Gunnison Valley Health

Gunnison, Colorado

Community Health Needs Assessment
and Implementation Strategy

GUNNISON VALLEY HEALTH

Adopted by Board Resolution on April 25, 2017

GUNNISON VALLEY HEALTH

Dear Community Member:

At Gunnison Valley Health (GVH), we have spent more than 78 years providing high-quality compassionate healthcare to the greater Gunnison community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how GVH will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

GVH 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.

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,

Rob Santilli
Chief Executive Officer
Gunnison Valley Health

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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Gunnison Valley Health ("GVH" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community, and to develop an implementation plan to outline and organize how to meet those needs.

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

The Significant Health Needs for Gunnison County are:

1. Mental Health
2. Physicians (i.e., access to medical/dental providers)
3. Cancer
4. Suicide

The Hospital has developed implementation strategies for all of these needs, including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track. The health system has also chosen to address Suicide (#4), Alcohol (Need #5) and Drug Abuse (Need #18) concurrently with Mental Health as the top issue. This is based on a belief that many of the same factors underlie all four community health needs, and efforts to address one need can have a positive impact on one or more of these other needs. In addition, multiple needs can be effectively addressed by the same individual(s)/team(s)/resources.

APPROACH

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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. ***While Gunnison Valley Health is <u>not</u> a 501(c)(3) hospital, this study is designed to comply with the same standards***[1] ***and helps assure GVH identifies and responds to the primary health needs of its residents.***

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.

Project Objectives

GVH partnered with Quorum Health Resources (Quorum) to:[2]

- Complete a CHNA report, compliant with Treasury – IRS
- 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:

- 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

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

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

[2] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

Data sources include:[3]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Gunnison County compared to all State counties	October 25, 2016	2012
www.cdc.gov/communityhealth	Assessment of health needs of Gunnison County compared to its national set of "peer counties"	October 25, 2016	2011
Truven Analytics (formerly known as Thompson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	October 25, 2016	2016
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	October 25, 2016	2010
http://svi.cdc.gov	To identify the Social Vulnerability Index value	October 25, 2016	2010
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	October 25, 2016	2015

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

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 63 Local Expert Advisors. Survey responses started October 11, 2016 and ended with the last response on October 26, 2016.

[3] 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

- Information analysis augmented by local opinions showed how Gunnison 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.
- 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
    - Women need additional healthcare access and services, specifically breast care
    - Translation services are needed for Hispanic, Cora Indian, and immigrant populations
    - Transportation is an issue for the rural areas and low income populations
    - Pediatric services are needed for large youth population
    - Geriatric services are needed for an aging population

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange. Consultation with 28 Local Experts occurred again via an internet-based survey (explained below) beginning October 31, 2016 and ending November 16, 2016.

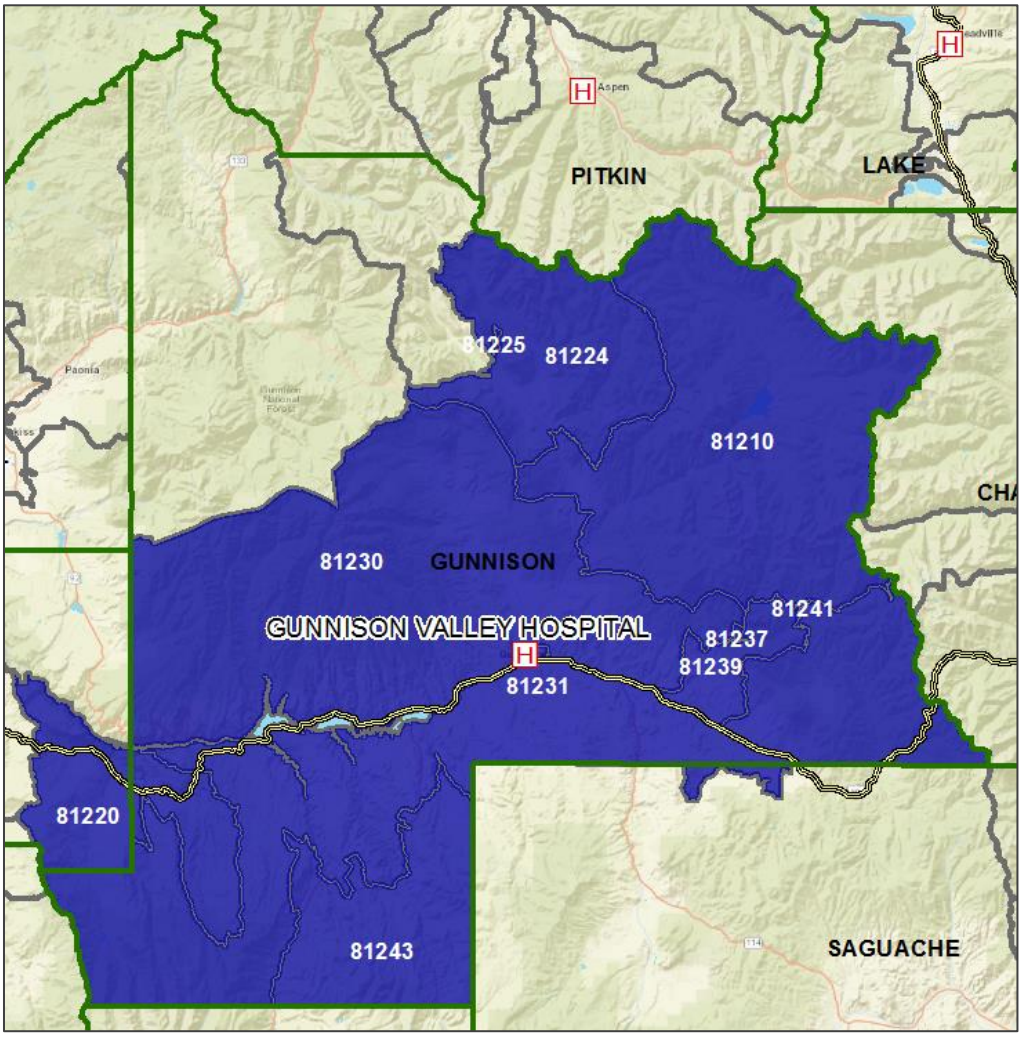
Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior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

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

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital



GVH, in conjunction with Quorum, defines its service area as Gunnison County in Colorado, which includes the following ZIP codes:[4]

81210 – Almont	81220 – Cimarron	81224 – Crested Butte	81225 – Mount Crested Butte
81230 – Gunnison	81231 – Gunnison	81237 – Ohio City	81239 – Parlin
81241 – Pitkin	81243 – Powderhorn		

In 2015, the Hospital received 75.0% of its patients from this area.[5]

[4] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[5] Truven MEDPAR patient origin data for the hospital

Demographics of the Community[6]

	Gunnison County	Colorado	U.S.
2016 Population[7]	**15,026**	**5,476,709**	**322,431,073**
% Increase/Decline	**3.8%**	**6.6%**	**3.7%**
Estimated Population in 2021	**15,602**	**5,839,105**	**334,341,965**
% White, non-Hispanic	**86.4%**	**68.5%**	**61.3%**
% Hispanic	**10.1%**	**21.4%**	**17.8%**
Median Age	**34.9**	**37.1**	**38.0**
Median Household Income	**$53,797**	**$61,844**	**$55,072**
Unemployment Rate (Aug 2016)	**2.1%**	**3.3%**	**5.0%**
% Population >65	**12.4%**	**13.4%**	**15.1%**
% Women of Childbearing Age	**20.7%**	**19.9%**	**19.6%**

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

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
Colorado	6.6%	37.1	13.4%	24.5%	19.9%	3.9%	$61,844	$61,650	$274,395
Selected Area	3.8%	34.9	12.4%	28.4%	20.7%	0.5%	$53,797	$40,573	$345,836

Demographics Expert 2.7
DEMO0003.SQP

[6] The tables below were created by Truven Market Planner, a national marketing company
[7] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner. **NOTE: Information from www.census.gov estimates a 2015 Gunnison County population of 16,067, a 4.8% increase since 2010; population >65 represented 11.5% of the total.**

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

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	14,570	308,745,538
2016 Total Population	15,026	322,431,073
2021 Total Population	15,602	334,341,965
% Change 2016 - 2021	3.8%	3.7%
Average Household Income	$66,506	$77,135

	2016	2021	% Change
Total Male Population	8,109	8,400	3.6%
Total Female Population	6,917	7,202	4.1%
Females, Child Bearing Age (15-44)	3,108	3,122	0.5%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	2,303	15.3%	2,294	14.7%	19.0%
15-17	492	3.3%	549	3.5%	4.0%
18-24	2,546	16.9%	2,273	14.6%	9.8%
25-34	2,139	14.2%	2,309	14.8%	13.3%
35-54	3,763	25.0%	3,884	24.9%	26.0%
55-64	1,920	12.8%	1,901	12.2%	12.8%
65+	1,863	12.4%	2,392	15.3%	15.1%
Total	15,026	100.0%	15,602	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

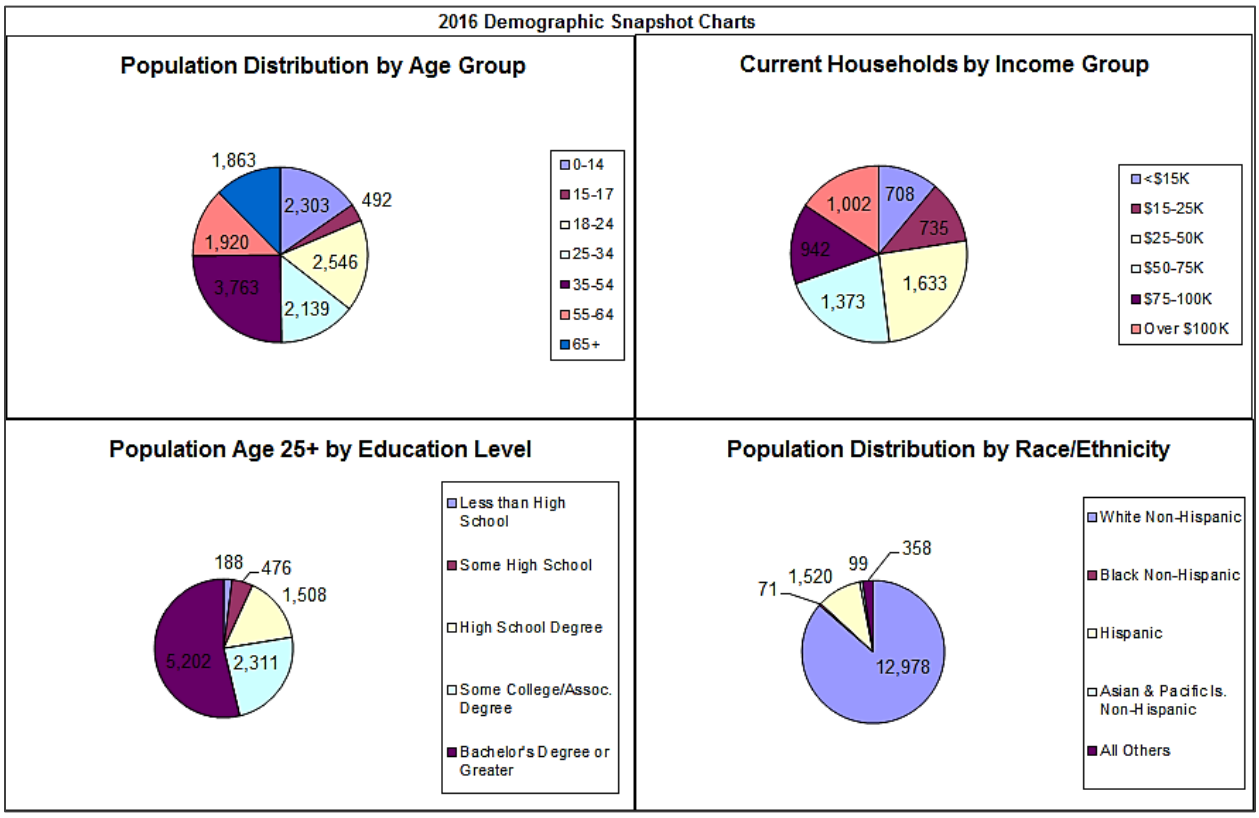
	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	708	11.1%	12.3%
$15-25K	735	11.5%	10.4%
$25-50K	1,633	25.5%	23.4%
$50-75K	1,373	21.5%	17.6%
$75-100K	942	14.7%	12.0%
Over $100K	1,002	15.7%	24.3%
Total	6,393	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	188	1.9%	5.8%
Some High School	476	4.9%	7.8%
High School Degree	1,508	15.6%	27.9%
Some College/Assoc. Degree	2,311	23.9%	29.2%
Bachelor's Degree or Greater	5,202	53.7%	29.4%
Total	9,685	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	12,978	86.4%	61.3%
Black Non-Hispanic	71	0.5%	12.3%
Hispanic	1,520	10.1%	17.8%
Asian & Pacific Is. Non-Hispanic	99	0.7%	5.4%
All Others	358	2.4%	3.1%
Total	15,026	100.0%	100.0%



Customer Segmentation

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

Claritas Prizm Segments	Characteristics	
Segment #1 (44%)	• Urbanicity: Town/Rural • Income: Low Income • Age Ranges: Age <55 • Presence of Kids: HH w/o Kids	• Homeownership: Renters • Employment Levels: Service Mix • Education Levels: High School • Ethnic Diversity: White, Black, Mix
Segment #2 (17%)	• Urbanicity: Town/Rural • Income: Upper Mid • Age Ranges: Age 45-64 • Presence of Kids: HH w/o Kids	• Homeownership: Mostly Owners • Employment Levels: Management & Professional • Education Levels: College Graduate • Ethnic Diversity: White
Segment #3 (14%)	• Urbanicity: Rural • Income: Lower Mid • Age Ranges: Age 45-64 • Presence of Kids: HH w/o Kids	• Homeownership: Homeowners • Employment Levels: Blue Collar Mix • Education Levels: High School • Ethnic Diversity: White
Segment #4 (8%)	• Urbanicity: Town/Rural • Income: Upscale	• Homeownership: Mostly Owners • Employment Levels: Management & Professional

	• Age Ranges: Age 35-54 • Presence of Kids: HH w/ Kids	• Education Levels: Graduate Plus • Ethnic Diversity: White, Asian, Mix
Segment #5 (6%)	• Urbanicity: Town/Rural • Income: Upscale • Age Ranges: Age 45-64 • Presence of Kids: HH w/o Kids	• Homeownership: Mostly Owners • Employment Levels: Management & Professional • Education Levels: Graduate Plus • Ethnic Diversity: White, Asian, Mix

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

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

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	114.7%	35.3%	Mammography in Past Yr	96.9%	44.2%
Vigorous Exercise	99.0%	56.8%	Cancer Screen: Colorectal 2 yr	93.6%	23.9%
Chronic Diabetes	135.9%	17.0%	Cancer Screen: Pap/Cerv Test 2 yr	89.4%	53.6%
Healthy Eating Habits	95.5%	28.3%	Routine Screen: Prostate 2 yr	94.1%	30.2%
Ate Breakfast Yesterday	96.8%	76.9%	**Orthopedic**		
Slept Less Than 6 Hours	122.8%	16.8%	Chronic Lower Back Pain	122.6%	28.9%
Consumed Alcohol in the Past 30 Days	92.6%	49.9%	Chronic Osteoporosis	102.6%	10.1%
Consumed 3+ Drinks Per Session	111.8%	31.7%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	102.5%	90.4%
I Will Travel to Obtain Medical Care	102.5%	23.3%	Used Midlevel in last 6 Months	104.3%	43.1%
I am Responsible for My Health	92.4%	60.4%	OB/Gyn 1+ Visit	96.2%	44.4%
I Follow Treatment Recommendations	97.0%	50.3%	Medication: Received Prescription	104.9%	63.3%
Pulmonary			**Internet Usage**		

Chronic COPD	100.2%	4.0%	Use Internet to Talk to MD	82.8%	10.1%
Tobacco Use: Cigarettes	99.8%	25.4%	Facebook Opinions	89.8%	9.2%
Heart			Looked for Provider Rating	93.2%	13.2%
Chronic High Cholesterol	109.6%	24.0%	Emergency Services		
Routine Cholesterol Screening	90.8%	46.1%	Emergency Room Use	108.6%	36.7%
Chronic Heart Failure	119.4%	4.7%	Urgent Care Use	107.4%	25.0%

While the top five segments in Gunnison County are accurate, the health behaviors often exhibited by these segments are not necessarily the same for the Gunnison Valley community. This community is ranked among the healthiest counties in the state and nation, and does not share some of the normal behaviors, specifically 'BMI: Morbid/Obese,' 'Chronic Diabetes,' and the heart health needs. In contrast, the population of Gunnison Valley experiences significant alcohol consumption, more so than may be represented above.

Leading Causes of Death

Cause of Death			Rank among all counties in CO (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (compared to US)
CO Rank	Gunnison Rank	Condition		CO	Gunnison	
2	**1**	Heart Disease	51 of 60	130.3	132.2	Lower than expected
1	**2**	Cancer	52 of 60	136.0	131.1	Lower than expected
3	**3**	Accidents	41 of 60	47.1	49.8	As expected
4	**4**	Lung	38 of 60	47.2	47.1	As expected
6	**5**	Alzheimer's	9 of 60	27.4	31.5	Higher than expected
5	**6**	Stroke	50 of 60	33.4	29.9	Lower than expected
7	**7**	Suicide	44 of 60	19.9	15.8	Higher than expected
8	**8**	Diabetes	45 of 60	15.5	12.1	Lower than expected
10	**9**	Flu - Pneumonia	52 of 60	13.3	10.2	Lower than expected
12	**10**	Kidney	46 of 60	8.5	6.9	Lower than expected
13	**11**	Parkinson's	41 of 60	8.7	4.8	As expected
11	**12**	Blood Poisoning	53 of 60	8.6	4.1	Lower than expected
14	**13**	Hypertension	47 of 60	4.3	3.3	Lower than expected
9	**14**	Liver	58 of 60	12.7	3.0	Lower than expected
15	**15**	Homicide	39 of 60	3.3	2.2	As expected

Priority Populations[8]

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

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

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the report trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[9]

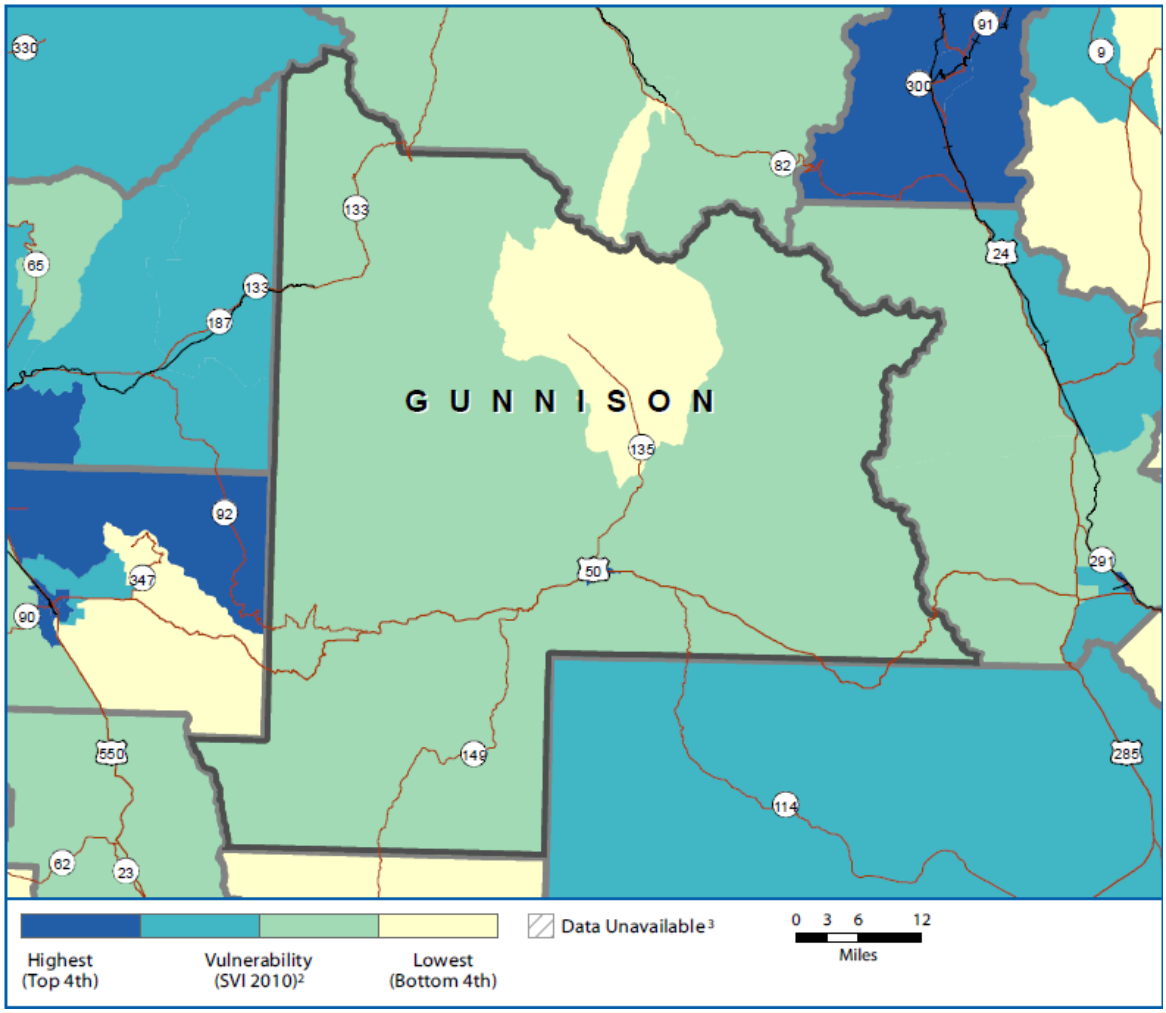
- Women need additional healthcare access and services, specifically breast care
- Translation services are needed for Hispanic, Cora Indian, and immigrant populations
- Transportation is an issue for the rural areas and low income populations
- Pediatric services are needed for a large youth population
- Geriatric services are needed for aging population

[8] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html
[9] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability

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

Gunnison County falls primarily in the *second lowest quartile* of social vulnerability. One small segment in the north central area is in the *lowest quartile*.



Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 63 individuals provided feedback on the 2014 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	6	39	45
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	14	32	46
3) Priority Populations	13	33	46
4) Representative/Member of Chronic Disease Group or Organization	6	40	46
5) Represents the Broad Interest of the Community	56	3	59
Other			9
Answered Question			62
Skipped Question			1

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

- Physicians
- Specialists
- Mental Health
- Extended Hours
- Priority Populations
- Continuum of Care

GVH received the following responses to the question: **"Should the hospital continue to consider the needs identified as most important in the 2014 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No
Physicians	50	3
Specialists	46	6
Mental Health	50	3
Extended Hours	39	9
Priority Populations	40	9
Continuum of Care	44	7

Comparison to Other State Counties

To better understand the community, Gunnison County has been compared to all 60 counties^ in the state of Colorado across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

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

	Gunnison County	Colorado	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	18/60		
Health Behaviors			
Overall Rank *(best being #1)*	22/60		
Excessive Drinking	23%	19%	12%
Clinical Care			
Overall Rank *(best being #1)*	52/60		
Uninsured Rate	24%	16%	11%
Population to Primary Care Physician	1,410:1	1,230:1	1,040:1
Population to Dentist	2,250:1	1,350:1	1,340:1
Population to Mental Health Provider	600:1	350:1	370:1
Preventable Hospital Stays *(per 1,000 Medicare enrollees)*	46	33	38
Diabetic Monitoring	59%	84%	90%
Social & Economic Factors			
Overall Rank *(best being #1)*	9/60		
Children in Poverty	17%	13%	16%
Physical Environment			
Overall Rank *(best being #1)*	6/60		

**Per 100,000*

^This number may be lower than the actual number of counties as some counties are too small to provide measureable data.

Comparison to Peer Counties

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile). In the below chart, Gunnison County is compared to its peer counties and the U.S. average, but only areas where the county is Better or Worse are listed. (The list and number of peer counties used in each ranking may differ.)

	Gunnison County	Peer Ranking	U.S. Median
Mortality			
Better			
Female Life Expectancy	84.3 years	1/12	79.8 years
Male Life Expectancy	81.7 years	1/12	75.0 years
Worse			
Chronic Lower Respiratory Disease (CLRD) Deaths*	42.9	6/7	49.6
Morbidity			
Better			
Adult Diabetes	2.0%	2/12	8.1%
Adult Obesity	7.7%	2/9	30.4%
Gonorrhea*	0.0	1/12	30.5
HIV*	37.2	1/11	105.5
Older Adult Asthma	2.0%	1/12	3.6%
Older Adult Depression	8.3%	3/12	12.4%
Syphilis*	0.0	2/12	0.0
Worse			
Preterm Births	11.6%	11/12	12.1%
Healthcare Access & Quality			
Better			
N/A	--	--	--
Worse			
Primary Care Provider Access*	64.9	10/12	48.0
Uninsured	23.6%	11/12	17.7%

	Gunnison County	Peer Ranking	U.S. Median
Health Behaviors			
Better			
N/A	--	--	--
Worse			
N/A	--	--	--
Social Factors			
Better			
N/A	--	--	--
Worse			
Poverty	16.0%	12/12	16.3%
Physical Environment			
Better			
Air Quality (Annual Average PM2.5 Concentration)	5.0 µg/m^3	3/12	10.7 µg/m^3
Worse			
Living Near Highways	5.2%	12/12	1.5%

**Per 100,000*

Conclusions From Statistical Data

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 Gunnison County statistics to the U.S. average, and lists the change since the last date of measurement.

	Current Date of Data	Statistic	Percent Change	Last Date of Data
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change				
Female Heavy Drinking	2012	12.2%	3.9% pts	2005
Male Heavy Drinking	2012	16.0%	2.1% pts	2005
Female Binge Drinking	2012	18.3%	1.5% pts	2002
Male Binge Drinking	2012	35.4%	3.0% pts	2002
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **FAVORABLE** change				
N/A	--	--	--	--
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **UNFAVORABLE** change				
Female Obesity	2011	23.7%	2.1% pts	2001
Male Obesity	2011	25.6%	3.5% pts	2001
Male Physical Activity	2011	64.9%	-2.3% pts	2001
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **FAVORABLE** change				
Female Life Expectancy	2013	82.9 years	4.4 years	1985
Male Life Expectancy	2013	79.5 years	5.7 years	1985
Female Smoking	2012	13.7%	-3.7% pts	1996
Male Smoking	2012	14.8%	-4.9% pts	1996
Female Physical Activity	2011	67.3%	4.9% pts	2001

Community Benefit

"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.

IMPLEMENTATION STRATEGY

Significant Health Needs

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

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies GVH current efforts responding to the need including any written comments received regarding prior GVH implementation actions
- Establishes the Implementation Strategy programs and resources GVH will devote to attempt to achieve improvements
- Documents the Leading Indicators GVH will use to measure progress
- Presents the Lagging Indicators GVH 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, GVH is the major hospital in the service area, and is a 24-bed critical access hospital located in Gunnison, Colorado and has a licensed CCEC (community clinic and emergency center) located in Mount Crested Butte. The next closest facilities are outside the service area and include:

- Montrose Memorial Hospital, Montrose, CO, 64.9 miles (79 minutes)
- Heart of the Rockies Regional Medical Center, Salida, CO, 65 miles (76 minutes)

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

1. **MENTAL HEALTH –** 2014 Significant Need; Population to Mental Health Provider ratio worse than CO avg and US best
4. **SUICIDE –** #7 Leading Cause of Death
5. **ALCOHOL**
18. **NEED WRITTEN IN – DRUG ABUSE**

Due to the similarity of the services, programs, and resources available to respond to these needs, only one implementation strategy has been developed. Also, while 'Alcohol' and 'Drug Abuse' did not score as 'Significant Health Needs,' the hospital has chosen to address them in this implementation strategy because of the severity of substance abuse issues in the community.

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

- ED Comfort Room available for mental health patients who are in acute crisis but are not a threat to themselves or others
- Telemedicine psychiatric support services available to GVH ED providers via Swedish Medical Center and Center for Mental Health (regional mental health services)
- Integrated behavioral health specialist in GVH Family Practice clinic in cooperation with Center for Mental Health
- Psych Line available to providers
- Support to Western State CO University Health Center for students in collaboration with Center for Mental Health
- Home health social worker referring patients to mental health resources
- Gunnison crisis website
- Conference hosted on physician training tools to better serve patients with potential substance abuse and opioid epidemic

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

- Explore expanding Integrated Behavioral Health program to Crested Butte/north end of valley
- Participate in community initiatives to expand mental health services and integrated behavioral health program
- Explore the opportunity for a larger collaboration with Center for Mental Health to centralize access to integrated behavioral health services
- Evaluate expanding Peer Training programs in local school district and university
- Explore increase in Sexual Assault Nurse Examiner (SANE)
- Consider becoming an opioid-free emergency department

Anticipated results from GVH 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 GVH intended actions is to monitor change in the following Leading Indicators:

- Increase current number of patients seen by integrated behavioral health specialist (40, as of 1/4/2017)
- Increase number of consultations by integrated behavioral health specialist (85 referrals/consultation requests (Jul-Dec 2016)
- Increase current Comfort Room utilization (36 total, 23 for mental health patients (2016)
- Increase current number of mental health consultations in ED (24 in 2016)
- Increase number of mental health referrals with law enforcement and Center for Mental Health = begin tracking in 2017

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

- Reduce the current suicide death rate (15.8 (per 100,000)[10]
- Reduce current drug overdose deaths (10.1 – 12.2 (per 100,000)[11]

[10] World Life Expectancy. CDC: 1999-2014 Final Data.
[11] County Health Rankings. Drug overdose deaths – modeled. Range of drug poisoning deaths per 100,000 population. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. 2014.

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

Organization	Contact Name	Contact Information
Center for Mental Health	Jon Gordon, Executive Director	http://www.centermh.org/ (970) 252-3200 710 N. Taylor St, Gunnison, CO 81230
Primary Care Physicians		
Western State Colorado University Counseling Center	Lorie Fuller	http://www.western.edu/current-students/office-student-affairs/counseling-center (970) 642-4615 600 North Adams St, Gunnison, CO 81231
Gunnison County Sheriff	Rick Besecker, Sheriff rbesecker@gunnisoncounty.org	www.gunnisoncounty.org/160/Sheriffs-Office (970) 641-1113 W Bidwell, Gunnison, CO 81230
Gunnison County Court Judge	Ben F. Eden, County Court Judge	(970) 642-8300
Swedish Medical Center (telepsych consult for providers)	Zachary J. D'Argonne	www.swedish.org (303) 788-5000
Community Crisis Coalition (36 organizations including Gunnison Watershed School District, GCSAPP (Gunnison County Substance Abuse Prevention Project), Project Hope, FAST (Family Advocacy and Support Team), and other juvenile services)	Nancy Osmundson	
Communities that Care (CTC) Grant – Gunnison County Substance Abuse Prevention Project (GCSAPP)	Kari Commerford, Project Director kcommerford@gunnisoncounty.org (970) 642-7393	www.communitiesthatcare.net University of Washington, Center for Communities That Care 9725 3rd Avenue NE, Suite 401 Seattle, WA 98115 (206) 685-7723

Organization	Contact Name	Contact Information
Gunnison County Public Health	Carol Worrall, Program Director cworrall@gunnisoncounty.org	www.gunnisoncounty.org/152/Public-Health 225 N Pine St # E, Gunnison, CO 81230 (970) 641-0209
Faith-based community support		

2. **PRIMARY CARE/MENTAL HEALTH PROVIDERS** – 2014 Significant Need; Population to Primary Care Physician, to Dentist, and Mental Health Provider ratios worse than CO avg and US Best; Primary Care Provider Access 10th worst of 12 peer counties; Emergency Room Use 8.6% above avg.

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

- Hospital-provided primary care services in Gunnison and Crested Butte, in addition to private practices
- Hospital-provided CCEC (Community Clinic and Emergency Center) at Mount Crested Butte for urgent and emergency services
- Physician Specialty clinics available at hospital
- Telehealth psychiatry consults available to GVH providers through Swedish Medical Center and Center for Mental Health
- Physician onboarding process to increase physician retention
- Foundation covered costs of two physicians moving to Gunnison
- Hospital-provided hospitalists (2) and a mid-level provider to allow PCPs to see more patients in office
- Participation in DHHS collaborative process to expand dental and mental health services

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

- Consolidate and coordinate physician specialty clinics at one location to improve access
- Explore opportunities through the Foundation to support additional primary care physician recruitment
- Collaborate with current primary care providers for succession planning and recruitment
- Renew Health Professional Shortage Area (HPSA) designation to help fund physician recruitment
- Consider developing an FQHC to provide primary care and dental services
- Explore developing a new urgent care center in Gunnison to increase access to care

Anticipated results from GVH 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 GVH intended actions is to monitor change in the following Leading Indicators:

- Reduce current wait times to see a physician (20.3 days (mid-January timeframe)
- Reduce current ED volume for ESI 4s and 5s patient types (966 in 2016 (14.99% of overall ED volume for the year)

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

- Reduce current Population to Primary Care Provider ratio (1,410:1[12])

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

Organization	Contact Name	Contact Information
Gunnison County Health & Human Services	Margaret Wacker	www.gunnisoncounty.org/149/Health-Human-Services (970) 641-3244 225 N Pine St # A, Gunnison, CO 81230
Health Resources and Services Administration (source of HPSA funding)	HRSA Contact Center	www.hrsa.gov (877) 464-4772

[12] County Health Rankings. Ratio of population to primary care physicians. 2013.

Organization	Contact Name	Contact Information
Center for Mental Health	Lorie Fuller	http://www.centermh.org/ (970) 252-3200 710 N. Taylor St, Gunnison, CO 81230
Community Dental Clinic – Montrose	Melanie Hall	https://www.facebook.com/pages/Community-Dental-Clinic/104076052991126 (970) 252-8896 1901 S Townsend Ave, Montrose, Colorado 81401
GVH Foundation	Nancy Osmundson, Executive Director foundation@gvh-colorado.org	www.gunnisonvalleyhealth.org/Foundation.aspx (970) 642-8406

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

Organization	Contact Name	Contact Information
Local PCP/Public Health providers		

3. **CANCER –** #2 Leading Cause of Death; Routine Cholesterol Screening 9.2% below average; Cervical Cancer Screening in Past Two Years 10.6% below average; Prostate Screening in Past Two Years 5.9% below average

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

- Cancer Center services include chemotherapy and biological infusion
- Expanded oncology nurse services
- Added stereotactic breast biopsies, ultrasound imaging, sentinel node biopsies, and surgeon specialty for breast care
- Medical oncology services
- Digital mammography services
- Colorectal screening services
- Genetic screening and counseling
- Community Health and Wellness Fair screenings
- GVH Foundation Community Wellness Series (cancer prevention)
- Breast Cancer Reconstruction Service Line
- Cancer rehabilitation and survivorship program
- Collaborate with "Tough Enough to Wear Pink" breast cancer awareness program as well as joint collaboration for oncology patient transportation (with third collaborator, Living Journeys)
- Collaboration with Wellbeing Connection to provide integrative therapy for cancer patients

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

- Expanding diagnostic imaging equipment to include 3D tomosynthesis
- Developing a regional focus with Montrose Memorial Hospital, Delta County Memorial Hospital, and St. Mary's Hospital and Regional Medical Center
- Hiring an oncology nurse navigator
- Collaborating with radiology specialists to expand local access to procedures

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

- Updated colorectal screening service equipment

Anticipated results from GVH 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 GVH intended actions is to monitor change in the following Leading Indicators:

- Increase current clinic volume for medical oncology patients (526 oncology visits Jan-Nov 2016)
- Increase current screenings and procedures for cancer prevention (1,992 mammograms in radiology in 2016)
- Increase current utilization of cancer rehabilitation program (24 cancer rehab and survivorship patients in 2016)
- Number of visits to oncology nurse = start tracking in 2017 (anticipate hiring nurse in Q1 2017)
- Increase current number of cancer screenings provided at wellness events (625 PSA screenings; 358 colorectal screenings in 2016)

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

- Reduce Cancer death rate = 102.2/100,000[13]

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

Organization	Contact Name	Contact Information
Tough Enough to Wear Pink	Heidi Sherratt Bogart, Executive Director tetwpdirector@gmail.com	http://gunnisontetwp.com/ P.O. Box 1203, Gunnison, CO 81230

[13] CHSI. Number of deaths due to cancer (ICD-10 codes C00-C97). 2005-2011.

Organization	Contact Name	Contact Information
Living Journeys Cancer Support	Darcie Perkins, Executive Director	www.livingjourneys.org (970) 349-2777 300 Belleview Ave, Crested Butte, CO 81224
Montrose Memorial Hospital	Steve Hannah, CEO shannah@montrosehospital.com	www.montrosehospital.com (970) 249-2211 800 S 3rd St, Montrose, CO 81401
Delta County Memorial Hospital	Jason Cleckler, CEO	www.deltahospital.org (970) 874-7681 1501 East 3rd Street, Delta, CO 81416
St. Mary's Hospital and Regional Medical Center (Grand Junction)	Brian Davidson, MD, President and Chief Medical Officer	www.stmarygj.org (970) 298-2273 2635 N 7th St, Grand Junction, CO 81501
Crested Butte/Gunnison WellBeing Connection	Terry Bonney	http://crestedbuttewellbeing.com/
Women's Wellness Connection (Gunnison County Public Health)	Margaret Wacker	www.gunnisoncounty.org/260/Womens-Wellness-Connection (970) 641-0209 225 N Pine St # E, Gunnison, CO 81230
GVH Foundation	Nancy Osmundson, Executive Director	foundation@gvh-colorado.org; 970-642-8406
Other medical oncologists		

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

Organization	Contact Name	Contact Information
Radiology Imaging Associates (Invision Sally Jobe)	Karin Bulman	www.riainvision.com (720) 493-3700

Other Needs Identified During CHNA Process

6. **SPECIALISTS – 2014 Significant Need**
7. **AFFORDABILITY/ACCESSIBILITY**
8. **MATERNAL/INFANT MEASURES**
9. **NEED WRITTEN IN - CARE CENTER FOR CITIZENS IN THE LAST FEW YEARS OF LIFE**
10. **CONTINUUM OF CARE – 2014 Significant Need**
11. **EXTENDED HOURS – 2014 Significant Need**
12. **DIABETES**
13. **OBESITY**
14. **PRIORITY POPULATIONS – 2014 Significant Need**
15. **NEED WRITTEN IN - CERTIFIED ER PHYSICIANS**
16. **ALZHEIMER'S**
17. **HEART DISEASE**
19. **LUNG DISEASE**
20. **KIDNEY DISEASE**
21. **FLU/PNEUMONIA**
22. **STROKE**
23. **ACCIDENTS**

Other Community Health Programs, Services, Resources

- GVH offers hospice and palliative care
- Partner with Swedish Medical Center for telehealth stroke program
- Level IV trauma center to care for accident victims
- Senior Care Center offers Memory Care Unit (Alzheimer's)
- Recognized breast feeding program to reduce obesity
- Registered Dietitian offers weight loss/nutritional counseling
- Evaluating senior care services – a new senior care campus – senior transitional living in a homelike setting

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility

1. Mental Health
2. Primary Care/Mental Health Providers
3. Cancer
4. Suicide

Significant needs where hospital did not develop implementation strategy

None

Other needs where hospital developed implementation strategy

5. Alcohol
18. Need Written In – Drug Abuse

Other needs where hospital did not develop implementation strategy

6. Specialists
7. Affordability/Accessibility
8. Maternal/Infant Measures
9. Need Written In - Care Center For Citizens In The Last Few Years Of Life
10. Continuum Of Care
11. Extended Hours
12. Diabetes
13. Obesity
14. Priority Populations
15. Need Written In - Certified ER Physicians
16. Alzheimer's
17. Heart Disease
19. Lung Disease
20. Kidney Disease
21. Flu/Pneumonia
22. Stroke
23. Accidents

APPENDIX

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

Hospital solicited written comments about its 2014 CHNA. 63 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. The comments were recorded as is, and may include typographical errors.

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.**

Local Experts Offering Solicited Written Comments on 2014 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	6	39	45
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	14	32	46
3) Priority Populations	13	33	46
4) Representative/Member of Chronic Disease Group or Organization	6	40	46
5) Represents the Broad Interest of the Community	56	3	59
Other			9
Answered Question			62
Skipped Question			1

Congress defines "Priority Populations" to include:

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

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

- *Yes. I work mostly with populations that fall under low-income groups, women, and ethnic minorities. I feel that a unique need in this community specifically is a greater number of professional interpreters in the medical arena.*
- *Women's breast care*
- *All of these populations exist in this community. Phychiatric care for children and adolescents. Senior / low income transportation to clinch appts in Grand junction/ Denver*
- *They all exist in our community.*

- *low-income*
  women
  children
- *Low-income, women, and children would be the mane groups*
- *yes. all apply*
- *Mental health services*
- *none*
- *women, children, older adults, residents of rural area, individuals with special needs*
- *Women*
- *Yes. Our rural setting (Lake City) makes access to mental health services exceptionally difficult.*
- *Yes women who are having to travel long distances to receive women's health services including advanced screenings for breast cancer and also treatment of breast cancer.*
- *At Western, we have students, faculty and staff that are representative of the "priority populations" listed above. Specifically, with regards to our students they do have needs around accessing health-care services as well having the ability to pay for services.*
- *Yes. Rural women and low income.*
- *Yes, they do exist in our community. Obviously, residents of rural areas applies as that is all of us. We have a need for high quality medical care so we aren't burdened with a 3 hour drive to St Mary's in Grand Junction (or further to get to the Front Range) to seek treatment. There is also a need for Breast Cancer treatment in the area as well so local women don't have to drive to Denver to be cared for.*
- *Yes. Yes, several, but I think they are all being addressed.*
- *Yes!!*
- *Low-income & children would be top on my list for needs within our community. There are far too many low income families who most likely don't have good access to health care. In addition, with all of the children in our valley getting a full time pediatrician is critical to continue to attract young, entrepreneurial families. I guess that also leads to "residents of rural areas", as that is what we are in Gunnison County.*
- *Older I suppose*
- *Yes, most if not all of them with the aging populations increasing as people retire here. Some with money as is the case in Crested Butte and others without more than Social Security.*
- *Yes,many of the above are in our community, including summer seasonal residents*
- *Rural population (access in winter via snowmobile, access to remote areas for HH, nursing, difficulty transporting to and from other major medical centers). Significant low income families in town.*
- *All of the above reside within this community and ALL have unique needs that need to be addressed*
- *Yes, many of these populations exist here.*

- *We serve the immigrant population and the ability, or not, to communicate with health care providers is of vital importance to the health of that population.*
- *Yes. Income to cost of living, health, and child care comparisons need to be addressed for health care.*
- *yes we have Cora Indians, Latino's, low income populations, and a large population of children in poverty as a % of the total youth population. They all have unique needs and challenges with regard to public health.*
- *All of the above are in our community and currently being served at the mental health clinic where I work part-time. Although we do our best to meet their needs there are some holes in the dike. We have no levels of care higher than outpatient treatment. A partial hospital program or intensive outpatient program would be very helpful but the personnel and funding are not available.*
  Transporting acutely disturbed patients to a psychiatric facility involves the use of peace officers and vehicles to safely move patients to Grand Junction or the front range. In many cases comorbid medical problems, including special surgical needs, head injury assessments and evaluation by subspecialists not in Gunnison County require transportation that is not easily available to indigent patients.
- *All of these populations exist in Gunnison. Gaps in the affordable Healthcare Act, still unable to afford to pay premiums, co-pays on expensive medications..*
  Transportation often present difficulties, for example, needing to go out of town for service not provided in Gunnison.
- *All of these groups exist within our community and all of them have unique needs related to health and wellness, some include: access to services, payment for services, stigma surrounding services, and a lack of understanding of available resources.*
- *Low income groups, Women, Older adults, residents of rural areas, individuals with special needs, LGBT, people with major comorbidity and complications are all populations that exist in our community and have unique needs to be addressed.*
- *Our area consists of a broad range of populations, however, people with disabilities and older people with chronic health needs appear to be underserved in our rural healthcare environment. Our communities are not accessible to disabled and there are not enough providers for people to be "seen" by their PCPs in a timely fashion. People with major co-morbities and complications many times must leave the Valley to receive the specialized care they need*
- *Yes, all of these exist in our community and each have specific, unique needs that should be addressed.*
- *The top 6 populations. Jobs, education,*
- *yes. essentially each has special and or unique needs.*
- *Yes these populations exist, but not sure of any unique needs.*
- *There is a fairly large group of senior adults in the Gunnison Valley, many of them with limited income and rural. In the North end of the valley there are also retirees with substantial income. We also have a fair number of minority folks here.*
- *Yes, housing.*

- *We serve all people in the Gunnison Valley. We are the agents for individuals, families and employer sponsored group plans*
- *Yes.....most all of the above . Yes, the Spanish community needs translators and health assistance In the public health arena. Hospice care for end of life individuals.*
- *All of these populations exist in our community. Transportation for health care and services is a major need*
- *A kids doctor in the valley would be great.*

  Low-income
  Older adults
- *Low-income groups-better access to affordable health care, language barriers, dental care*
  Older adults-affordable, graduated assisted living and nursing care and access to transportation
- *All of these populations exist in Gunnison County. Depending on the particular group's characteristics, each had unique needs. E.g., ethnic groups often do not have access to primary care and when they do, utilizing such care may require translators and/guides to the utilization of services. While transportation for senior citizens has improved this year, there remain issues for members of this group who live considerable distances from primary and other care if they must travel from remote parts of the county. Specialized (not routine) care for children is not available. GVH has done a good job of providing specialist care for cancer and other patients, including the use of telemedicine for stroke patients and those with behavioral issues, but there appears to be a real limit to what a small critical access hospital can do. For example, where residents need highly specialized care for kidney issues, they must travel (sometimes more than once/week) to Montrose or Grand Junction. The LGB group appears to be able to access care, but not the portion of LGBT. All low income folks experience difficulty accessing service although the County Health Department does a good job on what some say is a too limited budget.*
- *sure. we have some of these populations. probably all of them. i suppose the argument could be made that they all have 'unique needs.' but, same argument could be made for everybody.*
- *In Gunnison low-income and moderate income families struggle to insure their family. Cost of healthcare for school age children is not unique but is a problem.*
- *Racial and ethnic minority groups: Cora Indians experience language barriers - need equitable access to health practitioners with whom they can converse or easy access to a translator. Also need more feelings of 'belonging"" to the larger community. Hispanic population in general - have expressed a need to feel safer and to establish better relationships with law enforcement*
  Low Income - while not unique, this group needs expanded access to affordable daycare, acceptable housing, better-paying jobs
  Women: more information about options in pregnancy and access to help when they experience domestic violence
  Children: those who qualify for free and reduced lunch have hunger issues when school is not is session
  Older adults: the community (somehow) has to help our older population to feel comfortable asking for help - for instance, using the food pantry when their income doesn't stretch quite far enough. Loneliness is an issue that needs to be addressed for some of our more reclusive elders

Special needs: I really don't have information about those with disabilities or those who need chronic care. It is my opinion that our entire population should be more comfortable discussing end of life care and the whole process of dying.
LGBT: another area in which I have no specific information
Comorbidity: I had to look up the definition -- so, no expertise here -- except for my own -- which I manage by being very direct with my health practitioners and an advocate for my own needs. I do worry about those who are not as assertive as I am in exploring options, interactions, etc.

- *Yes, all of the above exist in my community.*
- *This community has small portions of all, and have needs not being addressed*
- *Of course. These populations exist in all communities. Unique needs: All of these groups in our community lack access to both a broad range of services and quality services.*
- *Yes, I think they all have unique needs but language or translation services is something that we had to address. I don't know of another addressable need at this time.*
- *Yes - women, children, low income, en-of-life care, rural areas. Travel to services not available in the valley and lodging when requiring an overnight stay.*

In the 2014 CHNA, there were 6 health needs identified as "significant" or most important:

1. **Physicians**
2. **Specialists**
3. **Mental Health**
4. **Extended Hours**
5. **Priority Populations**
6. **Continuum of Care**

3. **Should the hospital continue to consider the needs identified as most important in the 2014 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No
Physicians	50	3
Specialists	46	6
Mental Health	50	3
Extended Hours	39	9
Priority Populations	40	9
Continuum of Care	44	7

4. **Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.**

- *Child and adol psychiatry- including ADHD*
  Full hour EMS availability for ambulance transfer
  Increased availability of Echo and ultrasound
- *We need an after hours clinic/urgent care that should be considered whether through the hospital or through the private sector. We should consider increased nurse practitioners in the community as we are having a hard time filling physician positions.*
- *we should work on these first. after there is some resolution then we could add more projects*
- *Better services for patients with cancer, specifically for me breast cancer*
- *An Urgent Care option for late in the day care*
- *No.*
- *Yes. We need machines to have better radiology options for Women's with dense breasts who need better imaging than a mammogram or ultrasound.*
- *The option to get radiation treatment for cancer at GVH.*
- *Peds and derm.*
- *I see need for certified trauma/ER physicians in the E.R. at .*
- *Increasing expectation of networking capability and lack of good internet in valley and networking of existing EMR, etc.*
- *mental health issues are noted but the high levels of substance abuse and suicide in this community are alarming.*
- *Urgent Care is critical. Also well paid individuals are finding it impossible to afford health care. When I look at the actual cost of a service and what the hospital charges there is often a 7 x mark up. Is this because it has to pay for people without insurance.*
- *Although this overlaps somewhat with the above, we have a subpopulation of 'frequent flyers' who utilize the ER when primary care should be the option. Strategies for subacute interventions for low-grade urgent care and mental health would be good to consider.*
- *Nutritional services; Providing better access to consults, education and support.*
- *Coordination with other community resources to assure maximum efficiency with such scarce resources.*
- *cannot think of any new needs*
- *no*
- *The need for kidney dialysis continues to grow here as population grows and people have to drive anywhere from 80-150 miles one way, three times weekly for treatment.*
- *An urgent care facility to allow non emergency room visits*

- *Growing number of breast cancer cases, need for integrated therapy for all patients.*
- *There needs to be highly focused attention to the county suicide rate especially among men ages 40 - 60 or so. There currently is work on suicide prevention among teens but this area should have more resources committed to it (funds and staff).*
- *Mental health professionals still lacking*
- *cardiac - we need more services for cardiac patients*
  Trauma - we need more resources for trauma victims and their families
- *i think GVH does a remarkable job of addressing this small community's health needs already.*
- *I'm grateful for the response to a request for a pediatric forensic physician. A need identified since the last study and acted on quickly when it was brought to your attention.*
- *I think Telehealth provides rural communities with a direct connection to care but with our existing broadband we cannot take advantage of this. We are hopeful that the no redundant broadband in this valley will be addressed soon so we can at least explore the Telemedicine opportunities available.*

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

- *This remains as a priority in Gunnison. I consistently hear in the hospital that it is very difficult to get in to see PCP's.*
- *Low salaries - incentives for private clinic primary care physicians*
  Aging of current physicians
  Large numbers of high risk/ complicated patients, not enough primary care physicians willing / trained to care for them"
- *we need more PCP's as it takes a long time for a well check up. some times it takes a long time for a problem check up as well. we are trying to promote well beingand prevention in our community, to do this we need to have physicians available for people to see. we only have 2.5 doctors who deliver babies. one of these doctors must be available 24 hours a day, 7 days a week. this is difficult with so few providers. if one gets sick or takes a vacation (or has family leave) that leaves us barely enough to get a c-section done.*
- *We certainly have enough orthopedics for such a small community. Need to work with other communities for specialty care for the western Slope to control costs.*
- *There is still a lack of physicians in the area. To see a doctor in CB there is at least a 2 week wait.*
- *Concur with local expert concern and assessment*
- *I do not see this as a significant need.*
- *The radiology department and oncology need physicians who can handle the cases of breast cancer in this Valley. It is increasing dramatically.*
- *I haven't had experience with a primary care physician not being available. With one doctor I see annually, it takes a lot of planning to make an appointment, so it must be booked far in advance and I have to ensure*

that I make it or it will be a long time before I can get back in. This is frustrating, but more on the doctor's part and their scheduling.

- *As the local doctors age they are not always replaced by younger doctors, the average ages of our current general care physicians are getting higher.*
- *Across the west housing is becoming a premium and especially in Gunnison County with University students and a ski resort vying for housing. Attracting medical professionals who are avid outdoor recreationists is also key to maintaining an environment for health care employees. Gunnison County is needing to recruit more primary care professionals.*
- *Family physician availability (including those who will take new patients and Medicare) should be a top priority*
- *Have essentially lost 1.5 physicians (Dr. Matthews leaving and DR. Villanueva now having ongoing family crisis). Need primary care!!! Need more ED physicians to cover.*
- *This has to be a concern and a priority not only in recruiting but also in vetting; ensuring there is a right fit for this community. New recruits need to understand the concept of productivity as it relates to reimbursement, overhead, time off, pay etc. Few if any have any business acumen.*
  New recruits should understand thoroughly the demographic they are signing on to care for, plus the severity and extreme rural nature this area demands respect for.
- *same*
- *I don't personally see a lack of physicians as an issue it when they are available.*
- *GVH was off to a poor start after Dr. Wolcov's retirement in regard to the quality of interface between providers and patients. This has improved but most patients are still faced with limited options for primary care with only two clinics in town. Although I believe it is more complex than simply income potential, physician retention requires a positive workplace environment and adequate support staff.*
- *1) absolutely important*
  2) there is a lot of ""bleed"" to montrose, salida, gj and denver for specialists
  3) seems a need in the community
  4) not easy to find timely primary care so ER best option but it it is tooooo expensive
  5)something needs to change
  6)indeed
- *Gunnison still has a need for PCPs and greater accessibility to those physicians. Lead times are too long.*
- *Having the adequate amount of PCPs in our community is of the highest need. We have a particular practice that has physicians that are aging out over the next decade, and another practice that is not going to be able to pick up the slack. We need to continue to recruit physicians to the rural health care environment.*
- *Keeping physicians is a significant need as, the population needs to be able to access them in a timely manner which does not always happen.*
- *Same as listed*

- *difficulty both by word of mouth and personal experience in getting appointments in a reasonable time.*
- *Even though I have insurance, it is tough to schedule an appointment with a primary care physician. I can't even imagine those that don't have insurance.*
- ** I would agree that it is the most significant but I would add that nursing staff be included .*
  ** The hospital maintaining a hospitalist .....which allows for the continuity of care.*
  **. Heving the hospital involved in evaluating the quality of physician care community wide."*
- *Primary Care Physicians are not in shortage.*
- *No longer interested in this survey. GVH rules!*
- *At least two primary care physicians will be retiring in the not too distant future and it is urgent we begin recruitment now. In addition, with Dr. Matthews recent departure we are one down in primary care physicians who have at least a modicum of experience. If, as has been stated, Dr. Matthews left the community for a much higher income, we need to consider how we can keep the younger primary care physicians here when they can go elsewhere for better incomes. It is no longer sufficient to say folks will stay for the great environment!*
- *Need more family care and pediatric MD's*
- *we have great family docs. but ... some of them are probably getting near retirement age. assisting in the transition / attraction of new ones will be important.*
- *Still need more primary care physicians -- when you can't make an appointment until weeks out from when you call -- an issue. Not just for GVH, but for all the practices in town.*
- *It takes a long time to replace a Physician when they leave. Appointments for non emergency medical care still take too long to get in.*
- *I think that we have made progress here. However, another primary care provider did just leave a few months back from our valley so we may again have a need for more physicians.*

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

- *I have heard from patients that are part-time pregnant residents, they are finding it very difficult to transfer care to a local OB provider for temporary care.*
- *Specialists that visit here are also overburdened- it is great that they come*
  Convenient for patients
- *not a big concern. if you choose to live here, that is a chance you take of not having specialists here. the specialists that come is a bonus to those who need them. it is not the community's responsibility to provide these services. we do not have a big enough population to keep specialists here.*
- *Need to develop additional specialist that come to Gunnison to see clients. The hospital has done a good job in this area*
- *It would be nice to have a variety of specialists that could come to the hospital at least once/month. There is*

a lot of travel/time taken from work to travel to see specialists.

- *Concur with local expert concern and assessment*
- *More Mental Health Specialists are needed.*
- *This past year I went to see Dr. Timko with my husband in Salida because he was booking too far out in his Gunnison visits. I do appreciate the fat that he does come here, albeit maybe not enough. It is a nice option to have. Also, see comment above.*
  What are the chances of getting a pediatrician (not just a family doctor) in the valley on a part time basis? We are looking to start a family and this would assure us to top quality care in the valley more so than a family practice, in the event that something abnormal came up.
- *We have a good group of orthopedists, but the areas of Rheumatology, Oncology, Audiology, Optometry, Endocrinology and*
- *Gunnison County has few specialists that actually live here and not enough work to keep them here maybe. However, if we recruit health care people who are outdoor enthusiasts we will keep them here in the region. Even our Montrose and Delta County visiting physicians are coming from colder climates and often do not know what they can expect from winter.*
  Things seem a bit better regarding the specialists we do have here now. Except I would like to see a full time audiologist at GVH because there is a large need for that.
- *We are fortunate to have good orthopedic and surgical coverage. Other specialists are available within a reasonable distance.*
- *I feel the specialist issue has improved - neurology with more services though still not coming here very often. Cardiology improving. ENT/Urology about the same though access in Montrose for urology is better than it used to be. It would be nice to get visiting GI specialist and opthomologist.*
- *It is specifically because of the remote nature we practice that this is so important.....not to mention our changing demographic i.e a dramatic "up tic" tourism extending more into the "off season" and second home owners residing longer instead of returning to their primary home.*
- *same*
- *This seems like a particularly dire need. More specialists or at least more availability among the specialists who do visit Gunnison.*
- *They will understand the common injuries around here more than having new specialists every few years.*
- *In a small community, specialists (outside of Orthos) are difficult to support.*
- *It is unrealistic to expect our community to maintain a cadre of specialists similar to big cities. On the other hand, if GVH can continue to attract specialists to come here, even if it's only once a week or so, this not only enhances the quality of care but could go a long way in channeling complex cases to appropriately trained specialist --- with all due respect to family practitioner, PA's and NP's.*
- *i have gotten used to going to Denver for dermatology. wife goes to Montrose. specialists need consistency*
- *Some specialty practices are very important to our area, oncology is an area that is lacking. There is a large*

number of patients that leave the valley for their oncology care.

- *We have some specialists, but do not have a pediatrician, geriatrician which would be very beneficial.*
- *Same as listed*
- *Many issues seem to require attention of a specialist who is seldom here.*
- *To see a specialist, everyone has told me to go to either Denver or Grand Junction. Tough to schedule.*
- *Help reduce the amount of patient travel needed for care.*
- *There has simply been a lack of diverse specialist forcing out of town care.*
- *Radiologist, Oncologist are critical needs.*
- *Specialists will not locate here unless near retirement and not in need of income because there is just insufficient business for a pediatrician, for example. To the extent we need specialists GVH should do what it can to arrange for once or twice/month clinics here.*
- *Need more Trauma and Cardiac MD's*
- *i don't necessarily access to specialists is expected in a small community like ours. but ... if it can be accommodated (for cancer treatment, surgeries, etc), then that's obviously a bonus.*
- *It is so much easier to take the time to see a specialist without having to take half a day or more away from work to travel to a different location.*
- *It's a definite plus to be able to get good diagnostics and treatment locally. It seems the number and kind of specialists have increased since 2014, which is very good.*
- *I know a lot of work has gone into this and I think we have a great selection of specialists. Pediatrics would be a great addition but getting one to come here with the population we have in unlikely.*

7. Please share comments or observations about keeping <u>Mental Health</u> among the most significant needs for the Hospital to address.

- *Although I think that we are making progress on this with the use of telepsych, we still have a difficult time finding placement for mental health patients in a timely manner.*
- *Absolutely!!! In office mental health is a step in the right direction*
  Drug/ alcohol dependency in All ages is a huge problem
- *mental health is a huge and growing population in our community and there are very little resources available here. unlike the specialized physicians, i believe there is a big enough population here to fund a better mental health system. it is of a concern with the multiple suicides happening each year for the last several years.*
- *Don't know*
- *Concur with local expert concern and assessment. Specifically, lack of access to psychiatric care and emergency crisis counseling, intervention and client safety after hours are major concerns.*
- *Mental Health needs are across the country under-recognized, and in our West-Slope counties, high quality*

providers are in even more demand. A deliberate recruitment and retention program for mental health providers might help.

- *I have seen a private psychologist for a few years, which I very much appreciate. I have not personally needed psychiatric services, however i believe in strong mental health services in a community. We should put an emphasis on this, as it affects a lot of people in varying degrees, but having seen friends and family struggle with mental illness - I can speak to how much medicine and counseling can help.*
- *The suicide issues at eh high school over the last few years.*
- *We do need crisis professionals here rather than relying on Denver or Salt Lake for help. We have one "safe room" now set aside at GVH for the mentally ill in crisis and that is a help, but local beds in an actual center would be a huge bonus.*
- *Whether it is the Hospital or the community someone has to address substance abuse and suicide (especially in the younger generation) more effectively than it is currently being addressed. You cannot wait for it to happen or for the despondent to come to you, you have to reach out to them.*
- *Addition of co-doc for psychiatry and Lori Fuller for counseling has been good but still very difficult to place pts who require inpt care - often staying in our facility for several days.*
- *The hospital has to have a robust mental health program because this problem is not going away anytime soon and if fact is only going to get worse.*
- *same*
- *They will understand the way people develop mental health needs in our isolated, cold county with a history of substance abuse problems. They will see it 1st hand when they stick around for a long time.*
- *This is a very significant need around the country and in the Gunnison Valley.*
- *As a psychiatrist, I can unequivocally say that mental health needs in the Valley are only going to grow, yet the national shortage of psychiatrists continues grow. Again, remuneration is only part of the problem. Attracting more well-trained mental health professionals - especially psychiatrists - will significantly relieve pressure on primary care and emergency medicine. Consultation/liaison in the hospital now is almost non-existent which is problematic with overdoses, detox, post-surgical delirium, etc.*
- *Mental Health should hold the highest priority.*
- *I am not sure this is a need that the hospital itself can address realistically. Our Mental Health center is simply not adequate enough to meet the needs of our community. It is not ok that when a patient is referred to mental health for an acute need and that an assessment is completed however, the patient cannot get in to see a psychiatrist for 5 - 9 weeks. Maybe the ED at the hospital has that ability, but that is not available in the community setting to residents. While it is a step in the right direction, it does not sufficiently meet the needs of the community on a day to day basis*
- *Mental health is such an issue, as we don't have a psychiatrist living in the valley and limited availability of counselors. Suicide is high in the mountain communities and there doesn't seem enough personnel to help.*
- *Same as listed*

- *the profound and seemingly increasing need.*
- *Counseling is a need for most of my clients, but difficult to schedule for lack of Mental Health professionals in the community.*
- *Drug addictions and impacts on crime and keeping our law enforcement folks busy.*
- *A consistent lacking and understaffing.*
- *Mental Health lack of mental health days is due to the poor quality of mental health experts and providers in the Valley*
- *This may be once of the most important issues to address in the future and GVH has a good start with the behavioral room, telemedicine with Swedish Hospital and the behavioral specialist in the Family Medicine Clinic. It is likely that more than one such specialist will be needed in the future; the current one is 1/2 time which probably is insufficient.*
- *See prior comment*
- *See previous comment*
- *Need an inpatient acute MH facility and resources so these patients do not have to go to the jail.*
- *i'm not sure this is the hospital's responsibility. but mental health treatment is of course very important. i think the community's needs are being pretty well served in this arena as it now stands.*
- *This is an area where the community must work together to insure services are in place. The growing mental health concerns across the range of our population continues to be a concern.*
- *This needs to be way high on the list of concerns. Suicides must be seen to be a symptom of a broader mental health issue in the County.*
- *Mental Health is still difficult to access, too expensive for many who need it, and not covered by insurance for a lot of folks.*
- *I feel GVH has really improved here with the addition of a Behavior Health provider to the GVH team as well as purchasing Patient Tools software to provide screening for our patients.*
- *Mental health needs are the greatest need in my opinion.*

8. Please share comments or observations about keeping <u>Extended Hours</u> among the most significant needs for the Hospital to address.

- *Still a problem. I hear often from patients in the ER that they could not get in to see their PCP so they had to come to the ED.*
- *We have tried / and continue to provide extended hours 12-1, sat 8-12. I perceive no incentive for patients not to use the ED. Most prefer the " no wait"*
- *extended hours would help for those people who try to work and cannot leave for doctor appointments. I believe an urgent care would be helpful to reduce overuse and abuse in the ER. A triage nurse could send the minor things to an urgent care facility and keep the more appropriate ER patients. this would save monies*

that are never paid for ER services as well.

- *This is super important as to see a doctor in a reasonable time is not realistic*
- *Concur with local expert concern and assessment*
- *I don't see this as a need.*
- *Agreed, the ER is expensive but I believe it is everywhere you go. We try to avoid it at all costs. When necessary we use the Mountain Clinic for urgent care, which is slightly cheaper (I believe).*
- *The ER at GVH is a 24 hour a day facility and it is staffed by resident and "on call" physicians. There is a need to require doctors to stay at the hospital for their entire shift. Cost for any medical treatment is significant regardless. However, rural health care seems to be hit the hardest with insurance premiums to cover that cost.*
- *Emergency services seems to need additional clerical help to get access to medical staff more timely*
- *Has improved with clinic and mountain clinic - could still be better but unclear if true urgent care would help.*
- *Extended hours, urgent care access are integral to addressing health needs of all communities and should be part of a comprehensive plan*
- *same*
- *This seems to have improved and is probably no longer a "significant" need.*
- *We don't work regular jobs around here, and extended hours may be the only time people can get in to be seen for health needs.*
- *Providing urgent care services in the evening, weekends, and even during the day is needed. I would put this at the top of the list.*
- *Again this is tied to manpower.*
- *We need more then Extended Hours. Our community is still not clear on how this works for them, if they are not currently patient's in that particular practice. It is not well communicated in the community.Our community needs a REAL URGENT CARE.*
- *The medical center has added extended hours, but having further extension with more practitioners would be very helpful.*
- *Same as listed*
- *For the reason noted in 2014. the alternative is the added expense of services at the ER.*
- *Obviously, going to the ER is more expensive, but in most cases, there is no other option because some medical offices are closed or have random hours of operation.*
- *Emergency care is necessary .....requiring the extended hours*
- *An Urgent Care facility should be investigated.*
- *For me this does not have the highest priority.*

- *This would cut down on the ED business for non emergent patients*
  Need an urgent care center
- *one can always go to the ER. i don't think people expect family physicians to be open 24 hrs.*
- *Many people can't afford to take time off from work -- or their employers won't allow it. How do we keep a population healthy if there isn't time for folks to see the medical folks they need?*
- *The cost for extended hours at a medical center far outweighs the cost of emergency room treatment for all involved.*
- *I think GVH has responded to this need by providing extending coverage at the Mt. CB clinic and the Gunnison Family Medicine Clinic.*

9. Please share comments or observations about keeping <u>Priority Populations</u> among the most significant needs for the Hospital to address.

- *I feel their is a huge gap in communication options with the Cora Indian population. We often end up using the patient's child to assist in interpretation.*
- *There are fewer non English speakers- but this group is a significant challenge since the adults often have NO insurance- therefor for care for chronic problems*
  Our office continues to see all comers- but it is especially challenging to find specialists who will see Medicaid, Medicare or the uninsured- this care then falls back on us
- *I'm not sure about this, but I believe that we should serve all populations. there should be some sort of payment from everyone, it could be dependent on income. some is better than writing off the whole bill. again, with the urgent care or after hours, this deficit would be a little less.*
- *Don't know*
- *Concur with local expert concern and assessment*
- *I don't see this as a need.*
- *Women's health is critically important to this community for women of all ages and a proper facility for those services is needed.*
- *We have insurance through my employer, so it is difficult to fully comment on other's needs. However, it is not surprising that this was found as a priority item.*
- *Health insurance on the western slope is expensive and the state insurance commission cannot seem to get it aligned with the front range. Region 11 I know was going to the plate to try and get the costs down for rural insurance coverage, but for us it is a ghost. Transportation is being addressed by both public and private entities so hopefully in the near future we will have better patient transportation.*
- *All populations deserve good medical care*
- *Rural patients and access is still very important.*
- *This is all important....not sure if its a "top" priority*

- *same*
- *Seniors, minorities, and children and poverty all have significant needs. Making health care affordable and available to these populations should be a top priority.*
- *Working within any available ACO will likely be essential to keep the care of priority populations cost-effective.*
- *Our priority populations including children and elderly do not have specialists to serve their specific needs and could benefit from that.*
- *Same as listed*
- *Whether discussing the elderly, minorities, or low income, or others, there are great needs for services.*
- *Lack of insurance and because all providers do not take all insurance companies/plans, then care is limited. There is no real choice and you just have to use what is available. However, I have observe that the hospital does a payment plan for you to help you spread out the cost over months. But, can the hospital survive by doing that? Transportation for seniors has gotten a lot better.*
- *The (un)affordable care act has reduced un-insurance rate in the short term. Rising premiums, high deductibles, and lack of competition will reverse this trend long term and will be an issue the Hospital system will need to address as write-offs will increase, and more patients will be faced with medical bankruptcy rather than insurance.*
- *Equity. That's the name of the game -- we are one community and not leaving any one segment behind in key to being healthy and prosperous.*
- *We need to take care of each other. We especially need to commit to quality care for those who may not be able to get it for themselves.*
- *I know Transportation for seniors has improved but I can't comment on the insurance or growth or certain ethnic populations.*

10. Please share comments or observations about keeping <u>Continuum of Care</u> among the most significant needs for the Hospital to address.

- *I cannot comment on this, as I do not have enough knowledge regarding this issue.*
- *Medical care is getting more and more complex- community pooling oif resources makes sense Many patients are unwilling/ unable to "" manage"" their own health care- This is a huge roadblock- patients want fast service, fast results, yet are not invested in cost savings/ appropriate use of resources. This will take a great deal of reeducation/*
- *there are so many people who see so many different types of doctors. they are then prescribed meds for what ever this doctor is treating and whatever that doctor is treating. there needs to be some continuity of care so that medications/procedures are not interacting in a bad way with other medications/treatments. having more PCP's could help facilitate this as well.*
- *Don't know*

- *Concur with local expert concern and assessment*
- *The lack of communication between mental health providers and other health care providers is problematic.*
- *Provided you are in the hospital system, the continuum of care has met our needs, as it transfers files between the hospital and doctors, like CT scans and Xrays instantly. Probably depends on the doctor though. In terms of our insurance provider, we haven't had any issues to note.*
- *There is a certain amount of patient responsibility when it comes to collaboration with other doctors participation in patient care, but I would like to see some sort of a grant sought to upgrade compatibility of digital systems so patient records could be shared at least locally.*
- *Agreed, but it needs to include more assisted living units with larger units and independent living with some services provided*
- *I feel this has improved, electronic communication and connectivity still an issue.*
- *This is just good medicine and should always be important....*
- *same*
- *I need a little more definition on what this means. I know many have to travel to Montrose or Grand Junction for dental work.*
- *An integrated electronic record that really works throughout the community would be helpful. Beyond that, the physicians and their surrogates should feel that collegiality is important enough to take the time for appropriate communication with each other while also understanding how critical it is to take sufficient time with patients to be sure they are educated about the nature of their medical needs.*
- *Continuum of care has really not been addressed sufficiently. The hospital has talked about it, but when it comes right down to it, home health and hospice continues to be left out of that ""Continuum"". That makes no sense. Home Health and Hospice already has the infrastructure to treat the community, communicate with local and non local physicians as well as make appropriate community referrals for other services as needed.*
  They just need to be given the referrals from providers, as well as our own hospital. We have local orthopedic practitioners that do not see any benefit in allowing a patient to be at home the first week after surgery. Why not allow the patient to get over the initial ""trauma"" of surgery and let the expert team of physical and occupational therapists see the patient's in the comfort of their own home, then let home health refer back to outpatient when it is best for the patient. Not everyone is able to get in a car and have a family member to drive them to appointments on a consistent basis
- *Continuum of care is significant to reduce hospital readmits and costs down for both the hospital and the community. there is a need for further continuum.*
- *Same as listed*
- *For the reasons reflected in the 2014 information.*
- *It seems that it is very difficult to get everyone on the same page, but it is not for lack of trying. All of the meetings just get overwhelming and everyone cannot always get together at the same time. And...what can*

be shared, if you don't have permission.

- *Patient navigators are needed, especially for Cancer patients.*
- *I think the current continuum of care is impressive for a small community, but we should extend behavioral care to that continuum as well.*
- *Wow. Take it on -- birth to death -- we need to make more of the importance of having a home base for our care needs.*
- *The demographics of diversity include age. Caring for our citizens from cradle to grave is the hallmark of a great society.*
- *This is always a struggle and we hope that MU can provide some better communication with the summary of care or CCD. However, we are not there yet and using QHN does provide some relief to this issue.*

11. Please rank the following specialties from most needed to least needed in the community.

Specialty	Score
Radiology	11.61
Cardiology	10.79
Pulmonology	9.97
Neurology	9.47
Nephrology	8.90
Orthopedics	8.14
Urology	8.00
Obstetrics & Gynecology	7.03
Ophthalmology	6.17
ENT	6.03
Pediatrics	5.97
Physical/Occupational Therapy	5.90
Psychology/Psychiatry	5.36
Gastroenterology	4.79

12. GVH is considering building a replacement senior center to address the future needs of seniors in our community. Is this project needed?

Yes	82.93%
No	4.88%
Not Sure	12.20%

Comments:

- *Very worn dated facility Growing senior popatuon*
- *This a growing population who deserves the care and amenities provided by a comprehensive, state-of-the art senior center.*

- *High quality, flexible long term and end-of-life care is in high demand.*
- *The facility that is being proposed seems a bit out of reach and possibly more than needed.*
- *Current plans are to expensive---what will happen to the rates? Already families are taking parents out of town to less expensive facilities,*
- *Need to focus on assisted living as NH is not doing skilled and huge waiting list.*
- *This is long overdue!*
- *I think this is a critical need in supporting our senior and providing a respectful caring environment for them in their golden years.*
- *Anticipate more dementia patients and, on the other end, more need for assisted living.*
- *the population that wants to remain here is aging so a demographic need seems appropriate*
- *What would be the difference/benefits from the current senior center?*
- *I think it is what our community needs.*
- *growing elderly population*
- *Gunnison definitely needs a plan to care for seniors.*
- *Forcing two seniors into rooms designed for one is not respecting human dignity.*
- *The Senior Center is being driven by the older demographics of the Hospital Board and profit margins rather than the needs of the community as a whole*
- *It's past time!*
- *Keep it affortable-My sister and I researched a place for our folks memory care. Same level of care Gunnison: $13K, Bozeman, Mt: $8K. We moved them to Montana!*
- *We need to focus on the acute needs - people do not move to Gunnison to retire No need to rebuild when we can remodel*
- *would be great. a growing segment of our (and all) populations.*
- *This goes right along with the continuum of care and attending to the needs of the whole community.*
- *As our aging population continues to grow we must grow our facilities and they must keep up with the trends or we will not be able to keep seniors in Gunnison.*

13. Please rate the overall community's perception of GVH.

Excellent	7.32%
Very Good	48.78%
Good	19.51%
Okay	24.39%
Poor	0.0%

Comments:

- *Expensive Convenient location Process problems - i.e. Scheduling etc making it more challenging to use Caring staff- all areas*
- *I hope that the Gunnison community realizes and appreciates the incredible resource and service we are provided by GVH.*
- *I think it's better than its been in the past but the revolving door of doctors is a concern.*
- *There seems to be some discontent locally with GVH and I believe that part of it is the current administration had responsibility for the financial health first so now all the small things are floating to the top in employee and community issues. Not having a doctor on duty AT the facility/ER is also a big deal to the community when it comes to more severe injuries or illness.*
- *Perception has improved with current Board and Administrator*
- *There are many areas where the perception is excellent, however during that one patient encounter if the "front desk personnel or someone down the line including billing" has an off-putting demeanor to the patient, the patients' experience will be less than favorable. We are a service industry and EVERYONE needs to treat the patient as though their very paycheck and job depends on it.*
- *There was a big shakeup at the hospital years ago, and I don't think people have fully moved past that yet. Also, I just the hospital to schedule an appointment, and the person on the phone was not helpful or kind at all.*
- *it is not outstanding but good to have in the valley.*
- *discussions with others.*
- *Being new to the area, many people have told me "good luck" if you ever needed to go to the hospital. Lack of specialists was the major reason why. Diagnosis is hard to get here. Most of the time, one has to go to Denver to get a real diagnosis.*
- *What I "hear" on the street and personal experience.*
- *On some items and care, GVH does a world class job, on other items, the treatment is borderline malpractice. Consistency in treatment must improve drastically.*
- *The folks I speak with think highly of our facility, staff and services.*
- *i believe people are surprised - locals and visitors - that we have a hospital as large, sophisticated and*

professional as we do, for being such a small community.

- *I've never heard a single complaint about care at GVH - only good comments.*
- *Good word of mouth & GVH has won awards*

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

- *I feel that there is a need to look at increasing insurance costs and the effects of more and more private insurance companies pulling out of Colorado. This is creating hardship for many members of our community.*
- *Cost- Ideally GVH should be the leader in trying to direct all efforts to improved care in this valley- working toward a common goal- Thus should not include alienating private entities- i.e. Physicians, clinics, etc. that choose to remain private*
- *think about what is practical and needed by the majority in the community. if there isn't a big enough need, it will not work financially. also think about is it necessary... vs. just convenient.*
- *Keep up the good work*
- *Thank you for the opportunity to provide input. I do truly appreciate the medical/health care we have in the Gunnison Valley.*
- *Mental Health should be the top priority - quality and ease of access (including distance sessions via video conferencing to save on travel times - this should be a norm that is pursued heavily). Thank you!*
- *The hospital should take advantage of opportunities to expand health services to the whole community.....women's services would very a great place to make an impact!*
- *It is important to begin thinking of the regional future of the GVH, as costs rise and the area around us continues to grow in population, how is GVH positioned to be a leader and major provider not only in the currently recognized area of service but how will it be a major care provider to an ever growing population over a wider area.*
- *I believe in this quest for the high tech, up to date equipment, physicians and procedures we must also keep rural Colorado rural. By that I mean we need to have more face to face encounters with patients even in bad situations.We must keep our health care personal with understanding and compassion for not only the patient but the employees who are the front line of health care.*
- *It was difficult to complete Question 11 since there was no identification whether 1 or 14 represented the highest*
- *Teen depression, drug addiction in young adults.*
- *I think I've said enough.*
- *do fewer things well as opposed to to doing more things okay. people will travel for quality care*
- *EMS should always be a focus. Keeping them up to date and well funded. Also missed Oncology in your list of specialties.*
- *I have nothing else to share at this time*

- *no*
- *no*
- *The challenge is that Gunnison is in the "middle of nowhere". Having a strong healthcare is needed because of that reason, but getting specialists to want to live here seems tough. GVH does the best it can with that challenge, but the expectation is that one has to go elsewhere for any major healthcare.*
- *Please keep up the great work as Gunnison Valley Health continues to improve annually. Thank you.*
- *Higher pay for nurses with better benefits. Less money going towards advertisement. When money is raised for a department it should be utilized for that particular department, i.e. The OB raised money for a remodel and it still hasn't been done... There should be better psychological support for the employees and staff supervision.*
- *Strategic partnerships with local charitable organizations (TETWP, GVF) need to be utilized to maximize the benefits and improvements to the health system and increasing patient care and satisfaction.*
- *We need a public transportation/cab service desperately*
- *I'd repeat the comment about continuum of care. And, I think more emphasis on the end of life -- and the community's perception -- is key to healthier seniors.*
- *Lifetime care of individuals with disabilities.*

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

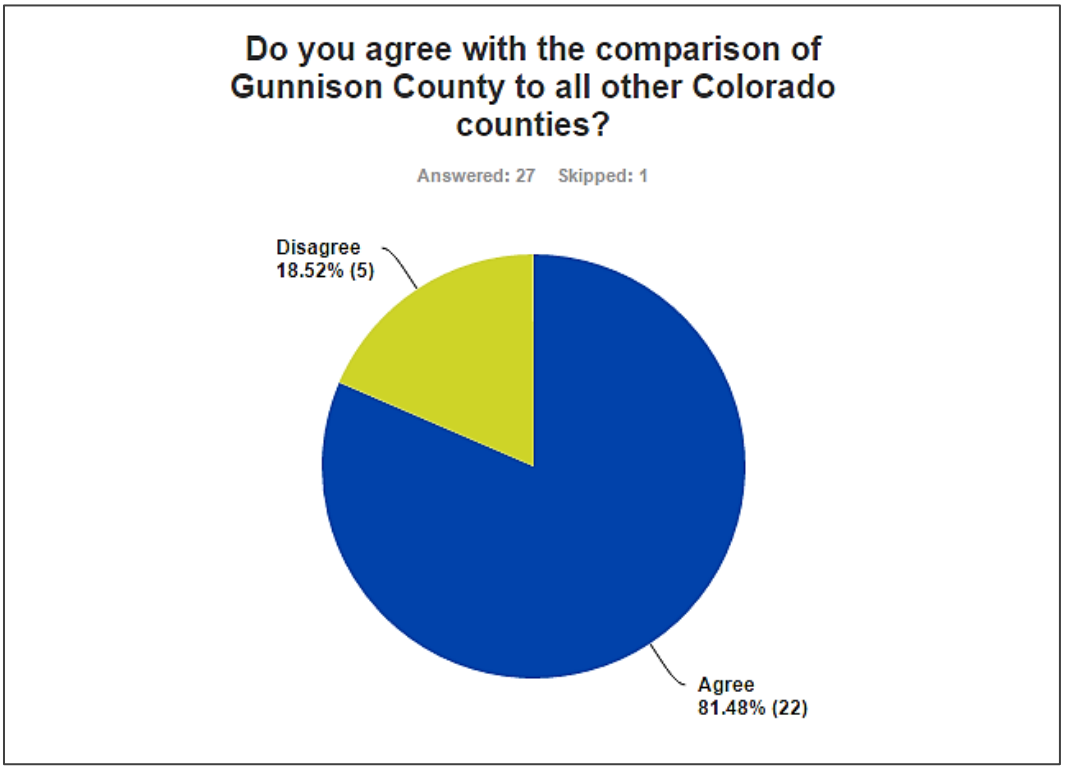
Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health – 2014 Significant Need	230	13	16.42%	16.42%	Significant Needs
Physicians – 2014 Significant Need	223	10	15.92%	32.33%	
Cancer	154	9	10.99%	43.33%	
Suicide	140	11	9.99%	53.32%	
Alcohol	95	9	6.78%	60.10%	Other Identified Needs
Specialists – 2014 Significant Need	92	9	6.57%	66.67%	
Affordability/Accessibility	78	7	5.57%	72.23%	
Maternal/Infant Measures	54	7	3.85%	76.09%	
Need Written In - Care Center for Citizens in the last few years of life	50	1	3.57%	79.66%	
Continuum of Care – 2014 Significant Need	49	7	3.50%	83.15%	
Extended Hours – 2014 Significant Need	44	6	3.14%	86.30%	
Diabetes	36	5	2.57%	88.87%	
Obesity	31	5	2.21%	91.08%	
Priority Populations – 2014 Significant Need	26	5	1.86%	92.93%	
Need Written In - Certified ER Physicians	20	1	1.43%	94.36%	
Alzheimer's	17	4	1.21%	95.57%	
Heart Disease	15	4	1.07%	96.65%	
Need Written In - Drug Abuse	10	2	0.71%	97.36%	
Lung Disease	9	4	0.64%	98.00%	
Kidney Disease	8	4	0.57%	98.57%	
Flu/Pneumonia	8	3	0.57%	99.14%	
Stroke	7	3	0.50%	99.64%	
Accidents	5	3	0.36%	100.00%	
Total	1,401		100.00%		

Individuals Participating as Local Expert Advisors

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	0	14	14
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	6	10	16
3) Priority Populations	6	10	16
4) Representative/Member of Chronic Disease Group or Organization	1	13	14
5) Represents the Broad Interest of the Community	24	1	25
Other			3
Answered Question			28
Skipped Question			0

Advice Received from Local Expert Advisors

Question: Do you agree with the comparison of Gunnison County to all other Colorado counties?

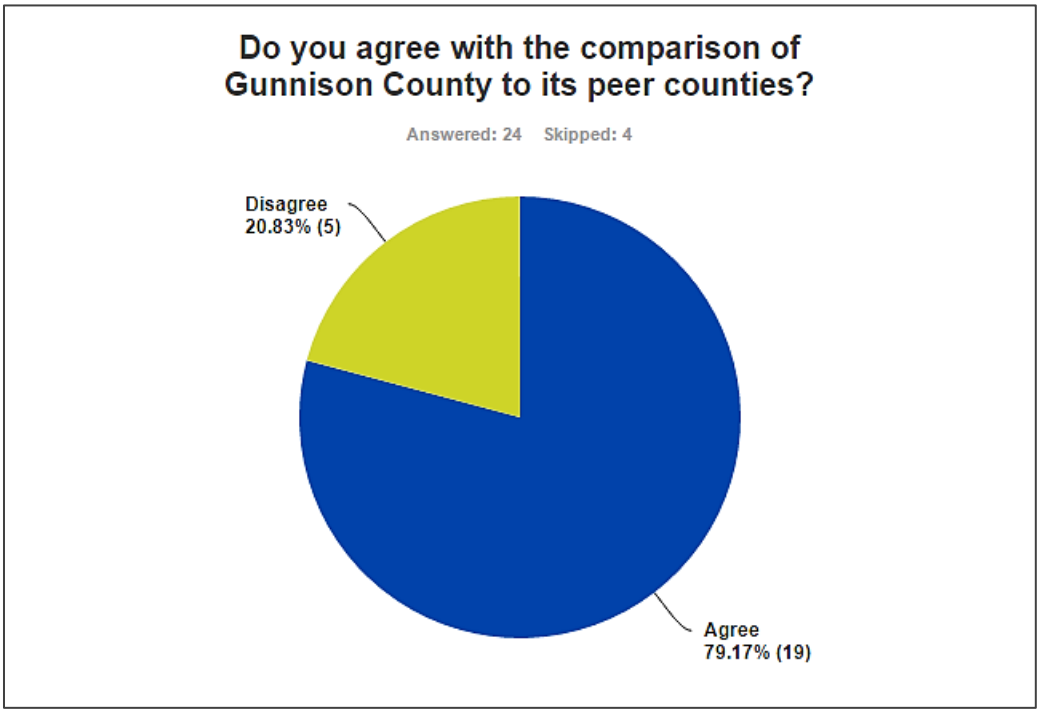


Comments:

- *What does 9 out of 60 in social and economic factors means - we are above average in Col for Poverty*
- *I would question the diabetic monitoring numbers- Does this reflect fewer diabetic patients ? or less monitoring?*
- *The rate of alcohol consumption is due to a young population in part and of course tied to jobs as well. It is more than likely a direct contributor to the mental health issues we face.*
- *Mental health providers seemed to be lacking however, general health care seems sufficient in general, with local specialist needed.*
- *I have limited knowledge on the clinical care piece*
- *The one area provided above that I'm unsure about is ratio of population to dentist; is it possible that we have sufficient # of dentists, but problems in access/cost/specialty? I just don't have a good sense of this particular information.*
- *i think some of the data are reflective - children in poverty, for example. i think other data are misleading - 'preventable hospital stays,' for example. 'healthy outcomes.' those seem very difficult to define, and therefore the criteria used may or may not be relevant, etc.*
- *One of the reasons for above average preventable hospital stays in Gunnison Cty may be related to the unavailability of PCP providers/urgent care facilities. Many times as a home health provider, we need our patient*

to be seen that day by their PCP, however there is no availability in their schedules so therefore the patient chooses to go to the ED. Our county also has a below the average amount of Diabetic patients to be monitored in our community

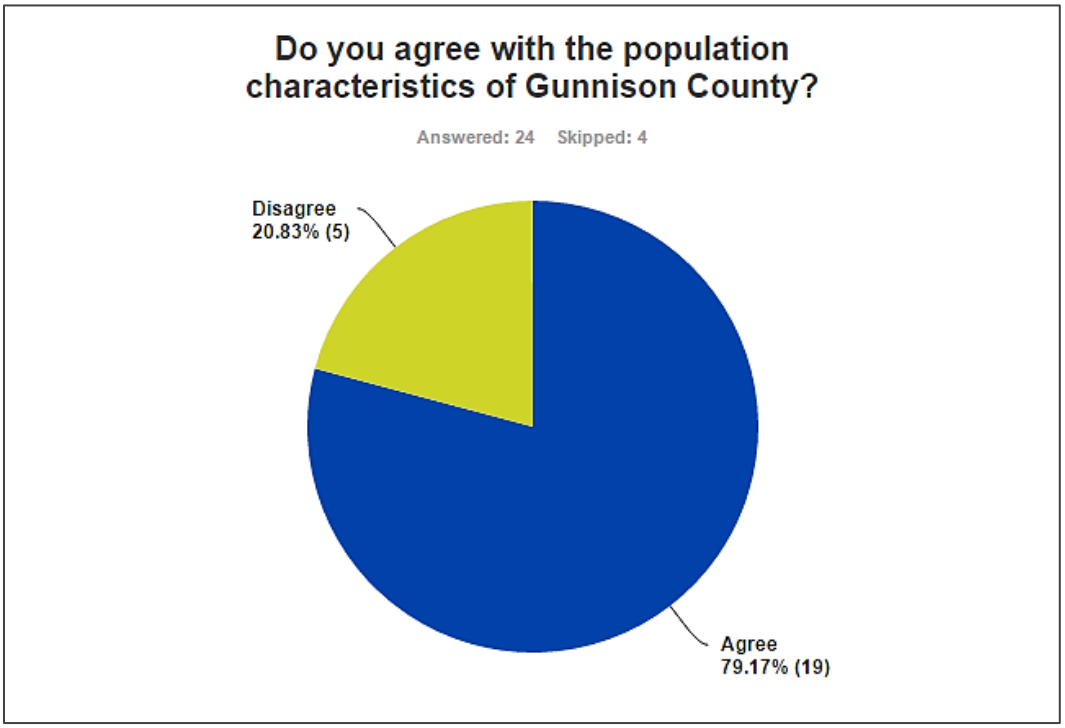
Question: Do you agree with the comparison of Gunnison County to its peer counties?



Comments:

- *I don't believe " living next to a highway" relates to a poor environment in Gunnison County. I would characterize Gunnison County as having high rates of drug, alcohol and mental health issues (poor health behaviors)*
- *I question the living near a highway result.Perhaps the definition of a highway is different... but I take this as being rural and this data doesn't seem to reflect the rural nature of Gunnison County. perhaps I'm misinterpreting though.*
- *Living near highways. Definition of "near" ? What is the impact of living "near" a highway in Gunnison? Certainly not air pollution! Noise pollution?*
- *same rationale as previous answer. we fare "worse" when it comes to "living near highways?" i think 90% of the population that is stuck in a freeway commute every day might disagree.*
- *Some of the above data is unclear. However, Gunnison Cty is very expensive, from food, to gasoline to housing. Job market is scarce, many times only offering entry level service positions that do not pay a living wage. Therefore, a higher then average poverty %. We are very rural, causing a natural unavailability to PCP care.*

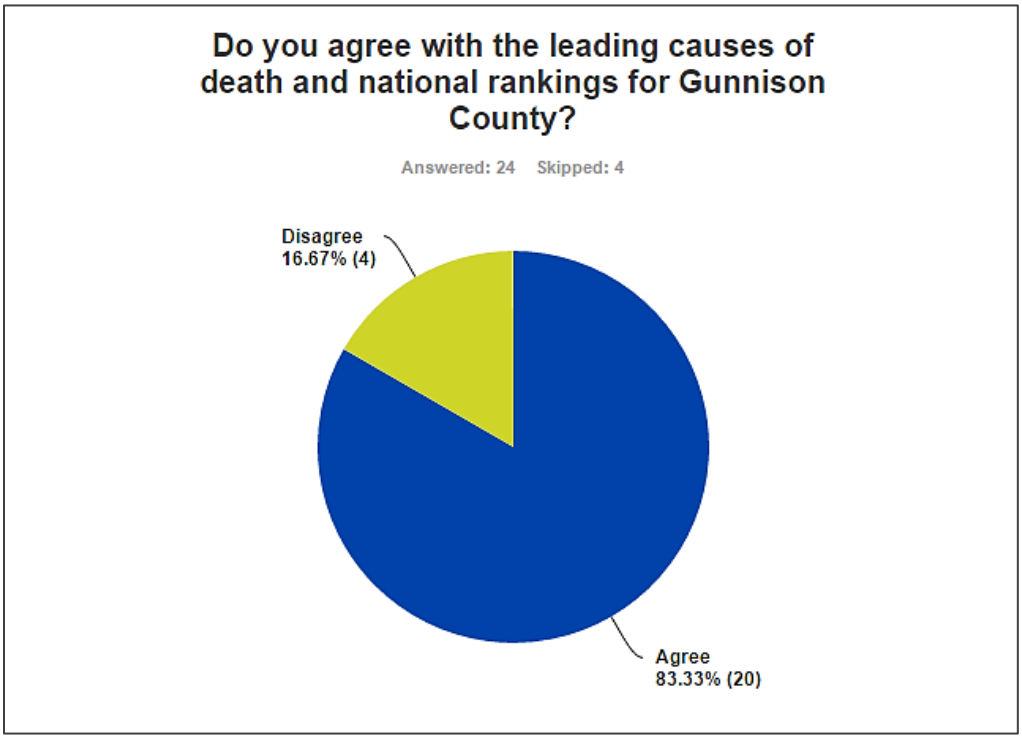
Question: Do you agree with the population characteristics of Gunnison County?



Comments:

- *Prostate screening is no longer recommended for men of any age.-We do not screen routinely for this. I believe the most recent ED visit statistics for visits so far in 2016 have increased well above 8.6% The above alcohol stats don't seem to match ???*
- *Drug and alcohol use seems to be higher*
- *BMI for Gunnison is not above the average. Unless you are only hanging out in front of mcdonalds. Doesn't make when you compare with the Cholesterol screening being 9.2 below average. Lots of healthy fat people?? ETOH consumed is below ave but few pages ago states "Excessive Drinking is above the CO average and the US best rate" ?? Contradictory stats??*
- *Alcohol consumption is incorrect.*
- *The BMI ranking seems high; I would have thought routine cholesterol and prostate screening would not have been below average given the health fair. Drinks/session and ER use seem accurate.*
- *these statistics appear more clearly defined / straightforward.*

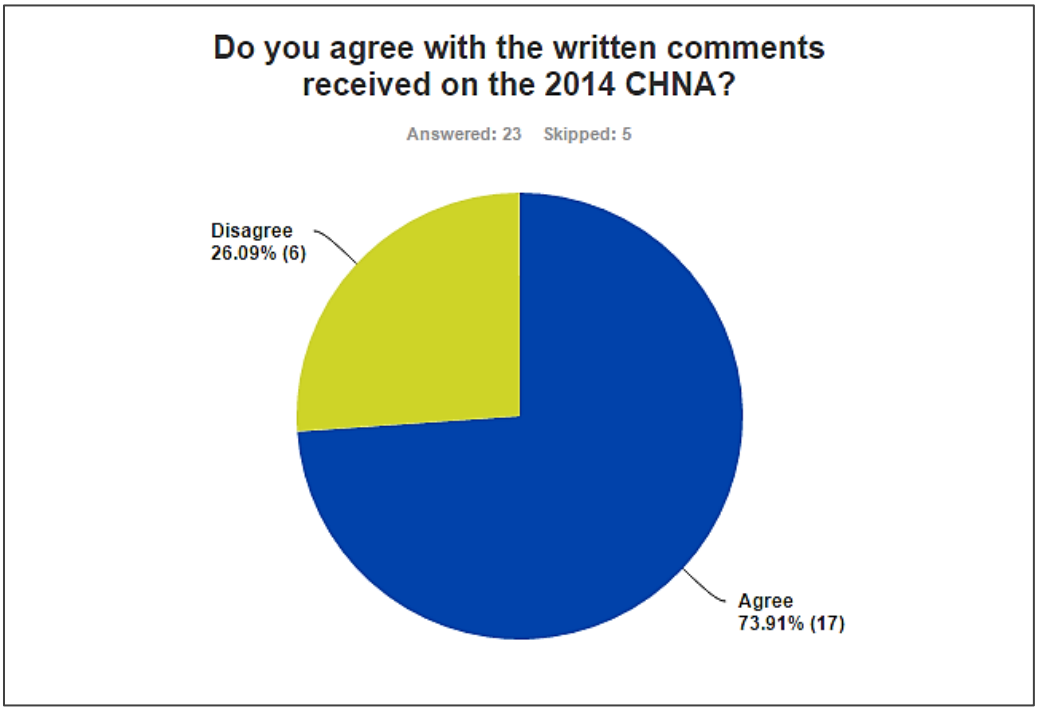
Question: Do you agree with the leading causes of death and national rankings for Gunnison County?



Comments:

- *Yes, unfortunately we have a drinking problem in this county. clearly.*
- *Again I question the statistical data. Maybe issues with the methods of data collection.*
- *All of these data seem old and while some of the trends may be the same with more recent data, I'm reluctant to place much confidence in some of this. In particular, I think the obesity data (given the youth of our population) are likely incorrect, live expectancy may have increased, and the drinking data questionable (although tax income from alcohol is high in the county).*
- *ditto from last answer*
- *I feel it is interesting that obesity has increased and yet, when you walk around the community it feels like a less than average obesity rate. As far as binge drinking, we have a high population of college students away from their homes probably for the first time that might contribute to this number*
- *The male and female life expectancy numbers and statistics are misleading. Because of the altitude and climate, many older residents leave the valley to retire or live other places later in life. Only the exceptionally healthy older individuals stay here through death and this fact skews the numbers.*

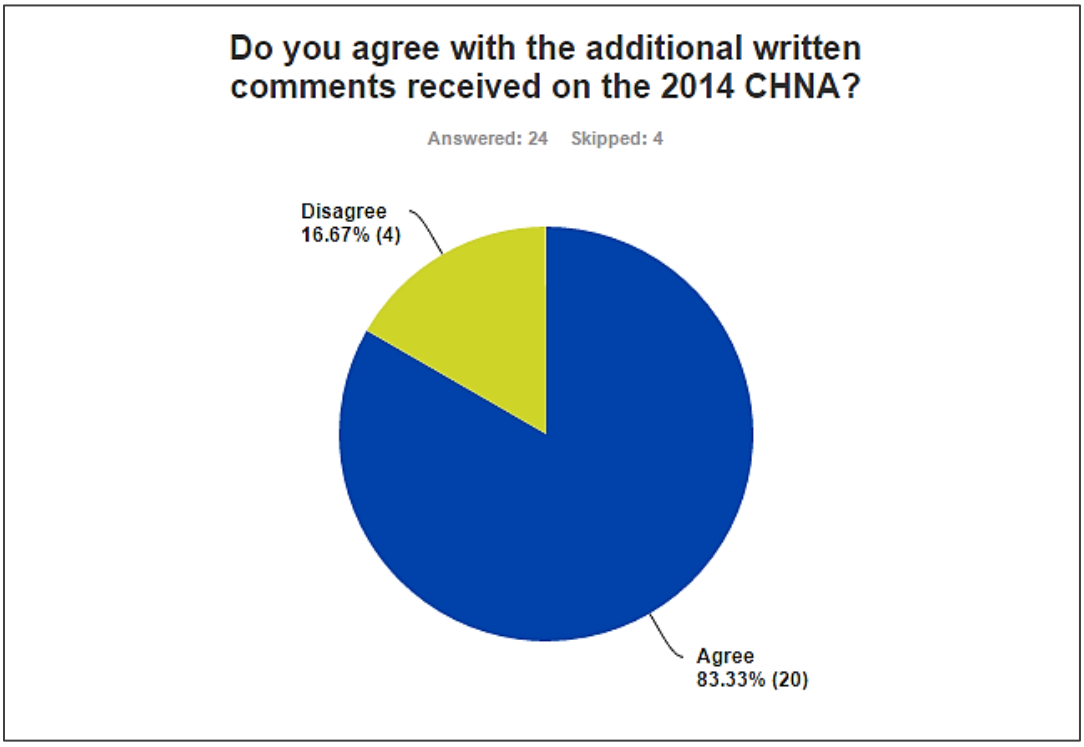
Question: Do you agree with the written comments received on the 2014 CHNA?



Comments:

- *??pediatric forensic physician????????? Enhanced computer connectivity between the Hospital and private clinics still needs improvement . As a private clinic- we cannot attract qualified Primary care physicians due to inability to pay competitive salaries!*
- *The priority.....mental health....physicians.....specialist*
- *RT therapy for cancer treatment is not financially viable. There is not enough volume to support the personnel, equipment and structure needed.*
- *Some of these are outdated; e.g., breast care and some of the concern about urgent RX given recent improvements. We do have some telehealth services now. The issue of sufficient # of primary care physicians has grown worse with no resolution in sight. There is more attention to behavioral health now which may address some of the items above.*
- *this strikes me as a "wish list." nobody ever gets everything they want on their wish list. prioritization and reality/sustainability are the key determinants.*

Question: Do you agree with the additional written comments received on the 2014 CHNA?



Comments:

- *Does priority populations include Uninsured?? All of the above still need attention*
- *Specialists are needed, however, having the volume of patients to make it financially viable is different. There is not enough need in the valley to accommodate all needs*
- *There have been improvements in the number of specialists since the last survey and we have more extended hours than at that time. Continuum of care is not as much of an issue as earlier and adding behavioral health care may begin to help address the mental health issue. We have not and need to focus more on priority populations*
- *again, this strikes me as a bit of a wish list. but i don't think many would argue that "physicians" would certainly rank as the highest priority of any community's health care system. specialists are great, but ... you know, we just can't have it all.*
- *I fully believe that physicians, mental health and urgent care should be priorities*

Appendix C – National Healthcare Quality and Disparities Report[14]

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

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

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

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

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

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

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[15] consistent with these trends.

[14] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html
[15] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.

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

Trends

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

Disparities

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

Trends

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

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

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[16]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[17]

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

Disparities

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

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

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

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

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

Disparity Trends

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

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

Trends

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

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

Trends

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

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

Achieved Success

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

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

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

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

Improving Quickly

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

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

time of surgery

Worsening

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

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

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

Disparities

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

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

Disparity Trends

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

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

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

Disparities Trends

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

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

Geographic Disparities

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

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

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

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[18]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

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

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

Trends

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

Disparities

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

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

Disparities Trends

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

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

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

Trends

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

Disparities

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

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

Trends

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

Disparities

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

Disparities Trends

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

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

Trends

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

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

Disparities

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

Disparities Trends

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

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

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

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[19]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

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

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

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

CONCLUSION

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

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