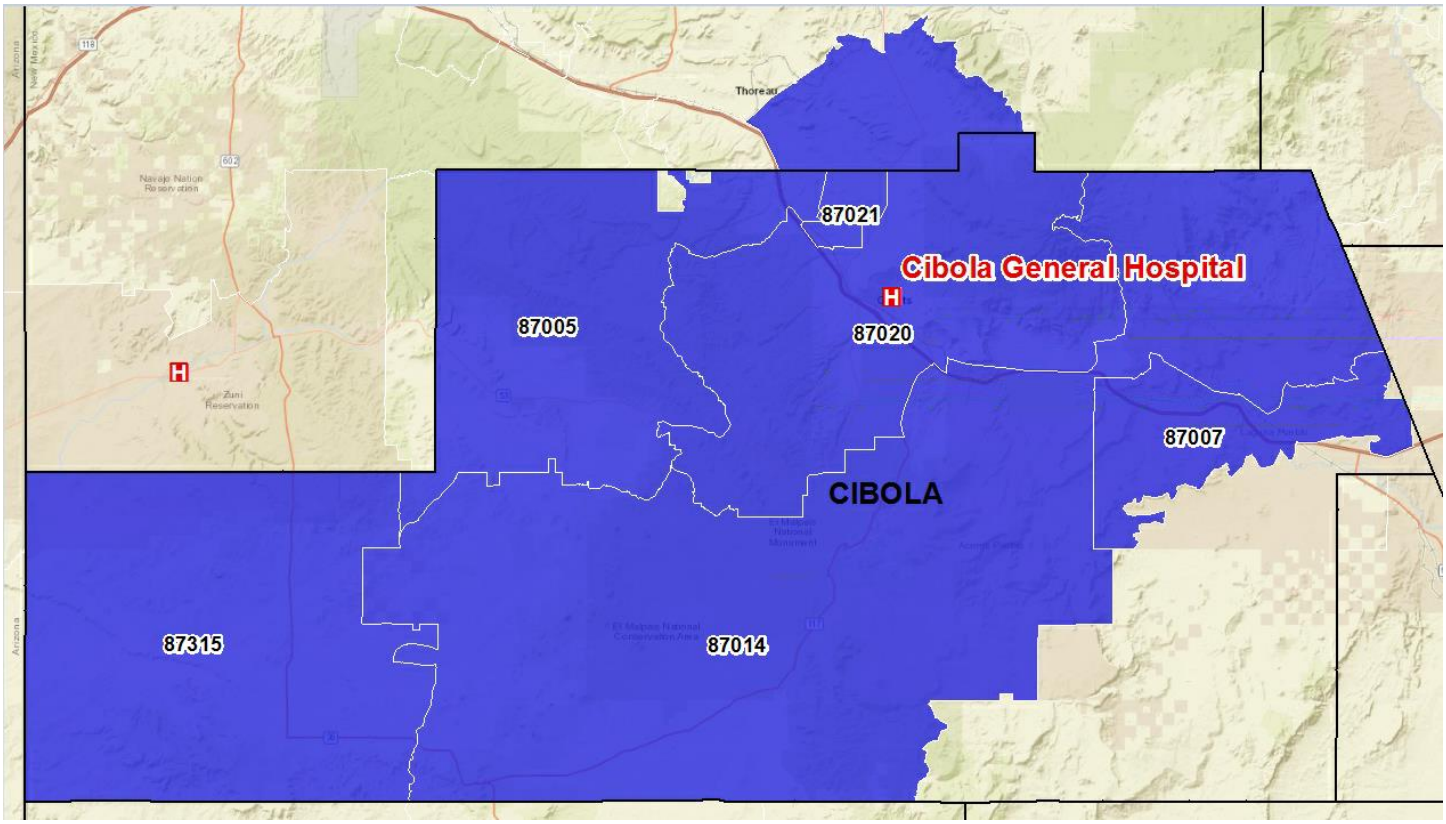
In the CGH process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list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

The ranked needs were divided into two groups: "Significant" and "Other Identified Needs." The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least fifty percent (60%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable break point in rank order occurred.[15]

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[16]



For the purposes of this study, Cibola General Hospital defines its service area as Cibola County in New Mexico, which includes the following ZIP codes:[17]

87005 – Bluewater 87007 – Casa Blanca 87014 – Cubero 87020 – Grants 87021 – Milan

87315 – Fence Lake

(Zip codes 87034, 87038, 87040, 87049, 87050, 87051, 87055, 87073 and 87357 are included in the above zip codes.)

During 2017, the Hospital received 79% of its Medicare inpatients from this area.[18]

[16] Responds to IRS Schedule H (Form 990) Part V B 3 a

[17] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below

[18] IBM Watson Health MEDPAR patient origin data for the hospital; Responds to IRS Schedule H (Form 990) Part V B 3 a

Demographics of the Community[19] [20]

Variable	Cibola, NM 2019	Cibola, NM 2024	Cibola, NM %Change	New Mexico 2019	New Mexico 2024	New Mexico %Change	United States 2019	United States 2024	United States %Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	27,631	27,868	0.9%	2,081,335	2,101,248	1.0%	326,533,070	337,947,912	3.5%
Total Male Population	14,127	14,243	0.8%	1,031,414	1,041,415	1.0%	160,763,625	166,448,475	3.5%
Total Female Population	13,504	13,625	0.9%	1,049,921	1,059,833	0.9%	165,769,445	171,499,437	3.5%
Females, Child Bearing Age (15-44)	5,045	5,149	2.1%	394,291	396,690	0.6%	63,920,735	64,819,726	1.4%
Average Household Income	$48,663			$67,637			$86,278		
POPULATION DISTRIBUTION									
Age Distribution									
0-14	5,680	5,803	2.2%	406,935	400,924	-1.5%	61,041,209	61,251,924	0.3%
15-17	1,101	1,119	1.6%	84,117	85,343	1.5%	12,768,680	13,285,276	4.0%
18-24	2,617	2,650	1.3%	202,199	202,060	-0.1%	31,582,678	32,239,015	2.1%
25-34	3,900	3,993	2.4%	275,975	270,346	-2.0%	43,889,724	43,505,348	-0.9%
35-54	6,579	6,337	-3.7%	491,580	489,987	-0.3%	83,269,718	83,715,341	0.5%
55-64	3,493	3,133	-10.3%	270,214	258,159	-4.5%	42,204,839	43,372,785	2.8%
65+	4,261	4,833	13.4%	350,315	394,429	12.6%	51,776,222	60,578,223	17.0%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	9,126	9,265	1.5%	809,277	820,462	1.4%	123,942,877	128,512,554	3.7%
2018 Household Income									
<$15K	1,725			122,628			13,504,093		
$15-25K	1,601			98,072			11,746,600		
$25-50K	2,495			197,182			27,363,648		
$50-75K	1,517			136,285			21,179,900		
$75-100K	825			91,460			15,192,390		
Over $100K	963			163,650			34,956,246		
EDUCATION LEVEL									
Pop Age 25+	18,233			1,388,084			221,140,503		
2018 Adult Education Level Distribution									
Less than High School	1,184			94,796			12,391,997		
Some High School	2,233			120,322			16,363,756		
High School Degree	6,692			370,815			61,028,690		
Some College/Assoc. Degree	5,978			435,120			64,253,906		
Bachelor's Degree or Greater	2,146			367,031			67,102,154		
RACE/ETHNICITY									
2018 Race/Ethnicity Distribution									
White Non-Hispanic	5,264			773,785			197,066,325		
Black Non-Hispanic	341			39,776			40,402,616		
Hispanic	10,500			1,018,806			59,581,510		
Asian & Pacific Is. Non-Hispanic	178			33,939			18,958,063		
All Others	11,348			215,029			10,524,556		

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

Consumer Health Service Behavior[21]

Key health services topics for the service area population are presented in the table below. In the second column of the chart, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

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

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	121.3%	37.0%	Cancer Screen: Skin 2 yr	74.2%	7.9%
Vigorous Exercise	88.9%	50.7%	Cancer Screen: Colorectal 2 yr	87.1%	17.9%
Chronic Diabetes	121.0%	19.0%	Cancer Screen: Pap/Cerv Test 2 yr	82.7%	39.9%
Healthy Eating Habits	93.4%	21.8%	Routine Screen: Prostate 2 yr	86.9%	24.7%
Ate Breakfast Yesterday	95.0%	75.2%	**Orthopedic**		
Slept Less Than 6 Hours	131.1%	17.9%	Chronic Lower Back Pain	112.6%	34.8%
Consumed Alcohol in the Past 30 Days	72.8%	39.1%	Chronic Osteoporosis	137.9%	14.0%
Consumed 3+ Drinks Per Session	127.3%	35.8%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	100.3%	81.6%
Search for Pricing Info	85.9%	23.2%	NP/PA Last 6 Months	102.1%	42.4%
I am Responsible for My Health	98.8%	89.5%	OB/Gyn 1+ Visit	84.0%	32.3%
I Follow Treatment Recommendations	98.3%	75.7%	Medication: Received Prescription	104.1%	63.1%
Pulmonary			**Internet Usage**		
Chronic COPD	133.1%	7.2%	Use Internet to Look for Provider Info	76.5%	30.6%
Chronic Asthma	106.9%	12.6%	Facebook Opinions	81.5%	8.2%
Heart			Looked for Provider Rating	72.8%	17.1%
Chronic High Cholesterol	109.2%	26.7%	**Emergency Services**		
Routine Cholesterol Screening	88.3%	39.1%	Emergency Room Use	105.3%	39.3%
Chronic Heart Failure	174.9%	7.1%	Urgent Care Use	97.1%	32.0%

[21] Claritas (accessed through IBM Watson Health)

Conclusions from Demographic Analysis Compared to National Averages

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

- 21.3% more likely to have a **BMI of Morbid/Obese**, affecting 37.0%
- 11.1% less likely to **Vigorously Exercise**, affecting 50.7%
- 27.3% more likely to **Consume 3+ Drinks per Session**, affecting 35.8%
- 11.7% less likely to receive **Routine Cholesterol Screenings**, affecting 39.1%
- 17.3% less likely to receive **Cervical Cancer Screening every 2 years**, affecting 39.9%
- 12.6% more likely have **Chronic Lower Back Pain**, affecting 34.8%
- 16.0% less likely to receive **Routine OB/Gyn Visit**, affecting 32.3%
- 5.3% more likely to **Visit the Emergency Room (for non-emergent issues)**, affecting 39.3%

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

- 27.2% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 39.1%

Leading Causes of Death[22]

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

Cause of Death			Rank among all counties in NM (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Cibola County Compared to U.S.)
NM Rank	Cibola Rank	Condition		NM	Cibola	
1	1	Heart Disease	22 of 32	150.5	159.3	Lower than expected
2	2	Cancer	16 of 32	138.8	158.9	As expected
3	3	Accidents	11 of 32	69.5	78.9	Higher than expected
6	4	Diabetes	2 of 32	27.2	57.3	Higher than expected
4	5	Lung	22 of 32	44.4	43.0	As expected
8	6	Liver	3 of 32	24.8	39.3	Higher than expected
5	7	Stroke	27 of 32	35.5	33.5	As expected
10	8	Flu - Pneumonia	6 of 32	14.6	22.3	Higher than expected
9	9	Suicide	22 of 32	22.4	20.2	Higher than expected
11	10	Kidney	5 of 32	11.6	16.8	As expected
7	11	Alzheimer's	20 of 32	23.4	15.1	Lower than expected
12	12	Blood Poisoning	3 of 32	9.4	13.3	As expected
15	13	Hypertension	2 of 32	5.9	9.4	As expected
14	14	Homicide	12 of 32	9.4	8.9	As expected
13	15	Parkinson's	6 of 32	7.8	8.3	As expected

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

Priority Populations[23]

Earlier in the document, a description was provided for Priority Populations, which is one of the groups whose needs are to be considered during the CHNA process. It can be difficult to obtain information about Priority Populations in a hospital's community. The objective is to understand the general trends of issues impacting Priority Populations and to interact with the Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

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 Hospital's performance and to identify areas of strengths and weaknesses 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 D.

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the CGH places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[24]

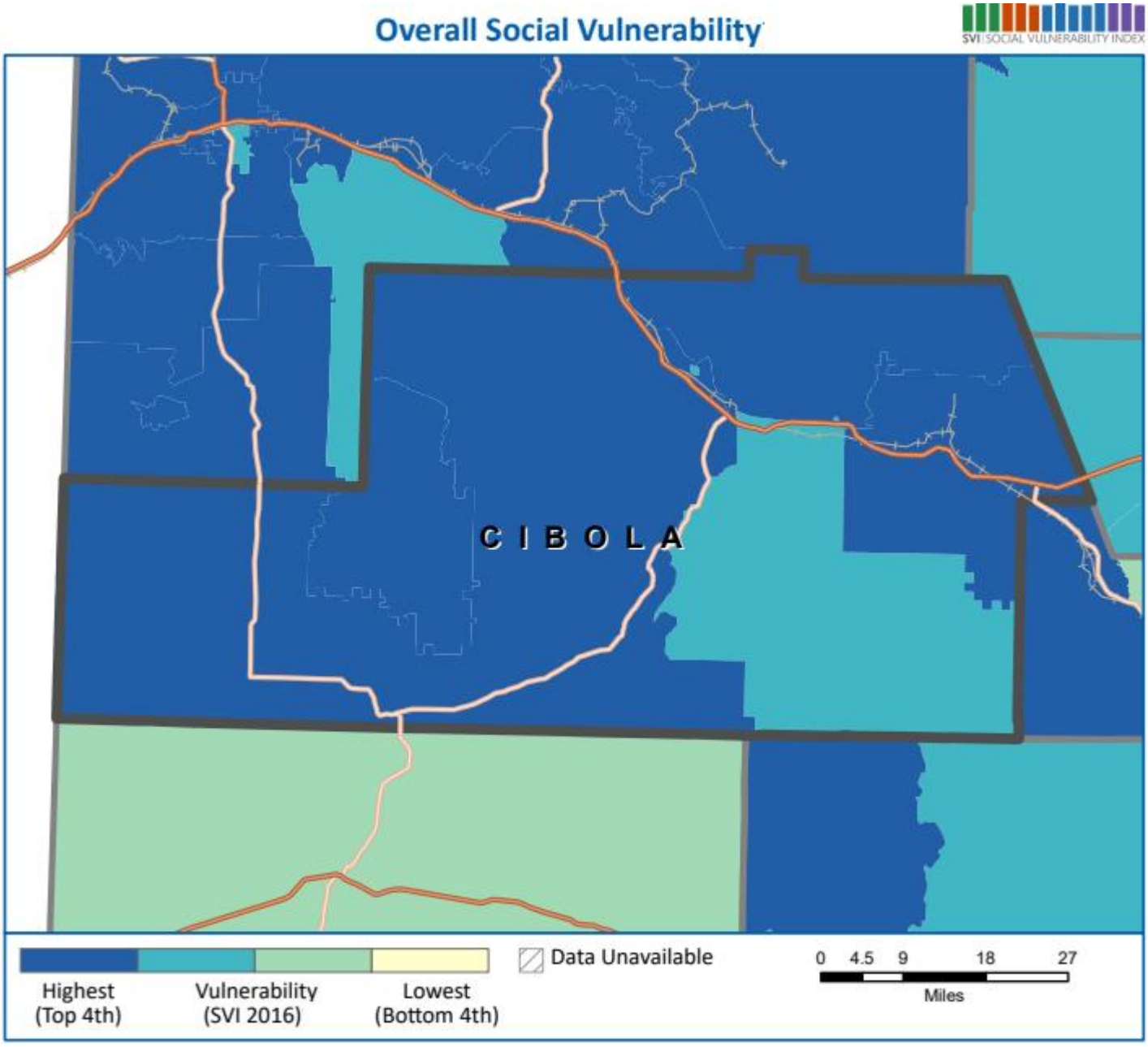
- The top three priority populations identified in the area are low-income groups, racial and ethnic minority groups, and residents of rural areas
- There should be a focus on behavioral health and substance abuse
- There should be a focus on affordable healthcare and accessibility

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

Social Vulnerability[25]

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

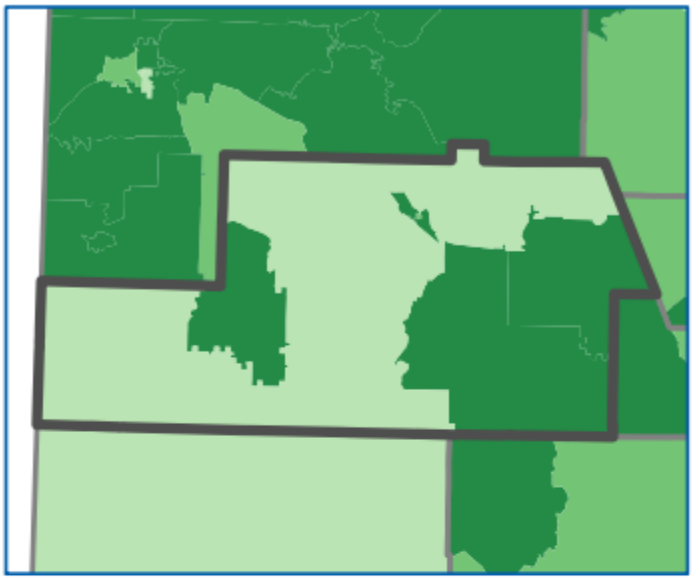
Overall, Cibola County's overall Social Vulnerability ranks fall into the second and third quartiles of vulnerability, making the right side (light blue) of the county more vulnerable than the left side (light green) of the county, but overall the county's vulnerability being average:



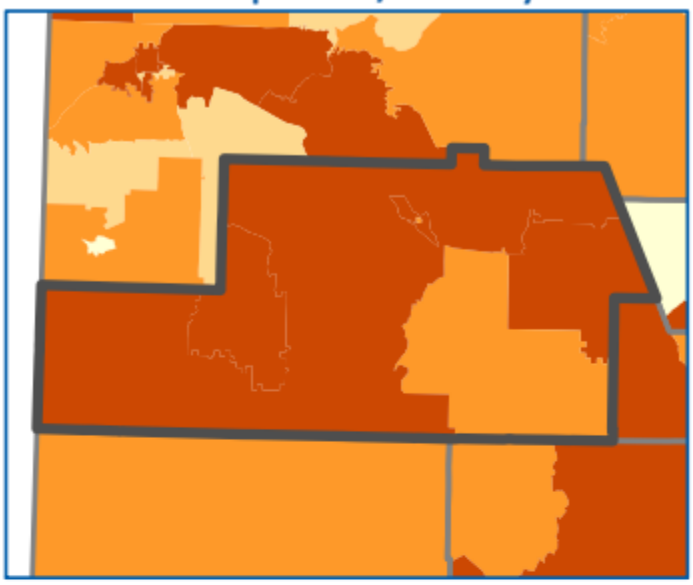
[25] http://svi.cdc.gov

SVI Themes

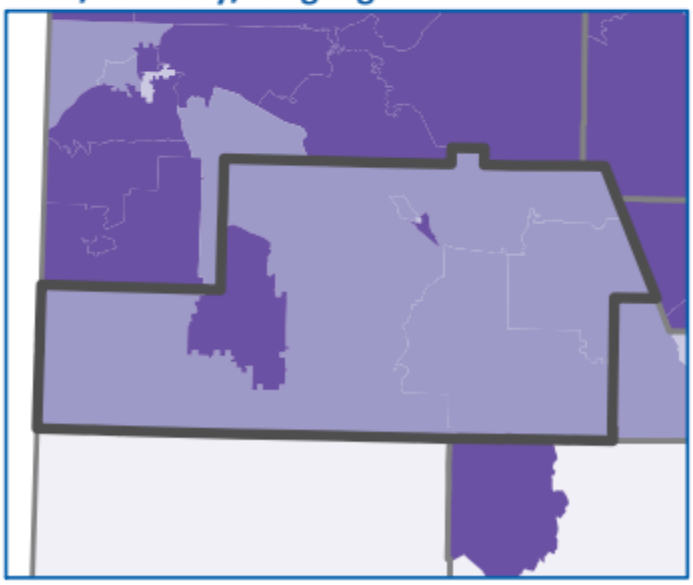
Socioeconomic Status



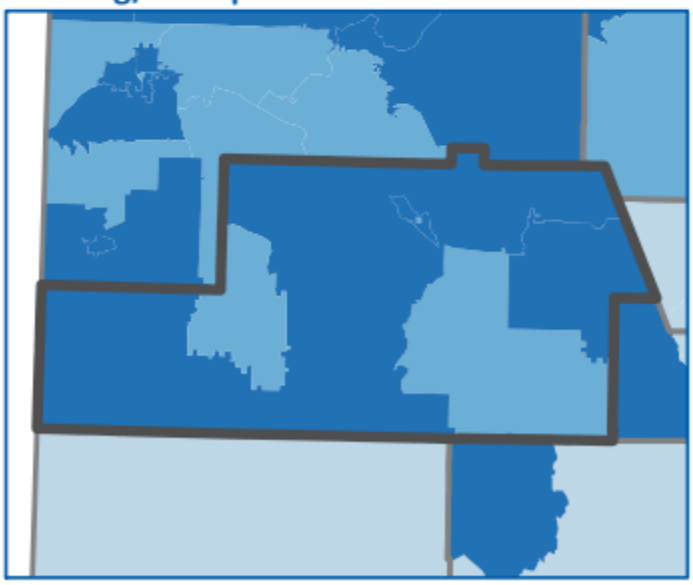
Household Composition/Disability



Race/Ethnicity/Language



Housing/Transportation



Comparison to Other State Counties[26]

To better understand the community, Cibola County has been compared to all 32 counties in the state of New Mexico across six areas: Length of Life, Quality of Life, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment.

In the chart below, the county's rank compared to all counties is listed along with measures in each area compared to the state average and U.S. Median.

	Cibola	New Mexico	U.S. Median
Length of Life			
Overall Rank *(best being #1)*	23/32		
- Premature Death*	10,400	8,400	7,800
Quality of Life			
Overall Rank *(best being #1)*	26/32		
- Poor or Fair Health	24%	21%	17%
- Poor Mental Health Days	4.6	4.0	3.9
Health Behaviors			
Overall Rank *(best being #1)*	30/32		
- Adult Smoking	22%	17%	17%
- Adult Obesity	30%	24%	32%
- Physical Inactivity	26%	19%	27%
- Excessive Drinking	16%	17%	17%
- Alcohol-Impaired Driving Deaths	26%	31%	29%
Clinical Care			
Overall Rank *(best being #1)*	28/32		
- Uninsured	14%	13%	11%
- Population to Primary Care Provider Ratio	2,100:1	1,320:1	2,040:1
- Population to Dentist Ratio	2,290:1	1,540:1	2,520:1
- Population to Mental Health Provider Ratio	320:1	270:1	1,050:1
- Preventable Hospital Stays	52	39	56
- Diabetes Monitoring	48%	73%	86%
- Mammography Screening	46%	57%	61%
Social & Economic Factors			
Overall Rank *(best being #1)*	28/32		
- Unemployment	8.3%	6.7%	5.0%
- Children in Poverty	34%	28%	21%
- Children in Single-Parent Households	54%	40%	32%
- Violent Crime*	607	590	198
- Injury Deaths*	108	99	79
Physical Environment			
Overall Rank *(best being #1)*	13/32		
- Air Pollution - Particulate Matter	5.6 µg/m³	6.4 µg/m³	9.2 µg/m³
- Severe Housing Problems	22%	18%	14%

Per 100,000 Population

[26] www.countyhealthrankings.org

Conclusions from Other Statistical Data[27]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Cibola County statistics to the U.S. average, as well as the trend in each measure over a 34-year span.

Cibola County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Cibola County measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change		
- Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	72.7	30.9%
- Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	81.2	29.8%
- Female Self-Harm and Interpersonal Violence Related Deaths*	14.4	15.7%
- Female Mental and Substance Use Related Deaths*	18.8	409.0%
- Male Mental and Substance Use Related Deaths*	42.1	107.0%
- Female Liver Disease Related Deaths*	30.4	72.9%
- Male Liver Disease Related Deaths*	51.2	47.6%
UNFAVORABLE Cibola County measures that are **WORSE** than the U.S. average and had a **FAVORABLE** change		
- Female Life Expectancy	79.7	3.1%
- Male Life Expectancy	74.1	6.8%
- Male Self-Harm and Interpersonal Violence Related Deaths*	50.4	-8.1%
- Female Transport Injuries Related Deaths*	16.7	-41.0%
- Male Transport Injuries Related Deaths*	37.5	-55.4%
DESIRABLE Cibola County measures that are **BETTER** than the US average and had an **UNFAVORABLE** change		
- Female Tracheal, Bronchus, and Lung Cancer*	32.2	6.4%
- Male Skin Cancer*	3.7	19.0%
DESIRABLE Cibola County measures that are **BETTER** than the US average and had a **FAVORABLE** change		
- Female Heart Disease*	108.7	-32.7%
- Male Heart Disease*	169.1	-50.3%
- Male Stroke*	41.4	-47.2%
- Male Tracheal, Bronchus, and Lung Cancer*	57.7	-36.0%
- Female Breast Cancer*	23.5	-27.8%
AVERAGE Cibola County measures that are **EQUAL** to the US average and had a **FAVORABLE** change		
- Female Stroke*	47.9	-31.8%
- Male Breast Cancer*	0.2	-17.3%
- Female Skin Cancer*	1.6	-11.9%

*rate per 100,000 population, age-standardized

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

Community Benefit

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 (FY2018) included:

- $6,748,420.00

IMPLEMENTATION STRATEGY

Significant Health Needs

CGH 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.[28] The Implementation Strategy includes the following:

- 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 primary hospital in the service area. CGH is a 25-bed, acute care medical facility located in Cibola, New Mexico. The next closest facilities are outside the service area and include:

- Acoma-Canoncito-Lagua, Canoncito, NM 20.0 miles (24 minutes)
- Crownpoint Health Care Facility, Crownpoint, NM; 57.5 miles (60 minutes)
- Rehoboth McKinley Christian Hospital in Gallup, NM 64.0 miles (64 minutes)
- Gallup Indian Medical Center, Gallup, NM; 64.2 miles (64 minutes)
- Presbyterian Hospital, Albuquerque, NM; 78.9 miles (77 minutes)
- Zuni Comprehensive Health Center, Zuni, NM; 74.1 miles (81 minutes)
- Lovelace Westside Hospital, Albuquerque, NM; 81.2 miles (82 minutes)
- Presbyterian Rust Medical Center, Albuquerque, NM; 81.7 miles (84 minutes)
- UNM Hospital, Albuquerque, NM 81.0 miles (86 minutes)

All statistics 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

[28] Response to IRS Schedule H (Form 990) Part V B 3 e

broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

1. **SUBSTANCE ABUSE – 2016 Significant Need; Cibola County's Mental and Substance Use Related Deaths rate is worse than the national average**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for full list of comments*

CGH services, programs, and resources available to respond to this need include:[29]

- 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 access to emergency services to assess, evaluate, and transfer as necessary
    - Social services are provided until midnight
- Provide in-house detoxification using CIWA protocol

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

- Working on developing outpatient behavioral health service line
- Outpatient group therapy, AA, etc.
- Provide suboxone training to providers to prescribe and dispense suboxone
- Work with community to develop Community Behavioral Health tasks force
- Provide opioid education to providers through the UNM ECHO Program
- Through a state grant, work with New Mexico Rural Health to provide opioid education to nurses and first responders.
- Renewal of mental health program protocols and processes
- Training of employees on how to respond to mental health crises through Mental Health First Aid
    - Available to train other community members upon completion
- Begin offering outpatient tele psych services

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

- Teamed with Milan Elementary on 10/24/16 to educate on substance abuse. Reached 500 students. (red ribbon week)
- AA Meetings began 10/12/16 in the Community room. Due to low attendance District 9 AA leader asked to cancel the meetings on 2/22/17 until further notice. Other meetings around town had low attendance as well.

[29] 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

- Participated and Coordinated the Annual Public Safety Day 2017 - worked with Cibola County Substance abuse coordinator to pass out information on opioid abuse.
- $1 Sports Physicals 2018 - worked with Cibola County Substance abuse coordinator to pass out information on opioid abuse.
- June 2017 joined Cibola County Substance Abuse Coalition.
- Began offering tele-medicine visits for outpatient behavioral health
- Purchased drug take back
- Hired full time case manager that works with the clinic and patient care coordinator with patients on assessing treatment needs; developing, monitoring and evaluating treatment plans and progress

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 2018: 378

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

- Estimated percentage of Cibola County population 27.2% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 39.1%

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

- *See Appendix C for full list of organizations*

Other local resources identified during the CHNA process that are believed available to respond to this need:[30]

- *See Appendix C for full list of organizations*

[30] 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

2. **MENTAL HEALTH & SUICIDE – 2016 Significant Need; Cibola County's Poor Mental Health Days is worse than the state and national averages; Suicide is the #9 Leading Cause of Death in Cibola County; Cibola County's Mental and Substance Use Related Deaths rate is worse than the national average**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- Perform $1 sports physicals annually and refer to primary care physicians any students with abnormal findings.
- Hospital employs licensed mental health professional who counsels on, provides discharge plans and referrals to local mental health facilities.
- Suicide risk assessment is completed on all patients who present with suicidal ideations.
- Provide 24-hour emergency services.
- Depression scoring is provided for ACO patients (PHQ 9)
- Ongoing education and awareness and suicide prevention through community health fairs.
- Employee assistance program is available to employees and families, including suicide prevention counseling

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

- Expand depression scoring to patients outside the ACO
- Working with the county and city to see if there is something – Behavioral Task Force – Look to identify those in the community that might have mental health and point them in the right direction
- Working on developing outpatient behavioral health service line
    - Outpatient group therapy, AA, etc.
- Provide suboxone training to providers to prescribe and dispense suboxone
- Work with community to develop Community Behavioral Health tasks force
- Provide opioid education to providers through the UNM ECHO Program
- Through a state grant, work with New Mexico Rural Health to provide opioid education to nurses and first responders
- Renewal of mental health program protocols and processes
- Training of employees on how to respond to mental health crises through Mental Health First Aid
- Available to train other community members upon completion
- Begin offering outpatient tele psych services

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

- Increased annual depression screenings in physician offices
- Brochures are posted around the hospital
- Post/promote suicide hotline services, and develop a community resource guide
- Team with NMSU through BCBS to provide mental health screenings at April health Fair 2019; Provide information on stress relief
- Crisis Prevention Institute (CPI) de-escalation training is provided for employees
- Instituted a patient safety alert system for employees who encounter a situation that is likely to harm a patient to make an immediate report and to cease any activity that could further harm
- Hired 24-7 security officer
- Hired licensed mental health therapist
- Hired full time case manager that works with the clinic and patient care coordinator with patients on assessing treatment needs; developing, monitoring and evaluating treatment plans and progress

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 crisis assessments performed for patients with suicide ideation or mental health related concerns in 2018: 149

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

- Suicide death rate – 20.2 deaths/100,000 residents adjusted

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

- *See Appendix C for full list of organizations*

Other local resources identified during the CHNA process that are believed available to respond to this need:[31]

- *See Appendix C for full list of organizations*

[31] 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

3. **OBESITY – 2016 Significant Need; Cibola County's Adult Obesity and Physical Inactivity rate are worse than the state average; Residents of Cibola County are 21% more likely to have BMI of Morbid/Obese than the national average**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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.
- Annually provided 10 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. (These are done at the hospital, clinic, at employer's business, and at local events).
- Annually provided nutrition, exercise, and dental education within schools during the Eat Smart, Play Hard Program with Future Foundations.
- Sponsor 5K run/walk in collaboration with Grants Recreation Department and Grants Fire & Rescue.
- 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.
- 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.
- On our website, we have a Health Library it constantly updates with different safety tips, healthy eating, and exercising provided by YouCareEverywhere (patient portal).
- Supplying healthy recipes from Diabetes Organization with doctor biographies and/on pharmacy's drug description provided on discharge on the flip side. (Given out at health fair's, discharge folder, and are in waiting rooms at CGH and CFHC).
- Perform $1 sports physicals annually for local students.

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

- Explore offering a wellness discount reward on employee insurance plans
- Explore offering the Naturally Slim Weight Loss Program, a counseling program that teaches participants healthy habits
- Explore hiring an outpatient registered dietician

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

- Providing fundraising - Pennies for the Pantry raising $400 towards the pantry to purchase healthier items in 2017
- Pam Gutierrez visited local food pantry to promote healthy food/eating in 2017
- Hired full time case manager that works with the clinic and patient care coordinator with patients on assessing

treatment needs; developing, monitoring and evaluating treatment plans and progress

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 participants at mini health fair
- Number of programs offered that promote healthy behaviors in 2018: 32

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

- Percent of population sample of age 20+ with BMI greater than 30 = 29%

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

- *See Appendix C for full list of organizations*

Other local resources identified during the CHNA process that are believed available to respond to this need:[32]

- *See Appendix C for full list of organizations*

[32] 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

4. **DIABETES – 2016 Significant Need; Cibola County's Diabetes Monitoring rate is worse than the state and national averages; Diabetes the in the #4 Leading Cause of Death in Cibola County; Cibola County's Diabetes, Urogenital, Blood, and Endocrine Disease Deaths rate is worse than the national average**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- Free diabetic services/counseling (with physician referral) to Pam Gutierrez, Diabetes Educator.
- Suppling healthy recipes from Diabetes Organization with doctor biographies and/on pharmacy's drug description provided on discharge on the flip side. (Given out at health fair's, discharge folder, and are in waiting rooms at CGH and CFHC)
- Offer 25% discount on services paid for same-day, outpatient cash prices for lab, radiology and cardiopulmonary services.
- Perform $1 sports physicals annually for local students.
- Provide reduced-cost labs (e.g., A1C, lipid panel) at annual health fair.
- Provided 'What the Health' program to employees and families – challenge to lose % fat over 3 months.
- Annually provided 10 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. (These are done at the hospital, clinic, at employer's business, and at local events)
- Annually provided nutrition, exercise, and dental education within schools during the Eat Smart, Play Hard Program with Future Foundations.
- Sponsor 5K run/walk in collaboration with Grants Recreation Department and Grants Fire & Rescue.
- Nutritionist visits inpatients weekly for consultation and education
- 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.
- On our website, we have a Health Library it constantly updates with different safety tips, healthy eating, and exercising provided by YouCareEverywhere (patient portal).
- Offers diabetic wound care services at CGH

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

- Explore hiring an endocrinologist
- Explore offering Friday clinics for diabetes educations through internal medicine candidate
- Research offering inpatient dialysis (DCI) for diabetic patients with renal disease

- Begin offering education and drug alternatives through the pharmacists
- Podiatrist that comes to the clinic 1-2 times a week
- Explore offering varicose vein surgery at CGH
- Consider offering Hemoglobin/AC1s checks that allows patients to be checked twice year
- Explore offering low-cost diabetic test stripes
- Explore hiring an outpatient registered dietician
- Explore offering a wellness discount reward on employee insurance plans
- Explore offering the Naturally Slim Weight Loss Program, a counseling program that teaches participants healthy habits

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

- 09/2016 worked with NMSU and cooking creations to provide diabetes cooking classes.
- 09/2017 worked with NMSU and cooking creations to provide diabetes cooking classes.
- 10/25/2017 Gave a diabetes presentation to Western NM Correctional Facility Staff.
- 09/2018 provided a diabetes cooking class at Hospital with Pam Gutierrez, Diabetes Educator.
- Team with NMSU through BCBS to provide free Hemoglobin A1C to the first 60 people at April health Fair 2018. Provide information on diabetes, and made the theme focus on Diabetes.
- Hired full time case manager that works with the clinic and patient care coordinator with patients on assessing treatment needs; developing, monitoring and evaluating treatment plans and progress

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	

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
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

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

- Cibola County Diabetic Death Rate = 57.3 per 100,000 adjusted

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

- *See Appendix C for full list of organizations*

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

- *See Appendix C for full list of organizations*

5. AFFORDABILITY – 2016 Significant Need; Cibola County's Uninsured rate is worse than the state and national averages

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- Free diabetic services/counseling (with physician referral) to Pam Gutierrez, Diabetes Educator.
- Offer 25% discount on services paid for same-day
- Perform $1 sports physicals annually for local students.
- 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.
- Annually provided 10 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. (These are done at the hospital, clinic, at employer's business, and at local events)
- 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.
- Employee assistance program available to employees and families, including suicide prevention counseling.
- Financial counselors available to patients.
- 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.
- Community-wide Flu Pod – provide supplies (bags, gloves, vaccine etc.) and staff.
    - 2016 – 198 Shots, 2017 – 800 Shots, 2018 – 974 Shots
- Cibola Family Health Center offers sliding-scale fee schedule.
- Participate in 340B program to provide low-cost prescriptions.

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

- Consider offering cash prices for OB/GYN services and some surgery packages
- Plan to train additional clinic and hospital employees on Medicare/Medicaid applications
- Explore extending after hours clinic to additional days a week
- Explore offering mobile telemedicine services to the outlying areas
- Explore offering low-cost diabetic test stripes

- Explore offering a wellness discount reward on employee insurance plans

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

- 12/8/17 Held an open enrollment event at hospital to sign people up for medical insurance.
- 12/5/18 Held an open enrollment event at hospital to sign people up for medical insurance and provide Medicare 101 Education
- Outpatient cash prices for lab, radiology and cardiopulmonary services.
- Revamp website to provide price transparency
- After-hours clinics three days a week
- Hired full time case manager that works with the clinic and patient care coordinator with patients on assessing treatment needs; developing, monitoring and evaluating treatment plans and progress

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 patients registered for Medicare/Medicaid
- Monitor after-hours clinic patients count

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

- Beneficiary mix of patients

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

- *See Appendix C for full list of organizations*

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

- *See Appendix C for full list of organizations*

Other Needs Identified During CHNA Process

6. **Cancer & Cancer Center – 2016 Significant Need**
7. **Alcohol Abuse**
8. **Education/Prevention**
9. **Accessibility**
10. **Heart Disease**
11. **Physical Inactivity**
12. **Women's Health**
13. **Chronic Pain Management**
14. **Liver Disease**
15. **Flu/Pneumonia**
16. **Stroke**
17. **Alzheimer's**
18. **Lung Disease**
19. **Smoking**
20. **Hypertension**
21. **Dental**
22. **Kidney Disease**
23. **Accidents**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[33]

1. Substance Abuse – 2016 Significant Need
2. Mental Health & Suicide – 2016 Significant Need
3. Obesity – 2016 Significant Need
4. Diabetes – 2016 Significant Need
5. Affordability – 2016 Significant Need

Significant needs where hospital did not develop implementation strategy[34]

1. None

Other needs where hospital developed implementation strategy

1. None

Other needs where hospital did not develop implementation strategy

1. None

[33] Responds to Schedule h (Form 990) Part V B 8
[34] Responds to Schedule h (Form 990) Part V Section B 8

APPENDIX

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

Hospital solicited written comments about its 2016 CHNA.[35] 38 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	11	22	33
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	16	18	34
3) **Priority Populations**	14	17	31
4) Representative/Member of **Chronic Disease Group** or Organization	6	23	29
5) Represents the **Broad Interest of the Community**	28	5	33
Other	8		8
Answered Question			38
Skipped Question			0

Comments:

- *Office of Substance Abuse Prevention*
- *Quality Assurance/Improvement, Training Manager, Paramedic for a multi-operational EMS Service*
- *Manager of the Village of Milan*
- *Retired hospital CFO*
- *Law Enforcement*
- *I am currently working for the Office Of Substance Abuse Prevention*
- *Director of an FQHC providing out-patient medical and behavioral health services*
- *I'm a surgeon at the hospital*

Congress defines "Priority Populations" to include:

- Racial and ethnic minority groups
- Low-income groups
- Women

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

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

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

- *Low income adds to the medical needs of these groups. Not having insurance keeps them from seeking medical help.*
- *Cancer detection.*
- *Obesity is high in our community.*
- *Substance abuse and mental health problems - co-occurring*
- *People with co-occurring issues... Substance Abuse/Poverty/Mental Health etc...*
- *11-year-old committing suicide, domestic violence women and children, patients who cannot afford prescriptions, lack transportation due to rural area, complex it's with 2-4 chronic illnesses which affect our local ethnic groups*
- *Continued medical checkups to promote healthy growth and to prevent/contain diseases. Hospital and providers are far from home.*
- *Uninsured*
- *Services that are readily available with affordable co-pays and no waiting list.*

In the 2016 CHNA, there were seven health needs identified as "significant" or most important:

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

3. **Should the hospital continue to consider and allocate resources to help improve the needs identified in the 2016 CHNA?**

	Yes	No	Response Count
Substance Abuse	36	0	36
Obesity	31	1	32
Mental Health & Suicide	35	1	36

Affordability	30	0	30
Diabetes	35	0	35
Cancer and Cancer Testing	32	1	33

Comments:

- *Domestic Violence and Sexual Assault and the effects on victims their children and families.*
- *Chronic pain; pain management*
- *Many issues are prevalent in the surrounding areas. Of those issues, these are a very good starting place. If I had to start with a #1 item, I would say Mental Health because these issues so often lead to many of the other issues noted.*
- *through this funding I am able to provide support and education to address all of these needs at the clinic*
- *Cibola County is a very rural area with high poverty rates. This area is designated as a health professional shortage area lacking an adequate number of primary care providers to take of the need*

6. Please share comments or observations about the actions CGH has taken to address <u>SUBSTANCE ABUSE</u>.

- *Cibola County has a severe Methamphetamine, Alcohol and Opioid Substance Abuse Problem , most being generational drug use, Cibola County being the 3rd highest county in NM for (Alcohol) Chronic Liver disease , Opioid Use amongst our youth to get high, Cibola General Hospital takes a strong initiative in caring for these individuals using these substances. Many folks in Cibola County are on State funded Medicaid it is my recommendation that CGH provide Certified Peer support workers to work with these individuals, as Medicaid will cover these services.*
- *Educating students and warning them about the consequences of abuse helps a great deal.*
- *Don't have enough information to comment.*
- *Continue to work with area agencies/groups to address the problem.*
- *This is a serious issue in this area*
- *We definitely need a good place for AA/NA, GA - well known location, not "seedy" feeling*
- *No detox centers.*
- *Community outreach, radio ads but we are very limited in the Substance Abuse services.*
- *maybe have peer support specialist*
- *A significant problem that has a lack of resources available in the service area. This is a crippling concern that is difficult to grasp and get consensus on as many agencies want to talk about it, but at some point, action needs to be taken. Unfortunately, action will take funding and significant resources.*
- *I do not have any knowledge of actions that CGH has or is taking on any of these issues.*
- *I am not aware of specific results for these actions.*
- *not aware of any*

- *none to my knowledge*
- *Ms. Tena participating in outreach events.*
- *I have seen CGH go above and beyond to assist individuals struggling with Mental health and Substance Abuse issues. I believe what is Needed is MAT Center or Crisis Response team of Certified Peer Support Worker and or licensed medical staff available to go out into the streets and work with individuals living on the streets or substance abuse frequent fliers needing mental health and medical care needs.*
- *CGH has provided a resource guide and resources for community members.*
- *Unaware of progress made on SA goals*
- *Working with the community*
- *Develop certificate or degree pathways in Dual Credit and/or College-level programs to more specifically address the focus*
- *As the CEO of ACLSU - I do not have detailed information about CGH coverage.*
- *Added folks to help w/behavioral health*
- *I have not seen much from the Hospital as far as outreach to help control substance Abuse. Such as alcohol or Narcotics. Need to be more proactive then reactivate.*

7. Please share comments or observations about the actions CGH has taken to address <u>OBESITY</u>.

- *CGH has a very good program in providing education to individuals struggling with Obesity.*
- *Cooking classes for diabetics a d education concerning healthy meals makes a huge impact.*
- *Good community information.*
- *I don't have any more comments in this area*
- *The hospital has a dietitian for Diabetes but the outreach for Obesity is slim to none for*
- *have the local Navajo nation CHRs involve to collaborate education on obesity*
- *As is the case on a national basis, obesity is a concern and needs to be addressed both through education, but through medical and psychological methods as well.*
- *I am not aware of specific results for these actions.*
- *Helped with programs for wellness and obesity prevention in clinic, community health fair and schools.*
- *website has good information about health and wellness, if people really access it though*
- *paper efforts, need challenge programs or affiliation with gym*
- *I have seen CGH emergency staff (doc) (nurses) assist individuals with Nutrition and proper food diet plans.*
- *Community resources and workshops.*
- *CGH does promote health and wellness; they do have care coordinator staff. I have no knowledge of progress*

made on the other action steps

- *Good plans-of-action*
- *As the CEO of ACLSU - I do not have detailed information about CGH coverage*
- *education on proper nutrition*
- *adding more practitioners and doing preventive health*

8. Please share comments or observations about the actions CGH has taken to address <u>MENTAL HEALTH & SUICIDE</u>.

- *CGH, it has been my observation that CGH deals with these individuals in providing a social worker to refer and get individuals transferred to proper care for Mental Health and Attempted Suicidal individuals. Unfortunately, NM has a shortage in Mental Health Providers. It is my suggestion that CGS look into providing Certified Peer Support workers to work with these individuals.*
- *The cost and availability of mental health professionals restricts the amount of care that can be given to these individuals. Outside funding is needed.*
- *Need more publicity in this area.*
- *Mental Health assessment and referral is available to ER patients. Depression survey is given to patients at the clinic.*
- *Suicide has been on the rise in this area especially among the ages of 11-21*
- *I heard that CGH is considering an outpatient clinic connected to the hospital; I like that. I think an Urgent Care could also help meet needs. Our community needs access to psychiatric care, perhaps utilize a psychiatric NP and encourage our medical providers to develop specialties in co-occurring d/o. I've even thought how great it would be to partner with UNMH for Behavioral Health and Substance abuse treatment and services.*
- *Has not made it a priority to bring in Mental Health Providers*
- *We are in need of services/*
- *need more collaboration with crisis response workers*
- *Please see #6 as these items go hand in hand. In addition, suicide prevention needs to be on going from early childhood through high school due to peer pressure situations and bullying. It also needs to be investigated when brought up and not swept under the rug. Whether it is a child or adult, suicidal concerns need to be open, available, and the stigma removed.*
- *Mental Health Meetings around inability to serve these folks. Still a need for providers that can produce meaningful outcomes.*
- *Brief depression screening - "have you been depressed in the last 2 weeks?" at each doctor visit.*
- *I am not aware of specific results for these actions.*
- *not aware of any*

- *need organized options*
- *Ms. Tena participating in outreach events.*
- *I have seen CGH go above and beyond to assist individuals struggling with Mental health and Substance Abuse Issues. I believe what is Needed is MAT Center or Crisis Response team of Certified Peer Support Worker and or licensed social workers staff available to go out into the streets and work with individuals living on the streets or substance abuse frequent fliers needing mental health and medical care needs. and suicidal issues.*
- *CGH has provided a resource guide and resources for community members.*
- *Unaware if CHG physicians screen for depression. The local FQHC PMS does screen every patient for depression. Over the past 4 months CHC has hosted a group of stakeholders interested in BH and addiction services and the community wide impact and issues that are a result of BH/addition. Unaware of progress toward a suicide hot line by CGH. PMS the FQHC has a crisis line.*
- *Creating committee to address the issue*
- *Good plans-of-Action. Additionally, I would recommend "town halls" to open the community discussion/s*
- *As the CEO of ACLSU - I do not have detailed information about CGH coverage*
- *hot line flyers*
- *Added folks to help w/behavioral health*
- *I see that the hospital has some responsibility and resources for Mental health and suicide but they are short turn which will have not reach because we will be dealing with a relapse of a person needing help.*

9. Please share comments or observations about the actions CGH has taken to address <u>AFFORDABILITY</u>.

- *I believe that Medical services are very affordable at CGH and Payments are easily arraigned*
- *Due to the depressed economy in Cibola County, this will continue to be a challenge. Our legislators need to know how important is to help support new industry and jobs.*
- *Need more public disclosure of hospital fees.*
- *We live in a poor community so affordability is critical.*
- *the only affordability is for those on Medicaid where there is no co-pay. Those who have no insurance or high deductibles or high co-pays still often opt to drive to Albuquerque or Gallup in order to receive services that are considerably less expensive*
- *There is a large difference in blood work done here and in Albuquerque which is 70 miles away.*
- *Medical costs are climbing and no end is in sight. I understand the as part of a democracy and free enterprise, medical care will cost what the market will bear. However, medical costs are out of control and something needs to be done to rein them in. Additionally, I believe medical issues have to be addressed as 1 system; not as medical handling the body, another entity handling the psychological aspect, but as 1 health system addressing the issues as a whole.*

- *I am not aware of specific results for these actions.*
- *We have sister pam fund for those that cannot afford. I work with our drug reps to acquire multiple samples to help those in need,*
- *not aware of any additional efforts*
- *I believe that CGH is always willing to offer individuals with payment plans, which is so needed in this small community, because it is a very low economy county*
- *Not Known*
- *Cannot comment since I don't have details of progress.*
- *Good plans-of-action*
- *Cash prices for the testing was an outstanding idea great job!*
- *As the CEO of ACLSU - I do not have detailed information about CGH coverage*
- *We need to vote the Democrats out and endeavor to end Obamacare*
- *None that I have see*

9. Please share comments or observations about the actions CGH has taken to address <u>DIABETES</u>.

- *It has been my observation that CGH handles quite a bit of individuals with Diabetes and does an amazing job. Very well trained and skilled Emergency staff and education provided to patients*
- *This need can best be addressed by providing nutritional education starting at an early age. Older people are being offered classes at the hospital.*
- *Good public information is being provided to community.*
- *Diabetic cooking classes are offered. Diabetes educator works part time at clinic.*
- *None*
- *There are high numbers of the population with Diabetes in this area.*
- *I don't any new ideas but we need to continue to fight the fight*
- *There is a clinic in Grants by another provider which does a good job in our community*
- *again, collaboration with NN CHRs*
- *Primarily education and follow-up with patients to keep them compliant with treatments and dietary requirements*
- *Unknown*
- *No observations made*
- *I am not aware of specific results for these actions.*
- *I am a RN CDE and educate people with diabetes both at hospital, clinic, schools and community through health*

fairs, cooking classes,1:1 session. We have seen a reduction in readmissions after education and improvement of diabetes control (HgbA1c).

- *not aware of any*
- *awareness, diabetic educator*
- *I think CGH has a very amazing woman that helps with Diabetes meal plans, and with proper instruction for self-care on monitoring diabetic sugar levels. As well as instruction for preparing diabetic meals*
- *CGH has provided a resource guide and resources for community members.*
- *The diabetic educator does a great job; hold cooking classes and one on one education I don't believe progress was made on the other action steps*
- *Good plans-of-action. Work diligently to renew grant with NMSU*
- *As the CEO of ACLSU - I do not have detailed information about CGH coverage*
- *education*
- *adding more practitioners and doing preventive health*
- *CGH has a good Diabetes as my father used to attend the workshop.*

10. Please share comments or observations about the actions CGH has taken to address <u>CANCER & CANCER TESTING</u>.

- *In my observation that GCH has handled Cancer Patients with Professional Care and Kindness and empathy and makes proper referrals to Cancer specialists.*
- *Patients are referred to facilities which have the ability and specialists to treat these patients.*
- *Need more community publicity on servicers available.*
- *Diagnostic studies (particularly X-ray) are available.*
- *no new ideas*
- *Good Job with increased opportunities for screening.*
- *This would be a good service, but I don't know if we have the population base to justify it.*
- *I am not real familiar with cancer testing and care in the CGH system, however, I would like to know more.*
- *I am not aware of specific results for these actions.*
- *A fund raiser volleyball game raised funds for mammograms and other ca prevention needs*
- *added 3D mammography*
- *breasts are not the only organ system in the human body*
- *Honestly I can't comment on this question because I haven't had anyone that has had cancer in the past 11 years, but I do know that CGH has cancer testing available*
- *CGH has provided a resource guide and resources for community members.*

- *Good advertisement regarding mammography services available. Unaware of progress in reference to the action steps of 3D mammography and smoking cessation training to families of employees or the community*
- *Good plans-of-action. Reallocate funding to move into quality 3-D screening*
- *As the CEO of ACLSU - I do not have detailed information about CGH coverage*
- *unknown*
- *Better mammography equipment*
- *I don't have much in put as far as cancer treatments*

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

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Substance Abuse – 2016 Significant Need	398	23	17.30%	17.30%	Significant Needs
Mental Health & Suicide – 2016 Significant Need	335	21	14.57%	31.87%	
Obesity – 2016 Significant Need	215	17	9.35%	41.22%	
Diabetes – 2016 Significant Need	193	18	8.39%	49.61%	
Affordability – 2016 Significant Need	179	16	7.78%	57.39%	
Cancer & Cancer Center – 2016 Significant Need	148	14	6.43%	63.83%	Other Identified Needs
Alcohol Abuse	102	10	4.43%	68.26%	
Education/Prevention	96	11	4.17%	72.43%	
Accessibility	83	13	3.61%	76.04%	
Heart Disease	75	10	3.26%	79.30%	
Physical Inactivity	75	11	3.26%	82.57%	
Women's Health	64	10	2.78%	85.35%	
Suicide	49	10	2.13%	87.48%	
Chronic Pain Management	43	8	1.87%	89.35%	
Liver Disease	38	8	1.65%	91.00%	
Flu/Pneumonia	37	7	1.61%	92.61%	
Stroke	36	9	1.57%	94.17%	
Alzheimer's	27	8	1.17%	95.35%	
Lung Disease	26	7	1.13%	96.48%	
Smoking	22	7	0.96%	97.43%	
Hypertension	21	7	0.91%	98.35%	
Dental	14	7	0.61%	98.96%	
Kidney Disease	13	6	0.57%	99.52%	
Accidents	10	6	0.43%	99.96%	
Points reserved for NEW health needs listed in Question 17 below	1	2	0.04%	100.00%	
Total	2300		100.00%		

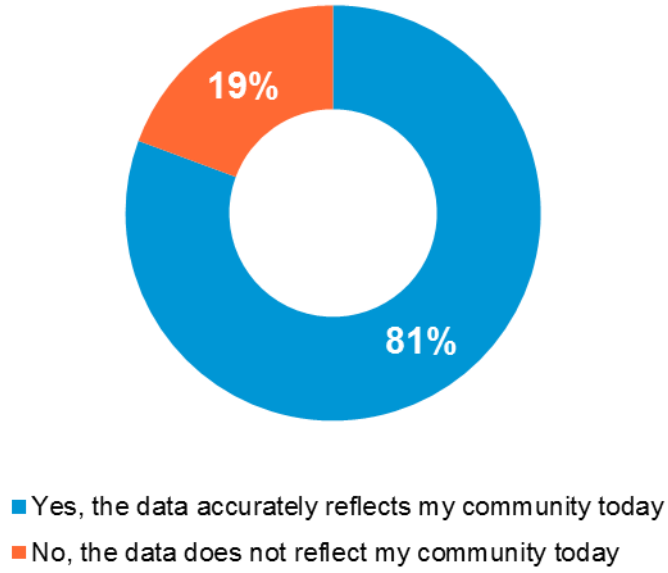
Individuals Participating as Local Expert Advisors[36]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	11	22	33
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	16	18	34
3) **Priority Populations**	14	17	31
4) Representative/Member of **Chronic Disease Group** or Organization	6	23	29
5) Represents the **Broad Interest of the Community**	28	5	33
Other	8		8
Answered Question			38
Skipped Question			0

Advice Received from Local Expert Advisors

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

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

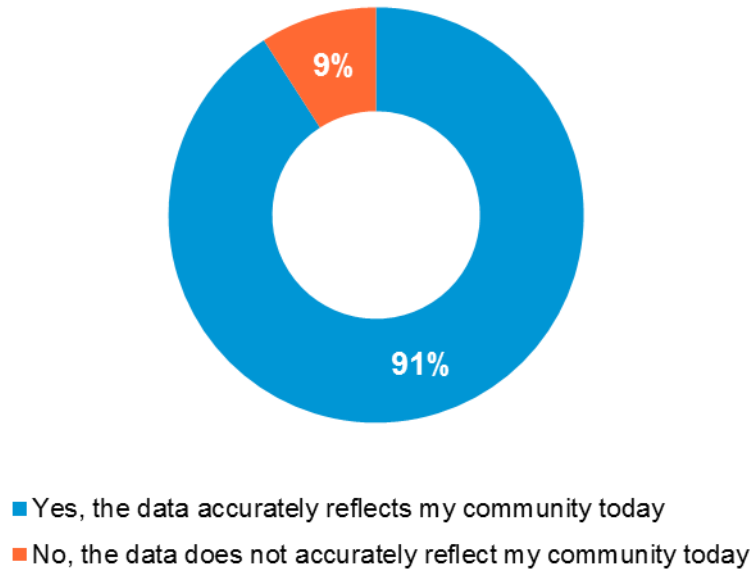


Comments:

- *Response is based on general impressions.*
- *I think in the area of income/employment, many people do not report their earnings and thus effects our numbers. I would like to see numbers for the reservations; how does this impact our averages? Certainly Acoma and Laguna stats are in this; if not, then we may be even worse off in the socioeconomic ratings.*
- *Too few Primary Care Providers and Mental Health Providers*
- *This seems extremally high... but I don't see a time frame for the data. 10,400 premature deaths in what period of time???*
- *Unsure really... How long ago was this data collected? It doesn't seem like out mental health provider ratio is entirely accurate also this only seems to address drinking and not all substance use issues, which if those aren't taken into account would lower our actual numbers on crime, hospital stays, etc...*
- *I do not know enough about this to give an opinion*
- *I think the violent crime is overstated.*
- *I think we rank higher in alcoholism, drugs, children in poverty than what is reported.*
- *I suppose it does but I do not have the data increments to analyze so I assumed each data point is correct.*
- *Like to see comparisons to other counties before answering the question.*
- *I agree for the most part. I would say the population to MH provider may be low*
- *I absolutely believe the data captures a reality-based view of what is happening.*

- *We have added primary care providers, and the above ratio is probably quite wrong.*

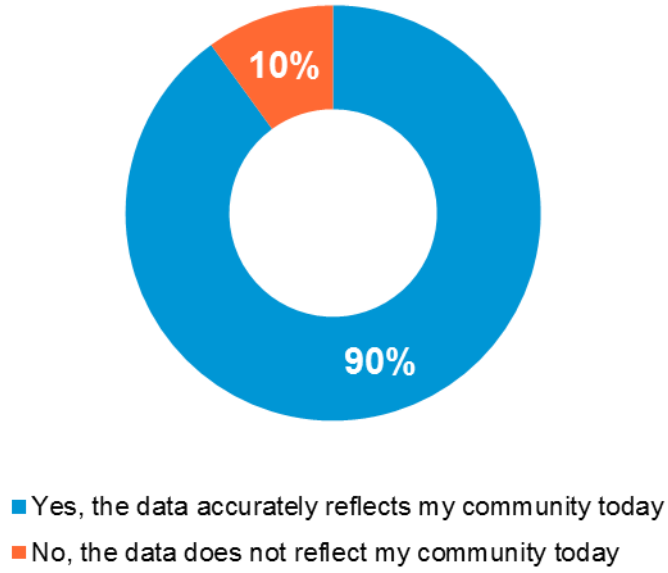
Question: Do you agree with the demographics and common health behaviors of Cibola County?



Comments:

- *I'm not sure of median age and population over age 64. My impression is that Cibola County has a much higher median age and population over 64.*
- *for the most part, but I am still concerned about under reporting of income skewing our percentages.*
- *No data on Native American Population!!!? It's hard to believe that the median household income is $36,614 when we have 34% of our children living in poverty. That's one third.*
- *According to this data, you must be either White or Hispanic? Why no representation of our Native American population?*
- *Same response as previous question #12.*
- *Think the stats are low*
- *Although there are factors that would contribute to fluctuations, I believe the data -- as things stand today -- are reflective of the community.*

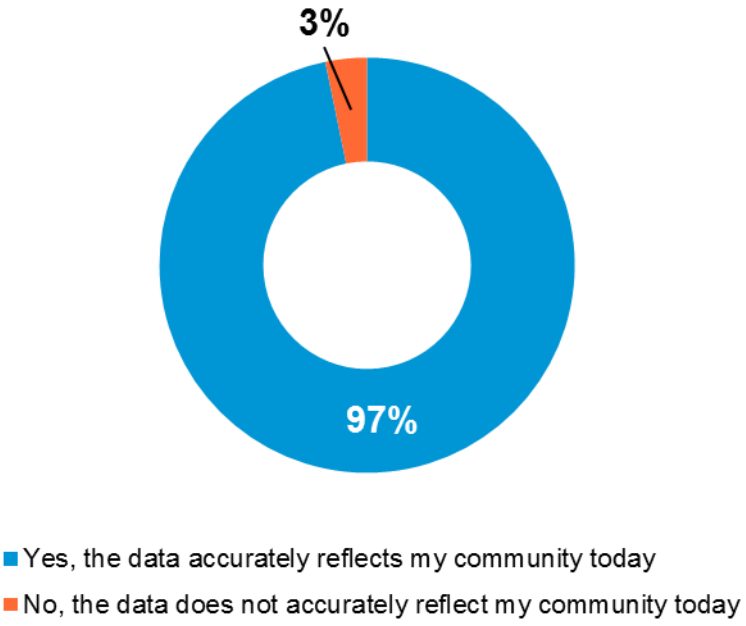
Question: Do you agree with the overall social vulnerability index for Cibola County?



Comments:

- *The vulnerability areas could be illustrated by voting districts (if that is not the case in above maps).*
- *Socioeconomic for the Laguna Reservation is incorrect. I was told by the Governor that they are at %100 employment. They might be under employed but they are not at risk.*
- *Unknown*
- *Not sure what this all means and what it tells us.*
- *I believe this data -- unfortunately -- reflects reality of the situation in Cibola County*

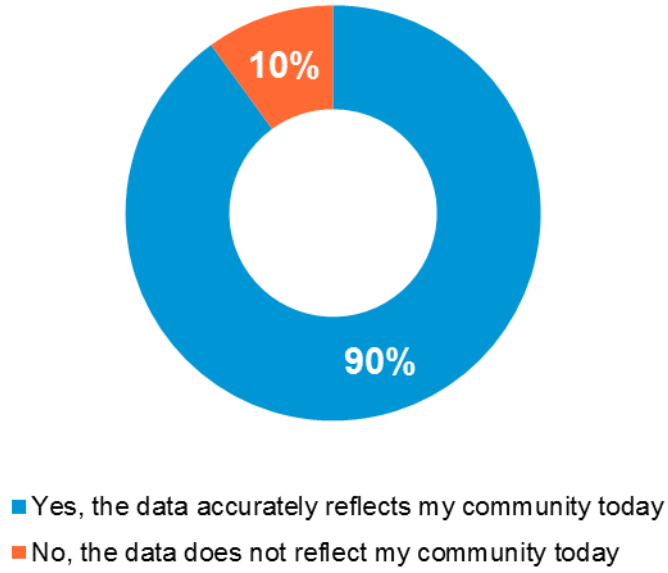
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *I would have thought that cancer deaths would be higher.*
- *Without information to the contrary, I believe this data is a realistic view.*

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



Comments:

- *Again, my impressions are based on personal experiences which may or not be in line with actual statistics.*
- *Please explain why Male/Female Self Harm and Interpersonal Violence Related Deaths are categorized together. What does one have to do with the other? The suggestion here is that being a victim of DV is a self-harm choice.*
- *I don't know*
- *data seems appropriate as I see it.*
- *self-inflicted "feel good" disease has jumped*
- *I do not have knowledge in this area.*
- *Unfortunately, I believe the data is representative of the current reality.*

Appendix C – Collaborating Facilities and Organizations

Organization	Contact Information	Substance Abuse	Mental Health & Suicide	Obesity	Diabetes	Affordability
Grants-Cibola County School District	505-285-2600			X	X	
Cibola County Public Health Office	505-285-4601	X		X	X	X
Turquoise Lodge	505-841-8978	X	X			
Alcohol & Narcotics Help Line	888-206-7272 or 24 Hour Help Line, 877-479-9777	X	X			
Alcohol and Drug Treatment Referral	800-454-8966	X	X			
Mesilla Valley (Las Cruces, NM)	505-382-3500	X	X			
University of New Mexico Hospital (Albuquerque, NM)	505-925-2300	X	X	X	X	X
Anna Kaseman Hospital (Albuquerque, NM)	505-291-2000	X	X	X	X	X
Pueblo of Laguna Service Center (Alcohol Treatment)	505-552-5720	X	X			
Hogares	505-285-3672					X
ACL Hospital	505-552-5300	X	X	X	X	X
Continental Divide Electric (Annual Health Fair)	505-285-6656			X	X	X
Future Foundations Family Center/Grants Recreation	505-285-3542			X		X
Cibola Family Health Center	505-287-6500	X	X	X	X	X
Grants Family Health Center - Presbyterian Medical Services	505-285-3542	X	X	X	X	X
Snap Fitness	505-240-6009			X	X	
JHM	505-287-2462			X	X	
Acoma Fitness Center	505-552-2134			X	X	

Organization	Contact Information	Substance Abuse	Mental Health & Suicide	Obesity	Diabetes	Affordability
Cibola Senior Citizens Center	505-285-3922	X	X	X	X	X
The Dance Center	505-290-7892			X	X	
T-Bones Gym	505-285-6758			X	X	
Acoma Elderly Nutrition Program	505-552-6316			X	X	
Pueblo of Zuni Wellness Center	505-782-2665			X	X	
Navajo Nation Health Education	928-871-6562			X	X	
Pueblo of Acoma Health and Wellness/Special Diabetes Program	505-552-5145			X	X	
Global Nutrition Services	505-332-8070			X	X	
ACL WIC PROGRAM	505-552-6068			X	X	X
Alliance Hospice	50-5615-8053			X	X	X
Area 46, District 9 AA Fellowship	district9@nm-aa.org	X	X			
Basin Coordinated Healthcare	505-287-3855		X	X	X	
Blue Cross Blue Shield	505-816-4000	X	X	X	X	X
Children, Youth and Families Department	505-240-0745	X	X	X	X	X
Cibola County Substance Abuse Prevention Coalition	505 285 3542 Ext 110	X	X			
Cibola Home Visiting	505-285-3542		X			
Cibola Trail Alliance	505-290-0370			X	X	
Critical Nurse Staffing	505-287-9744	X	X	X	X	X
Diamond G Home Center	diamondghomecenter@outlook.com			X		
Entrust Home Healthcare LLC	505-285-9958	X	X	X	X	X
Farm Bureau Financial Services	505-285-5547					X

Organization	Contact Information	Substance Abuse	Mental Health & Suicide	Obesity	Diabetes	Affordability
First Nations Community Health source	505-262-6556	X	X	X	X	X
Forward Flag	505-582-6909	X	X			
Goodwill Industries of New Mexico	505-863-6066					X
Grants Police Department	505-287-4404	X	X			
Milan Police Department	505-285-3466	X	X			
Laguna Police Department	505-552-6666	X	X			
Acoma Police Department	505-552-6601	X	X			
Grants Family Counseling	505-876-1890	X	X			
Grants Fire and Rescue	505-876-2245	X	X	X	X	
Hospice Compassus and Palliative Care	505-206-7698	X			X	
Klarus Home Care	505-514-7615	X	X	X	X	X
Laguna Rainbow	505-552-6034				X	
Milan Fire	505-287-7366	X	X	X	X	
San Rafael Fire	505-287-3084	X	X	X	X	
NAPPR, Inc.	505-345-6289	X	X	X	X	X
New Mexico Corrections Department	505-876-8420	X	X	X	X	
NMSU Grants	505-287-6628	X	X	X	X	X
Open Skies Healthcare	505-382-0562	X	X			
Parkhurst Pharmacy	505-287-4641	X	X	X	X	
Prostate Cancer Support Association of New Mexico	505-254-7784					X
Recycle Cibola!	608-632-0266			X	X	

Organization	Contact Information	Substance Abuse	Mental Health & Suicide	Obesity	Diabetes	Affordability
Robert Keene, Dementia Behavior Management	505-615-8053		X			
Roberta's Place, Inc.	505-287-7200	X	X			X
Search and Rescue	505-876-2040	X	X			
Sheriff Department	505-876-2040	X	X	X	X	
Silver Lining Services LLC	505-285-3445		X	X	X	X
SoloWorks Cibola	505-287-6670	X	X			
Southwest Pueblo Consultants & Counseling Services	505-888-9769	X	X			
State Farm	505-287-4551					X
Superior Ambulance Service	505-252-3446	X	X	X	X	
TK Bank, SSB	505-240-0907		X			X
Tristate	505-876-2271		X	X	X	
US Dept. Of Veteran Affairs, Vet Center	505-274-1747	X	X	X	X	X
Wellness Health Services, LLC	505-288-8833	X	X	X	X	X
WellsFargo	505-287-9482					
Western Sky Community Care	505-205-4878	X	X	X	X	X
Westside Family Acupuncture	505-967-9309		X	X		X
Youth Visions, Inc.	youthvisionsnm@gmail.com	X	X			X

Appendix D – National Healthcare Quality and Disparities Report[37]

The National Healthcare Quality and Disparities Reports (QDR; annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 300 healthcare process, outcome, and access measures, covering a wide variety of conditions and settings. Data years vary across measures; most trend analyses include data points from 2000-2002 to 2012-2015. An exception is rates of uninsured, which we are able to track through 2017. The reports are produced with the support of an HHS Interagency Work Group (IWG) and guided by input from AHRQ's National Advisory Council and the Institute of Medicine (IOM), now known as the Health and Medicine Division of the National Academies of Sciences, Medicine, and Engineering.

For the 15th year in a row, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving healthcare quality and reducing healthcare disparities. As mandated by the U.S. Congress, the report focuses on "national trends in the quality of health care provided to the American people" (42 U.S.C. 299b-2(b)(2)) and "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations" (42 U.S.C. 299a-1(a)(6)).

The 2017 report and chartbooks are organized around the concepts of access to care, quality of care, disparities in care, and six priority areas—including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Summaries of the status of access, quality, and disparities can be found in the report.

The report presents information on trends, disparities, and changes in disparities over time, as well as federal initiatives to improve quality and reduce disparities. It includes the following:

- **Overview of Quality and Access in the U.S. Healthcare System** that describes the healthcare systems, encounters, and workers; disease burden; and healthcare costs.
- **Variation in Health Care Quality and Disparities** that presents state differences in quality and disparities.
- **Access and Disparities in Access to Healthcare** that tracks progress on making healthcare available to all Americans.
- **Trends in Quality of Healthcare** that tracks progress on ensuring that all Americans receive appropriate services.
- **Trends in Disparities** that tracks progress in closing the gap between minority racial and ethnic groups and Whites, as well as income and geographic location gaps (e.g., rural/suburban disparities).
- **Looking Forward** that summarizes future directions for healthcare quality initiatives.

Key Findings

Access: An estimated 43% of access measures showed improvement (2000-2016), 43% did not show improvement, and 14% showed worsening. For example, from 2000 to 2017, there were significant gains in the percentage of people who reported having health insurance.

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

Quality: Quality of healthcare improved overall from 2000 through 2014-2015, but the pace of improvement varied by priority area:

- Person-Centered Care: Almost 70% of person-centered care measures were improving overall.
- Patient Safety: More than two-thirds of patient safety measures were improving overall.
- Healthy Living: More than half of healthy living measures were improving overall.
- Effective Treatment: More than half of effective treatment measures were improving overall.
- Care Coordination: Half of care coordination measures were improving overall.
- Care Affordability: Eighty percent of care affordability measures *did not* change overall.

Disparities: Overall, some disparities were getting smaller from 2000 through 2014-2015; but disparities persist, especially for poor and uninsured populations in all priority areas.

Trends

- Trends show that about 55% percent of quality measures are improving overall for Blacks.[38] However, most recent data in 2014-2015 show that about 40% of quality measures were worse for Blacks compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Asians. However, most recent data in 2014-2015 show that 20% of quality measures were worse for Asians compared with Whites.
- Trends show that almost 35% of quality measures are improving overall for American Indians/Alaska Natives (AI/ANs). However, most recent data in 2014-2015 show that about 30% of quality measures were worse for AI/ANs compared with Whites.
- Trends show that approximately 25% of quality measures are improving overall for Native Hawaiians/Pacific Islanders (NHPIs). However, most recent data in 2014-2015 show that nearly 33% of quality measures were worse for NHPIs compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Hispanics, but in 2014-2015, nearly 33% of quality measures were worse for Hispanics compared with non-Hispanic Whites.
- Variation in care persisted across the urban-rural continuum in 2014-2016, especially in access to care and care coordination.

Looking Forward

The National Healthcare Quality and Disparities Report (QDR) continues to track the nation's performance on healthcare access, quality, and disparities. The QDR data demonstrate significant progress in some areas and identify other areas that merit more attention where wide variations persist. The number of measures in each priority area varies, and some measures carry more significance than others as they affect more people or have more significant consequences. The summary charts are a way to quantify and illustrate progress toward achieving accessible, high-quality, and affordable

[38] Throughout this report and its appendixes, "Blacks" refers to Blacks or African Americans, and "Hispanics" refers to Hispanics or Latinos. More information is available in the Reporting Conventions section of the Introduction and Methods.

care at the national level using available nationally representative data. The summary charts are accessible via the link below.

This report shows that while performance for most access measures did not change significantly over time (2000-2014), insurance coverage rates did improve (2000-2016). Quality of healthcare improved in most areas but some disparities persist, especially for poor and low-income households and those without health insurance.

U.S. Department of Health and Human Services (HHS) agencies are working on research and conducting programs in many of the priority areas—most notably opioid misuse, patient safety, effective treatment, and health disparities.

Link to the full report:

https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2017qdr.pdf

Appendix E – Illustrative Schedule H (Form 990) Part V B Potential Response

Illustrative IRS Schedule h Part V Section B (Form 990)[39]

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 footnote 16 and 18 on page 11

   b. **Demographics of the community**

      See footnote 19 on page 12

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

      See footnote 30 on page 28

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 29 on page 26

   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 36 on page 53

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

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

See footnotes 8 and 9 on page 7

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

See footnote 10 on page 8, footnotes 13 and 14 on page 9, and footnote 23 on page 16

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

N/A

4. **Indicate the tax year the hospital facility last conducted a CHNA: 20__**

2016

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**

Yes, see footnote 14 on page 9 and footnote 35 on page 44

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**

No

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

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

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)**

https://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)**

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**

Yes

9. **Indicate the tax year the hospital facility last adopted an implementation strategy: 20__**

   2016

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

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

       https://cibolahospital.com/community-health-needs-assessment/

    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 30 on page 28

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