Pampa Regional Medical Center

CPAs / ADVISORS

blue

December2018

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LETTERFROM THECEO

To Our Community Members:

Pampa Regional Medical Center is committed to providing high quality healthcare and exemplary customer services. Our goal with the attached Community Health Needs Assessment (CHNA) is to better understand the range of issues affecting community health needs including local healthcare services provided and any gaps that may exist in meeting those needs. Moreover, through this assessment process, report and subsequent actions, we hope to strengthen the understanding and working relationships among and between the hospital and the other various health care, social service, and community providers that all play a role in shaping the health status of our community. In the new era of population health management, it will be imperative that various providers and organizations work together in a collaborative fashion to better serve patients and provide care and service that is more focused on prevention, health promotion and wellness than ever.

The significance of better understanding our community's needs was highlighted with the Patient Protection and Affordable Care Act requirements passed on March 23, 2010. New requirements for tax-exempt hospitals were added to the Internal Revenue Code mandating hospitals to conduct a community health needs assessment every three years and to adopt an implementation strategy to address applicable needs detected during the assessment process.

During 2018, a CHNA was conducted by Pampa Regional Medical Center for the Gray and contiguous counties in the panhandle region of Texas. Pampa Regional Medical Center will be developing an implementation strategy for the applicable needs addressed and the results will be summarized in a separate report approved by the Pampa Regional Medical Center Governing Board.

We are pleased to present this comprehensive CHNA which represents a comprehensive assessment of health care needs in our community. We look forward to working with you and others in the community to optimize community health and continue meeting the Pampa Regional Medical Center mission through serving the healthcare needs, and improving the health, of the people in our community.

Edwin Leon
Chief Executive Officer

December 2018

PAMPA REGIONAL MEDICAL CENTER'S MISSION, VISION, AND VALUES

MISSION

"To deliver compassionate, quality care to patients and better healthcare to communities."

VISION

Pampa Regional Medical Center is consistently at the forefront of evolving national healthcare reform. Our organization provides an innovative and integrated healthcare delivery system. We remain ever cognizant of our patients' needs and desires for high quality affordable healthcare.

VALUES

Quality

We are committed to always providing exceptional care and performance.

Compassion

We deliver patient-centered healthcare with compassion, dignity and respect for every patient and their family.

Community

We are honored to be trusted partners who serve, give back and grow with our communities.

Physician Led

We are a uniquely physician-founded and physician-led organization that allows doctors and clinicians to direct healthcare at every level.

EXECUTIVE SUMMARY

On behalf of Pampa Regional Medical Center (the "Hospital"), a community health needs assessment (CHNA) was conducted in 2018 primarily to identify the major health needs, both met and unmet, within the surrounding community. The community's geographic area is comprised of Gray County and the following ten counties: Armstrong, Carson, Collingsworth, Donley, Hemphill, Hutchinson, Lipscomb, Ochiltree, Roberts and Wheeler. The primary objectives of the CHNA were to: 1) identify major health needs within the community in an effort to improve the health of the area's residents and facilitate collaboration among local healthcare providers, and 2) satisfy the federal guidelines within the Patient Protection and Affordable Care Act (PPACA) of 2010.

Data for this CHNA was collected from primary and secondary sources to identify key findings and gaps that may exist between health needs and services provided within the community. Three methods of collection for primary data were used: 1) surveys 2) focus groups and 3) personal interviews. Several secondary data sources were reviewed and analyzed to identify key findings with strategic implications and for benchmarking of the Hospital's service area.

Finally, it is important to note that our data collection did not include a statistically representative sample of the community, in that members of disadvantaged populations were less likely to participate via a web-based survey. These individuals may include immigrants, the homeless, as well as individuals with low education and income levels. Focus groups were conducted with community leaders and others who work directly with members of disadvantaged populations in order to consider broad interests of the community served.

Highlighted, subsequently, are important findings identified through the data collection, analysis and assessment process:

- Increasing primary care physicians,
- Increasing educational awareness programs,
- Increasing the number of mental healthcare providers and professionals, especially focusing on adolescents,
- Increasing substance abuse prevention,
- Expanding transportation services to/from treatment services, and
- Increasing access to pain management services for treatment.

Pampa Regional Medical Center has identified the above needs for its community and prioritized them based on the order above. The section later in this report titled "SURVEY RESULTS FROM FOCUS GROUP AND PERSONAL INTERVIEWS" will go through all of the health needs identified during the CHNA process.

ORGANIZATIONAL BACKGROUND

Pampa Regional Medical Center

Located in Pampa, Texas, a city of approximately 18,034 residents, Pampa Regional Medical Center (the Hospital) provides inpatient, outpatient, in-home and emergency care to area residents assuring patients of a continuity of quality care all within a few minutes drive from home. The Hospital is dedicated to serving the healthcare needs, and improving the health of the people in the community. The Hospital is not-for-profit and accepts all patients regardless of their ability to pay.

History

Founded in 1950 when Gray County formed a hospital district. In 1979, Hospital Corporation of America (HCA) purchased the Hospital and built a new 120-bed, for-profit prototype HCA facility. During its 68 year history, the Hospital has been sold and purchased by several different owners; however, the Hospital has continuously served the people of the Texas panhandle since its original opening by HCA. In January 2012, the Hospital was purchased by Prime Healthcare and became a non-profit in January 2014. Since the purchase of the Hospital, Prime Healthcare has invested over $30 million dollars into the facility. Altogether, there are 15 not-for-profit hospitals operated under the Prime Healthcare Foundation, with another 33 for-profit hospitals in the Prime Healthcare system.

Prime Healthcare is an award-winning hospital management company operating 38 acute care hospitals in eleven states. It is one of the nation's leading healthcare service providers with more than 40,000 employees and staff dedicated to providing the highest quality healthcare and contributing to the communities they serve. Founded in 2001, Prime Healthcare, based in Ontario, California, is committed to preserving access to healthcare and turning hospitals into thriving, community assets.

Today, the Hospital is a 115-bed, not-for-profit hospital with a service area consisting of eleven counties with a population of approximately 83,700 people in the Texas Panhandle. The Hospital is one of the largest employers in the community employing more than 265 full-time and part-time staff members with an annual payroll expense of approximately thirteen million dollars. The Hospital is accredited by the Joint Commission on Accreditation of Healthcare Facilities (JCAHO), and is governed by six trustees. Four of the Hospital Governing Board members are physicians.

The Hospital has enjoyed a growing relationship with Texas Tech University including assisting in the training of family practice residents from the Texas Tech University Hospital family practice residency program. The Hospital implemented and operates an Electronic Medical Record (EMR) which positively impacts care delivery by allowing doctors and other providers to appropriately access patient health information in multiple settings.

In 2017, the Hospital had total gross patient revenue of almost $192 million with 4,991 discharges and 17,666 patient days equating to an average daily inpatient census of 20.6 patients per day. The Hospital offers a number of medical and surgical specialties such as diagnostic cardiac catheterization, lithotripsy, geriatric psychiatry, orthopedics and joint replacement, neurology and urology. Given the number of specialty services provided, the Hospital's overall case mix index was 1.54 representing a slightly higher level of patient acuity than many other hospitals of similar size.

In partnership with more than 30 area physicians, the Hospital provides a full range of medical services to meet the healthcare needs of the community it proudly serves. Services offered by the Hospital include:

- Dietary
  - Nutritional Consults and Counseling
- Radiology & Diagnostic Services
  - CT and Digital Imaging
  - Fluoroscopy
  - Mammography
  - MRI
  - Nuclear Medicine
  - Ultrasound
  - Electrocardiography
  - Laboratory Services
  - Stress Test
- Medical Services
  - Cardiac/Medical ICU
  - Cardiology/Pacemaker
  - Emergency Department
  - Family Medicine
  - Hematology
  - Internal Medicine
  - Neurology
  - Pampa Medical Clinic - Outpatient Department
  - Pediatrics
  - Pulmonary Medicine
  - Urology
- Specialty Services
  - Geriatric Psychiatry , Golden Phoenix Center
  - Music Therapy
  - Occupational Therapy
  - Pastoral Care
  - Physical Therapy
  - Respiratory Therapy
  - Social Services
  - Speech Therapy
- Surgical Services
  - Cardiac Cath Lab
  - Colon/Rectal Endoscopy/Special Procedures
  - Endoscopy
  - Inpatient Surgery
  - Laparoscopic Surgery
  - Lithotripsy
  - Major Joint
  - Orthopedics
  - Outpatient Surgery
  - Urology
- Women's Health Services
  - Gynecology
  - Nursery
  - OB-Birthing/LDR
  - Women's Services

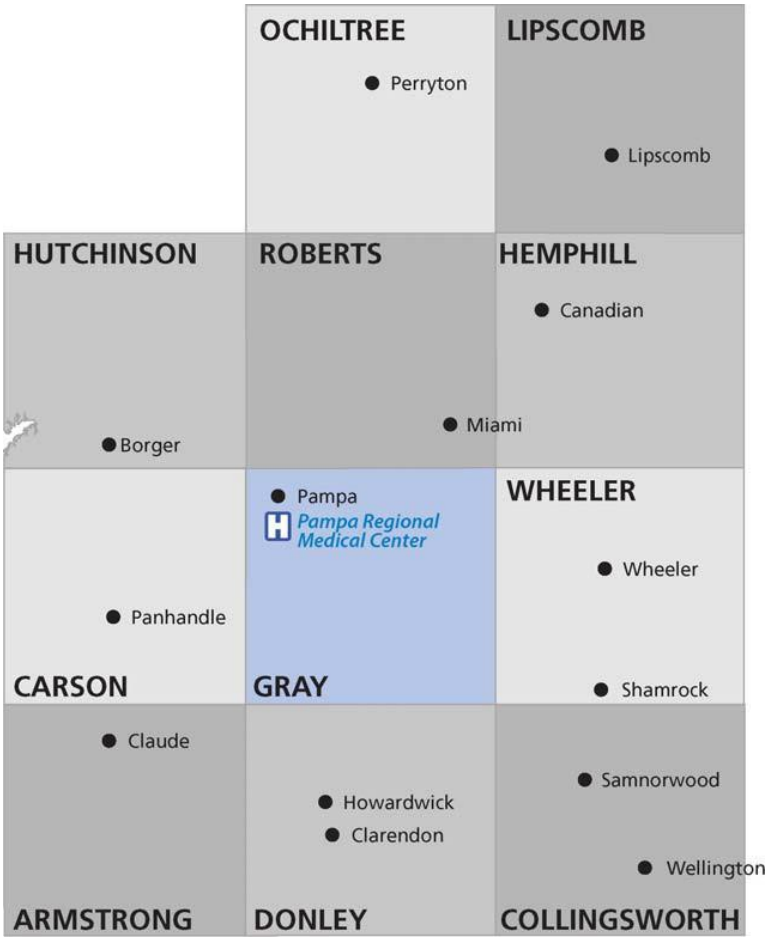
SERVICE AREA

SERVICE AREA AND COMMUNITY OF THE HOSPITAL

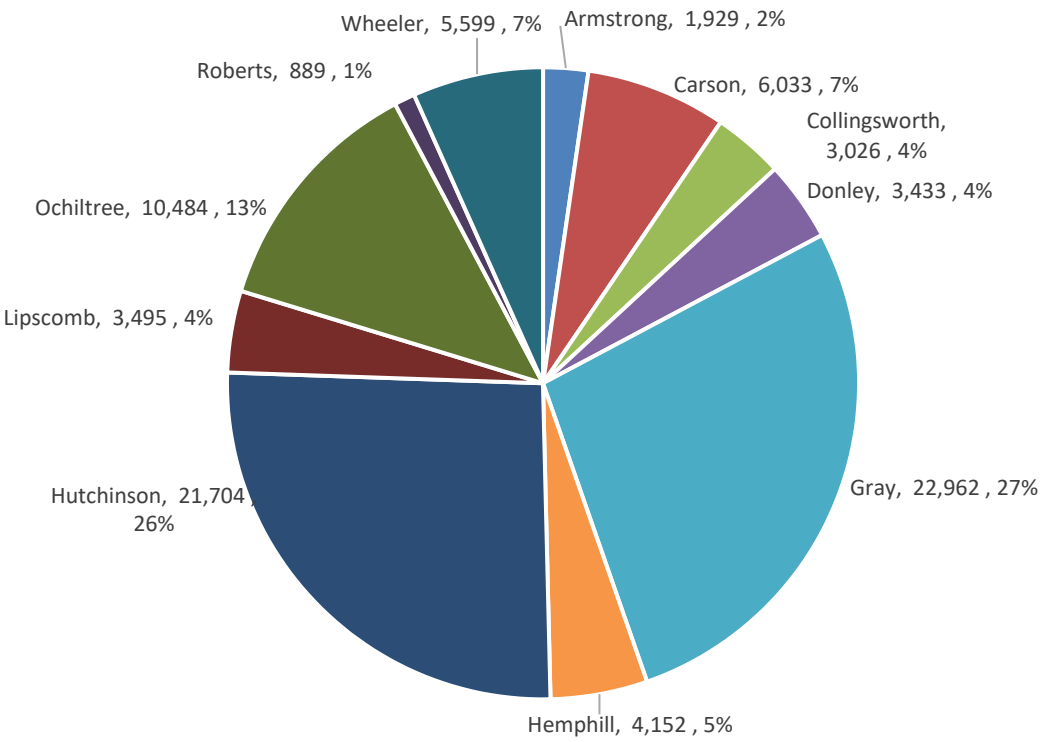
The CHNA was conducted by the Hospital during 2018 on behalf of the approximately 83,706 (2017 US Census) residents of Armstrong, Carson, Collingsworth, Donley, Gray, Hemphill, Hutchinson, Lipscomb, Ochiltree, Roberts and Wheeler counties located in the panhandle area of Texas.

The Hospital's service area includes a rural area which covers roughly 10,083 square miles, with the local economy and surrounding areas focused on healthcare, agriculture, oil and gas, tourism, and retail activities. Gray County and its population of 22,962 represents approximately 27% of the total service area population. Median age in the service area is 38.3 years. The median age for the state of Texas is 34.3 years. Persons from age 18 to 64 represent the largest population range (57.94%) for the service area. The youngest age range is 0 to 4 years, and this range comprised 7.08% of the service area. The defined community served within this report did not exclude the medically underserved, low-income, or minority populations who live in the below geographic areas. In addition, the report did not exclude patients based on whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy.

SERVICE AREA MAP



SERVICE AREA POPULATION BREAKDOWN BY COUNTY



CONDUCTING THE ASSESSMENT

OVERVIEW

The Hospital engaged Blue & Co., LLC (Blue) to assist the Hospital in conducting a CHNA and analyzing the data for the CHNA requirements set forth in section 9007 of the Patient Protection and Affordable Care Act (PPACA) of 2010. Blue is a Certified Public Accounting firm that provides, among other services, tax consulting and compliance to the healthcare industry. The Hospital provided all of the financial support for the assessment process.

The CHNA requirements were effective starting taxable years beginning after March 23, 2002. On December 29, 2014, the Treasury Department and the IRS published final regulations for section 501(r) located in 26 CFR part 1, 53, and 602. The Hospital is licensed by the Texas Department of State Health Services as a hospital facility and is required to be in compliance with 501(r)(3)(B).

The assessment was developed to identify the significant health needs in the community and gaps that may exist in services provided. It was also developed to provide the community with information to assess essential healthcare, preventive care, health education, and treatment services. This endeavor represents the Hospital's efforts to share information that can lead to improved healthcare and quality of care available to the community, while reinforcing and augmenting the existing infrastructure of services and providers.

COMMUNITY HEALTH NEEDS ASSESSMENT GOALS

The assessment had several goals which included identification and documentation of:

- Community health needs,
- Quantitative analysis of needed physicians by specialty in the service area,
- Health services offered in the Hospital's service area,
- Significant gaps in health needs and services offered, and
- Barriers to meeting any needs that may exist.

Other goals of the assessment were:

- Strengthen relationships with local community leaders, healthcare leaders and providers, other health service organizations, and the community at large, and
- Provide quantitative and qualitative data to help guide future strategic, policy, business and clinical programming decisions.

INFORMATION GAPS

The data collection process did not include a statistically representative sample of the community, in that members of disadvantaged populations were less likely to participate via a web-based survey. Blue was able to speak with community leaders and others who work directly with members of disadvantaged populations. In addition, participant responses provided can contain biases due to individuals' views. Finally, a challenge encountered was the inconsistency in years available for statistical data collection. The most current statistical data has been used where available and the years available have been documented throughout the report.

The service area includes Roberts County; however, the health ranking data for this county was not available due to the population having too few people living within the county's borders. Therefore, this county has been excluded from the tables, charts and graphs related to the County Health Ranking data and analysis within the Secondary Source Health Data Synopsis.

PROCESS &METHODOLOGY

Documenting the healthcare needs of a community allows healthcare organizations to design and implement cost-effective strategies that improve the health of the population served. A comprehensive data-focused assessment process can uncover key health needs and concerns related to education, prevention, detection, diagnosis, service delivery and treatment. Blue used an assessment process focused on collection of primary and secondary data sources to identify key areas of concern.

Blue conducted focus group conversations with community leaders as well as medical, social services, clinical and professional staff. Blue also obtained input from local physicians, hospital employees, public health experts, and community leaders and officials. In addition, written and on-line surveys were used to solicit feedback from various members of the community. The community outreach data collection strategy was targeted at engaging a cross-section of residents from the community as discussed above.

Once data had been collected and analyzed, meetings with hospital leadership were held to discuss key findings as well as refine and prioritize the comprehensive list of community needs, services and potential gaps.

PRIMARY DATA COLLECTION METHODS

The primary data was collected, analyzed, and presented with the assistance of Blue. The Hospital contacted and arranged focus groups and interviews with local officials, public health experts, physicians, and other key participants which were all facilitated by Blue personnel. Additionally, surveys were provided during the focus groups and to the general community. No written comments were received on Pampa's 2015 Community Health Needs Assessment and Implementation Strategy.

Three methods of collection for primary data were used: 1) surveys, 2) focus groups, and 3) personal interviews.

Surveys

A survey was developed by Blue and used as a method to solicit perceptions, insights and general understanding from community members and special expertise regarding health needs. The survey "Community Input 2018" (see Attachment D) was made available on social media of Pampa Regional Medical Center. A total of 19 surveys were completed.

The survey comprised ten questions in total. Community members were asked to identify the top three most significant health needs in the community. They were asked about their perception on the availability, health status, provider coordination, and barriers that exist. Additionally, the participants were given the opportunity to write in issues that were not listed. The results of the survey can be found in the Key Findings section of the report.

Focus Groups and Personal Interviews

Focus groups and personal interviews were conducted by Blue with a total of 9 participants during December 2018, with each session lasting approximately 45 minutes each. These sessions were conducted with members from the communities being served by the Hospital including community leaders, health experts, public officials, physicians, hospital employees, and other health professionals and providers including those associated with the Hospital. For example, the Sheriff of Gray County participated in a one on one interview for their community perspective and input. The primary objective was to solicit perceptions regarding health needs and services offered in the community, along with any opportunities or barriers that may exist to satisfy needs. The results of the survey can be found in the Key Findings section of the report.

SECONDARY DATA SOURCES

Blue reviewed secondary statistical data sources including: Deloitte 2018 Survey of Health Care Consumers in the United States to identify health factors with strategic implications. The health factors identified w e r e supported with information from additional sources including US Census Quick Facts, County Health Rankings, and the Texas State Department of Health. In addition, hospital-specific data provided by the Hospital was reviewed. (See Attachment E for a complete list of citations.)

KEY FINDINGS

AREAS OF CONCERN

The following represents key findings generated from the data collection and analysis process:

Financial Resources and Funding

Financial resources and funding for healthcare services are limited, thus preventing providers from meeting identified unmet health needs in the community.

- There is growing concern about the increasingly limited funding and financial resources available for healthcare services from both public and private sources.

Professional Shortages

Shortage of critical healthcare workforce decreases needed access to healthcare services.

- There is a shortage of critical healthcare manpower in a number of areas including physicians in specialties such as family practice, pediatrics, ophthalmology, emergency room, anesthesiology, radiology and pathology in the community.
- There is also a significant need for mental health and substance abuse providers including psychiatrists, therapists, and counselors in the community.

Limited Access to Healthcare Services

Access to healthcare services is limited, particularly for various at-risk populations.

- Transportation services are limited, particularly in more of the outlying, rural areas, which in turn limits access to needed healthcare services for at-risk populations.
- Access to mental health and substance abuse services for at-risk populations was noted as a particular problem.

Limited Access to Mental Healthcare and Addiction Services

Access to mental health services is limited, particularly for various at-risk populations; therefore, the offering of new or expanded mental health services is needed to meet these needs.

- Availability and access to mental health, alcohol and substance abuse providers and services are severely limited.
- Improvement is needed with interfacing, coordinating and communication among healthcare and social service providers, particularly those impacting low income and other at-risk populations.

- Although services are being provided for at-risk populations, these services are limited. This is especially true as it relates to services for the seriously mentally ill, detox, adult alcohol and drug abuse, co-occurring disorders, child and adolescent psychiatric, and child and adolescent alcohol and drug abuse populations.
- Determining the entry-point into the mental healthcare system can be confusing for potential patients, particularly for low income/at-risk populations. The Hospital emergency department is viewed as a less-than-ideal entry point.
- As a point-of-entry during mental health crises, the Hospital emergency room has a limited amount of specialized resources.

Community Perception of Accessibility of Health Education, Promotion, and Preventive Services

There is a perception the community suffers from a shortage of education, promotion, and preventive services.

- There is a need for a resource board or shared services system listing to provide information about how much services cost and what is available for no cost to low-income and at-risk populations.
- There is a need for additional and more effective health education, health promotion and prevention services specifically targeted at low-income and at-risk populations in some regions of the service area.
- Topics for education, promotion, and preventive services needed included: diabetes, smoking, nutrition, mental health and women's health.
- There is a need for education on health risks of smoking in Gray County and throughout the service area including targeted education of school age children and youth.
- There is a need for increased programs for smoking cessation programing and campaigning in Gray County and throughout the service area.

COMMUNITY SURVEY RESULTS

The following represent the survey responses obtained during the data collection and analysis process:

Top Prevention, Treatment and Awareness Needs in the Community

Participants were instructed to provide the top three most significant health care prevention, treatment, and awareness needs in the community. In the table below, each need that was provided as an option to select is listed on the left. On the right, is the ranking of each need from most important to least important, based on all responses received from the surveys. The top three ranked responses are considered primary needs with the remainder of the needs considered secondary.

NEEDS IN THE COMMUNITY	
Primary, Prevention, Treatment, and Awareness Needs	Ranking of Responses From Listed Needs
Affordable health insurance	1
Primary care provider availability	2
Addiction care service availability	3
Secondary Prevention, Treatment, and Awareness Needs	
Affordable health care prices	4
Specialty care provider availability	5
Lack of community interest	6
Financial issues	7
Mental health services availability	8
Healthy food availability	9
Community events lacking	10
Other	11
Places to exercise lacking	12
Health promotions services lacking	13
General health education lacking	14
Mental health education lacking	15
Lifestyle/health information	16
Food and nutrition education	17

Responses for Awareness of Health Care Services Available in the Community

Participants were instructed to respond to the following statement, "Are you aware of the health care services available in your community?" The participants were given three choices (completely aware, somewhat aware, and not aware) to select from with over half of the respondents somewhat aware of the health care services available in the community, and over a third of the respondents were completely aware of the health care services available in the community.

EXISTING BARRIERS	
Responses	Percent of Responses
Completely aware	47%
Somewhat aware	42%
Not aware	11%

Responses for General Health Status

Participants were instructed to respond to the following question, "How do you generally describe the health status of your community?" The participants were given four choices (excellent, good, fair, or poor) to select from. Nearly half of the respondents measured the community's general health status as good and the remainder of respondents generally described the status as fair.

HEALTH STATUS OF THE COMMUNITY	
Responses	Percent of Responses
Excellent	0%
Good	42%
Fair	47%
Poor	11%

Responses for Health Needs S t at us

Participants were instructed to respond to the following question, "Are the health care needs currently being met in your community?" The participants were given four choices (completely agree, somewhat agree, somewhat disagree, and completely disagree) to select from. Over half of the respondents agreed that the health care needs of the community are being met.

COMMUNITY NEEDS BEING MET	
Responses	Percent of Responses
Completely agree	16%
Somewhat agree	53%
Somewhat disagree	21%
Completely disagree	10%

Participants were also given the opportunity to share any health care needs of the community that they feel are not being met. Below are the responses received:

- Competent medical care. Competent ER, length of time required for ER care because insurance payments are based on time, not quality of care. Urgent care hours. Pediatric care not always available at Urgent care. PCPs not influenced by hospital politics. Competent PCPs driven from town by the hospital. Facilities with resources, including Human Resources and equipment and/or available technicians to run the equipment in the event of an emergency. Birthing plan options, undue birthing risk. Education and improved access to resources for drug addiction recovery.
- Affordable care for uninsured.
- Cannot think of any.
- Substance or chemical addiction.
- Mental healthcare.
- Cardiology, Endocrinology, Oncology, Diabetic Education.
- Cancer treatment; sleep apnea.
- None.
- Cannot keep good Doctors for any length of time.
- Cheaper health care.
- Not aware of any.
- Healthcare information.
- We are lacking in long term Primary Care providers. It is not good to have them come and leave so often.
- Specialty services.
- I feel Mclean has a need for elderly care (primary doctors and specialists.) our church gets so many transportation aid requests each week it is mind boggling. I also know that addiction services are a need in our community and financial hardship is prevalent.
- Diabetes.
- Having a cardiologist that is an interventionalist on staff more than half of the month, and hospitalist willing to accept admissions that would benefit by staying here instead of being transferred out of town.
- Possibly a pain control clinic.

Responses for Coordination of Care in the Community

Participants were instructed to respond to the following statement, "Health care providers work well together and coordinate care in this community." The participants were given four choices (completely agree, somewhat agree, somewhat disagree, and completely disagree) to select from with over half of the respondents in agreement that the health providers do work well together and coordinate care in the community while the remainder of respondents somewhat disagreed or completely disagreed.

COORDINATION OF CARE	
Responses	Percent of Responses
Completely agree	21%
Somewhat agree	58%
Somewhat disagree	16%
Completely disagree	5%

Responses for Barriers Existing to Preventing a Healthier Community

Participants were instructed to respond to the following statement, "There are barriers that exist in government, the general community, public health community, or health care provider community that prevent us from creating a healthier community." The participants were given four choices (completely agree, somewhat agree, somewhat disagree, and completely disagree) to select from with the majority of the respondents agreeing there are barriers that exist which keep the community from becoming healthier and the remainder of respondents somewhat disagreed or completely disagreed with the statement.

BARRIERS TO CARE	
Responses	Percent of Responses
Completely agree	42%
Somewhat agree	42%
Somewhat disagree	11%
Completely disagree	5%

Participants were given the opportunity to share any barriers that exist in government, the general community, public health community, or health care provider community that prevent creating a healthier community. Below are the responses received:

- Financial restrictions.
- Again. Competent PCPs driven out by bureaucratic hospital occupation. Consistently poor, slow care, especially for children or in the event of technician availability or rather lack thereof.
- It seems that no one has the general public in mind. The government wants votes. And health care providers set pricing for insurance companies. And insurance companies charge way too much for coverage to compensate for the extremely high health care costs.
- Cannot think of any.
- Affordable insurance and lack of primary care physicians.
- Education and advertising.
- Financial barriers.
- Health insurance; medical costs; costs so high many simply do not get checked.
- Insurance.
- No personal knowledge of this, but have been told by many that one doctor who has been in Pampa for years is responsible for many other doctors leaving.
- Insurance
- Personal funds are lacking for numerous individuals who need healthcare.
- Lack of communication.
- Lack of good quality food and affordable prices. We have no "healthy" places to eat a quick lunch etc.
- City is one sided on care.
- I am not sure that those who qualify for government assistance within our community are aware or knowledgeable about how to gain the assistance they qualify for.
- Funding.
- Lack of education about patient needs and wants, lack of education about local EMS services and knowledge, lack of respect towards pts desires about staying in town and close to family.
- The community in general has a negative view of the hospital. Has been that way for many years.

Additional Community Comments Received

At the end of the survey participants were given the opportunity to share any general comments. Below are the general comments received:

- Insurance coverage for all major insurance companies provided by employers.
- Dental health. Urgent care hours improved hours and pediatric care at urgent care during all hours open. Autonomy in birthing choices. Prompt ER care with available technicians. Improved access and respect of autonomy of PCPs. Less interest in bottom line. More focus on medical care. Encouraged access to addiction recovery. Education access for diabetes patients.
- I would love to see an affordable Rehab facility. As well as some form of homeless shelter.
- I think health needs are pretty much met! Obviously, for specialized needs we must go to a larger city.
- Need for substance abuse.
- None.
- I think the Hospital is generally good, just need more GP's who will stay.
- I think that we have an excellent hospital that tries to deliver the highest quality of care possible but there are those for one reason or another who do not seek healthcare because they lack money. Many probably need yearly medical tests.
- More health providers – doctors and NPs.
- Stability.
- Our clinic is very hard to get in.
- For Mclean, transportation assistance is huge to help those reach their doctor appointments.
- EMS could be improved.

SURVEY RESULTS FROM FOCUS GROUP AND PERSONAL INTERVIEWS

The following represent the focus group and personal interview responses obtained during the data collection and analysis process:

Top Five Health Needs in the Community

Focus group and during the personal interviews participants were instructed to select the top five most significant health needs in the community with one (1) being the most important and five (5) being the least important, from the topics provided, with the option to discuss additional response. The responses were given a weighted score and rank. The top five ranked responses are considered primary needs with the remainder of the needs considered secondary.

NEEDS IN THE COMMUNITY – TOP 5 HEALTH NEEDS	
Primary	**Ranking of Responses**
Access to healthcare	1
Programs and resources for substance abuse	2
Program and resources for chronic disease	3
Programs and resources for mental health improvement	4
Access to prenatal care	5
Secondary	
Access to dental/oral healthcare	6
Programs and resources for Asthma awareness and prevention	7
Programs and resources for infant mortality prevention	8
Resources for hearing/vision issues	9
Resources for injury prevention	10
Programs and resources for obesity prevention	11
Other*	12

*Participants were given the opportunity to specify other needs not listed. Other responses included:

- Diabetes education
- Pain management
- Adolescent behavioral health

Top Three Mental Health Needs in the Community

Focus group and personal interview participants were instructed to select the three most significant mental health needs in the community with one (1) being the most important and three (3) being the least important from the topics listed with the option to provide a write-in response. The responses were given a weighted score and rank. The top three ranked responses are considered primary needs with the remainder of the needs considered secondary.

NEEDS IN THE COMMUNITY – TOP 3 MENTAL HEALTH NEEDS	
Primary	**Ranking of Responses**
Increase substance abuse programs and resources	1
Increase programs for depression prevention and awareness	2
Increase programs for suicide prevention and awareness	3
Secondary	
Increase awareness for mental health services and resources	3
Increase number of treatment facilities	4
Increase program for other mental health prevention and awareness	5
Increased continued care and collaboration with after care treatment plans	6
Increase mental health screenings from doctors	7
Increase programs for domestic abuse prevention and awareness	8
Increase programs for anxiety prevention and awareness	9
Other*	10

* Participants were given the opportunity to specify other needs not listed. Other responses included:

- Mental health in the community needs improved for age group under 55

Top Three Social Issues in the Community

Focus group and personal interview participants were instructed to select the three most significant social issues in the community with one (1) being the most important and three (3) being the least important from the topics listed with the option to provide a write-in response. The responses were given a weighted score and rank. The top three ranked responses are considered primary needs with the remainder of the needs considered secondary.

NEEDS IN THE COMMUNITY – TOP 3 SOCIAL ISSUES	
Primary	**Ranking of Responses**
Health	1
Poverty	2
Transportation	3
Secondary	
Housing	4
Education	5
Public safety	6
Hunger	7
Environment	8
Pollution	9
Other*	10

* Participants were given the opportunity to specify other needs not listed. Other responses included:

- Substance abuse and patient non-compliance.
- Lack of employment, based on the oil and gas business.
- Kids activities.

Top Three Healthcare Challenges in the Community

Focus group and personal interview participants were instructed to select the three most significant healthcare challenges in the community with one (1) being the most important and three (3) being the least important from the topics listed with the option to provide a write-in response. The responses were given a weighted score and rank. The top three ranked responses are considered primary needs with the remainder of the needs considered secondary. Ten percent (10%) of the responses indicated there were no challenges receiving healthcare which has been listed as the last item.

NEEDS IN THE COMMUNITY – TOP 3 HEALTHCARE CHALLENGES	
Primary	**Ranking of Responses**
Lack of insurance	1
Unable to find a specialist	2
Lack of transportation	3
Secondary	
Unable to find a doctor	4
Co-pay costs	5
Language barriers	6
Limited hours at doctors' offices / clinics	7
Lack of doctors who accept specific insurance	8
Do not have any challenges receiving healthcare	9

Primary Transportation Taken to Doctor's Appointments and Other Healthcare Treatment

Focus group and personal interview participants were instructed to select the primary transportation from the following: person vehicle, public transportation, taxi, family/friend, walk, I am unable to make it to appointments due to lack of transportation, or other transportation. Of the responses most used a personal vehicle, however, recognized PRMC's non-medical transportation van as a good solution for transportation.

Primary Source for Information about Healthcare

Focus group and personal interview participants were instructed to select the primary source for information about healthcare from the following: doctor's office or clinic; family, friend, co-workers, or neighbor; school clinic or nurse; community center; church; internet; media (radio, TV, magazines, newspapers); I do not receive information about healthcare; or other sources. Of the responses 35% received information from media sources, 29% received information from family, friends, co-workers, or neighbors, and 18% received information from the doctor's office or clinic; 18% used the internet.

General Comments Received During Focus Groups

Focus group and personal interview participants were asked to characterize the community's overall awareness of Pampa Regional Medical Center and its services; and, to provide any feedback regarding how to improve awareness about the contributions the Hospital makes to the community. The following comments were received.

- Promotion and understanding of services are good. Electronic records, patient portals for reminders. Advertising as Top 100 hospital. Providing new services. -- Media spots on the radio to provide education/awareness. Very involved in Community. Donations to school and involved in activities of local community. Biggest decline is primary care! Urgent cares are staffed with NPs.

- Population is aware of the medical center as resource. Hospital supports public events, radio stations, health fairs.

- The awareness of services would be spotty but would know of the hospital. There is a Facebook page that provides reviews about the hospital. Seems to be positive. Hospital does reach out and provides awareness/education. Use of radio/media activity. Personal patient experience is promoted. -- provide more health fairs in the community, involvement in Rodeo.

- People are aware of the hospital, reputation has not been the best over the last several years, rebuilding the culture, recruiting physicians that want to serve, rebranding service lines, great culture, patient care being excellent, pouring back into the community to rebuild trust and respect in the Community.

- Community knows the Medical Center is here but does not know all of the services. It is not for a lack of trying to education the community. Unsure if there is something that could be done to promote anymore.

- Community knows Med Center is here. The community has a negative perception on docs leaving, ED throughput, Education and Awareness is lacking. -- Flu clinics

- The team is actively involved in the community for outreach. Keep being involved, takes time to build trust.

- Continue to sponsor events, Walk with a Doctor, communication of nationwide awards to the community.

- A lot better than it was ten years ago, perception in town was not good. Many physicians left town to Amarillo, many patients followed them. Been an uphill road. Must have stability in staff and doctors.

NATIONAL, STATE, AND COUNTY TRENDS

NATIONAL HEALTHCARE TRENDS SYNOPSIS

Healthcare spending continues to slowly grow at the national level each year. The following data describes the recent trends in national healthcare, and was obtained from the Centers for Medicare & Medicaid Services, the American Health Rankings 2018 Edition, the United States Census Bureau, and the Deloitte 2018 Survey of Health Care Consumers in the United States, the American Hospital Association 2018 Environmental Scan, and Healthy People 2020.

2017 Health Expenditures

- Total health expenditures increased 3.9% to $3.5 trillion from 2016.
- Healthcare represents 17.9% of the Gross Domestic Product (GDP).
- Health expenditures reached $10,739 per capita.

As a nation, there has been a strong awareness on the impact our lifestyles have on our health. The following data obtained from America's Health Rankings 2018 Edition represents the improvements and challenges in healthcare factors for 2018.

2018 National Health Highlights

- In the past three years, drug deaths increased 25% from 13.5 to 16.9 deaths per 100,000 population
- In the past year, obesity increased 5% from 29.9% to 31.3% of adults
- In the past 15 years, air pollution decreased 36% from 13.2 to 8.4 micrograms of fine particles per cubic meter
- In the past year, HPV immunization among males aged 13 to 17 increased 18% from 37.5% to 44.3%
- In the past five years, children in poverty decreased 19% from 22.6% to 18.4% of children aged 0 to 17
- In the past year, mental health providers increased 8% from 218.0 to 234.7 per 100,000 population
- In the past two years, primary care physicians increased 8% from 145.3 to 156.7 per 100,000 population
- In the past three years, cardiovascular deaths increased 2% from 250.8 to 256.8 deaths per 100,000 population

2018 National Health Highlights (continued)

- In the past two years, frequent mental distress increased 7% from 11.2% to 12.0% of adults
- In the past five years, premature death increased 6% from 6,981 to 7,432 years lost before age 75 per 100,000 population

The Deloitte Center for Health Solutions' report titled *2018 Survey of Health Care Consumers in the United States: The performance of the health care system and health care reform* provided the following national health related data:

Deloitte Consumers & Health Care System 2018 Survey Results

- 53 percent said they were likely to use a tool to look up quality ratings for specific physicians or hospitals, but only 23 percent did so in the past year, and though 50 percent said they were likely to use a tool to look up pricing in the future, only 27 percent did so in the past year.
- 35 percent of respondents were interested in using a virtual assistant to identify symptoms and direct them to a physician or nurse.
- 31 percent were interested in connecting with a live health coach that offers 24/7 text messaging for nutrition, exercise, sleep, and stress management.
- 29 percent were interested in using an app that uses voice-recognition software to recognize depression or anxiety from changes in the tone of voice.
- 51 percent are comfortable using an at-home test to diagnose infections (such as strep throat and urinary tract infection) before going to the doctor for treatment.
- 45 percent are comfortable using an at-home genetic test to identify existing or future health risks.
- 44 percent are comfortable using an at-home blood test (a quick prick with a fine needle) that connects to an app to track overall health trends (for instance, cholesterol, fasting blood glucose, inflammation, triglycerides).
- 41 percent are comfortable sending/mailing a stool sample to a laboratory service that identifies gut bacteria, which in turn can help guide nutritional choices.
- Slightly more than half of consumers are willing to share health data for emergency situations (to alert either family members or emergency responders).
- 40 percent are willing to share their data for health care research or to improve the device.

Deloitte Consumers & Health Care System 2018 Survey Results (continued)

- Across the board, chronically ill consumers are more willing to share their tracked health information.
- Consumers vary in their interest in and use of tools. Care providers and technology/software developers should recognize the importance of targeting different segments, not only by age, but also by health condition and perceived health status.
- Organizations should facilitate the use of consumer information (for example, from fitness devices) that goes to physicians and care teams. Technology/software developers should make it easy for care teams to use the data, and organizations may need to train consumers and professionals on how to use the tools and interpret the data. Physician adoption of new technologies could depend on the company's ability to convince them of the tool's efficiency or cost-effectiveness and whether it is integrated with providers' EHR systems and workflows.
- Different users/customers seek different benefits: Consumers seek convenience, health improvements, and cost savings, with variation based on consumer segments.
- Physicians want ease of use/simplification of workflow and/or improvement in outcomes and efficiency of care, and accuracy and reliability of data from these devices.
- Health systems look for efficiency of care, lower cost, cybersecurity, and ease of integration with HIT systems.
- The growth of at-home diagnostic tests and genetic tests, coupled with increasing use of wearables and tools to measure health and fitness goals, can provide a wealth of consumer-generated information that can be used to better understand the patient journey. This data can support discovery, development, and commercialization.
- All stakeholders have an opportunity to build trust through transparency, efficiency, and delivery of value. In addition, partnerships with physicians and health systems may help overcome consumers' lack of trust for organizations who have low levels of trust.
- Organizations should pay attention to the areas where consumers are asking for advocates the most and how they can consider digital means or other tools to support those needs.
- All stakeholders developing tools should provide meaningful and easy-to-understand data and access to care and care support such that consumers can recognize the benefit of technology engagement.
- There will be a growing expectation for physicians and health systems to take in all these additional data streams and determine what to do with them. Partnerships with technology companies (including EHR vendors) could potentially help this effort. There also may be additional opportunities for health plans to be data brokers/data aggregators.

American Hospital Association (AHA) Environmental Scan (2018)

The 2018 American Hospital Association Environmental Scan provides insight and information about market forces that have a high probability of affecting the healthcare field. It was designed to help hospitals and health system leaders better understand the healthcare landscape and the critical issues and emerging trends their organizations will likely face in the future. The Scan provided the following information:

Access: Coverage

- In 2016, 28.1 million people were uninsured, and the uninsured rate fell to a record low of 8.8%.
- 20.5 million people have gained health insurance since 2010.
- About 12 million people bought health insurance through the ACA's insurance markets for 2017, and 7 million of them (58%) qualified for Cost Sharing Reduction payments.

Economic Forces

- Total annual spending on prescription drugs has reached $309 billion, the fastest growing segment of the U.S. health care economy. The price of drugs, not utilization, is the predominant contributor to the increase.
- 38.7% growth in inpatient drug spending on a per admission basis over a two-year period.
- More than 90% of hospitals said spending on pharmaceuticals was of moderate or severe concern.
- Four in 10 (43%) adults with health insurance say they have difficulty affording their deductible, and roughly a third say they have trouble affording their premiums and other cost sharing; all shares have increased since 2015.
- Three in 10 (29%) Americans report problems paying medical bills. Of this group, seven in 10 (73%) report cutting back spending on food, clothing or basic household items.
- Half of the public says they are at least somewhat worried they will not be able to afford needed health care services.

Physicians

- The nation faces a shortage of between 40,800 and 104,900 physicians by 2030.
- First-year enrollment at U.S. medical schools has increased by 28% since 2002, with 22 new schools accounting for nearly 40% of the growth.
- ACGME-accredited, entry-level residency positions are continuing to grow at a rate of about 1% per year. Federal caps on Medicare-funded residency training positions remain effectively frozen at 1996 levels.
- 49% of physicians often or always experience feelings of burnout.

Healthy People 2020

HealthyPeople.gov provides 10-year national objectives for improving the health of all Americans by 2020. The topics are the result of a multiyear process with input from a diverse group of individuals and organizations. Eighteen federal agencies with the most relevant scientific expertise developed health objectives to promote a society in which all people live long, healthy lives. The primary goals for Healthy People 2020 are:

Goals for Healthy People 2020

- Eliminate preventable disease, disability, injury, and premature death.
  - Emphasize the importance of prevention and health promotion.
  - Address "all hazards" preparedness as a public health issue.
  - Create a multi-sectoral approach with a strong public health workforce and infrastructure.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
  - Achieve health equity and eliminate health disparities.
  - Measure health equity and health disparities over time.
- Create social and physical environments that promote good health for all.
  - Create an ecological approach to health promotion.
  - Address the social and physical environments effecting health.
- Promote healthy development and healthy behaviors across every stage of life.
  - Recognize the importance of life stages and developmental stages to health.
  - Tailor a clustering of life stages and population metrics for healthy development.

The 2020 topics are organized into 42 areas with measurable and developmental objectives maintained by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services. The objectives relevant for this assessment are as follows:

Healthy People 2020 Objectives

Adolescent Health

- Increase educational achievement of adolescents and young adults.
- Reduce the proportion of adolescents who have been offered, sold, or given an illegal drug on school property.
- Increase the proportion of adolescents whose parents consider them safe at school.

Access to Health Services

- Increase the proportion of persons with health insurance.
- Increase the proportion of persons with a usual primary care provider.
- Increase the number of practicing primary care providers.
- Increase the proportion of persons who have a specific source of ongoing care.
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.

Education

- Increase the proportion of preschool Early Head Start and Head Start programs that provide health education to prevent health problems in the following areas: unintentional injury; violence; tobacco use and addiction; alcohol or other drug use; unhealthy dietary patterns; and inadequate physical activity, dental health and safety.
- Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity.
- Increase the proportion of elementary, middle, and senior high schools that have health education goals or objectives which address the knowledge and skills articulated in the National Health Education Standards (high school, middle, and elementary).

- Increase the proportion of elementary, middle, and senior high schools that provide school health education to promote personal health and wellness in the following areas: hand washing or hand hygiene; oral health; growth and development; sun safety and skin cancer prevention; benefits of rest and sleep; ways to prevent vision and hearing loss; and the importance of health screenings and checkups.
- Increase the proportion of worksites that offer an employee health promotion program to their employees.
- Increase the number of community-based organizations providing population-based primary prevention services.

Health Communication and Health Information Technology

- Improve the health literacy of the population.
- Increase the proportion of patients whose doctor recommends personalized health information resources to help them manage their health.
- Increase individuals' access to the Internet.
- Increase social marketing in health promotion and disease prevention.

Immunization & Infectious Disease

- Reduce, eliminate, or maintain elimination of cases of vaccine-preventable diseases.
- Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children.
- Increase the percentage of children and adults who are vaccinated annually against seasonal influenza.
- Increase the percentage of providers who have had vaccination coverage levels among children in their practice population measured within the past year.

Injury & Violence Prevention

- Reduce physical violence by current or former intimate partners.
- Reduce sexual violence by current or former intimate partners.
- Reduce psychological abuse by current or former intimate partners.
- Reduce children's exposure to violence.
- Increase the number of States and the District of Columbia that link data on violent deaths from death certificates, law enforcement, and coroner and medical examiner reports to inform prevention efforts at the State and local levels.

Mental Health

- Increase the proportion of children who receive treatment of their mental health problems.
- Increase the proportion of juvenile residential facilities that screen admissions for mental health problems.
- Increase the portion of persons who receive treatment for co-occurring substance abuse and mental disorders.
- Increase depression screening by primary care providers.
- Increase the proportion of homeless adults who receive mental health services for their mental health problems.
- Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs).

Substance Abuse

- Reduce average alcohol consumption.
- Decrease the rate of alcohol-impaired driving.
- Reduce steroid use among adolescents.
- Reduce past-year nonmedical use of prescription drugs.
- Reduce the number of deaths attributable to alcohol.
- Reduce the proportion of adolescents who use inhalants.

STATE HEALTHCARE TRENDS SYNOPSIS

In Texas, the overall health ranking reported in the 2018 American's Health Ranking was 37 out of 50 decreasing from 34th in 2017; however, the ranking for senior health was 41st in 2014. The strengths for the state are high home health care worker rate, high percentage of hospice care use, and high percentage of diabetes management. The challenges faced by the Texas population are low percentage of four- and five-star nursing home beds, high percentage of ICU use, and high percentage of seniors living in poverty.

2018 Texas Highlights

- In the past year, flu vaccination coverage decreased 14% from 66.3% to 57.3% of adults aged 65+.
- In the past three years, SNAP reach decreased 20% from 79.4 to 63.5 participants per 100 adults aged 60+ in poverty.
- In the past four years, hospital readmissions decreased 7% from 15.8% to 14.7% of hospitalized patients aged 65+.
- In the past year, frequent mental distress increased 32% from 6.2% to 8.2% of adults aged 65+.
- In the past two years, suicide decreased 3% from 16.4 to 15.9 deaths per 100,000 adults aged 65+.
- In the past five years, low-care nursing home residents decreased 20% from 14.3% to 11.4%.

COUNTY HEALTH CARE TRENDS SYNOPSIS

According to County Health Rankings, the citizens of the service area are predominantly white (66.1%) and made up of 49% female. The age of the service area population is older compared to the state of Texas, with 15.7% of the service area population 65 and older compared to 12% for the state of Texas. The service area location as a whole averages 70.7% in rural Texas with six of the eleven counties 100% rural, which is significantly higher than the state at 15.3%. Roughly 57% of residents have some level of college education; slightly below the state of Texas at 60%. The median household income of $55,364 is marginally below the state level of $56,600. The state of Texas had reported unemployment rate of 4.6% and the service area is on par with a 4.6% unemployment rate. The percentage of children living in poverty for the service area is 19% which is slightly lower than the state at 22%. Children in the service area living in single-parent households is 30% versus 33% in the state. Approximately 49% of the children residing in the service area are eligible for a free school lunch, compared to 59% in the state of Texas.

Approximately 24% of the population in the service area does not have health insurance, as compared to 23% in the state of Texas. Approximately 16% of children age 19 or below do not have some form of health insurance in the service area as compared to 10% in the state of Texas. The number of people in relation to the number of dentists in the service area is 3,191 to one dentist, compared to the state of Texas at 1,790 to one. The number of people in relation to the number of mental health providers in the service area is 5,928 to one compared to 1,010 to one in the state of Texas. The ratio for population to primary care physicians in the service area is 3,033 individuals to one primary care physician; compared to 1,670 to 1 in the state of Texas.

The percentage of adults who are obese is at 29% in the service area versus 28% in the state of Texas. The percentage of adults with diabetes is higher in the service area at 11% versus 10% in the state of Texas. There is less access to physical exercise equipment, facilities and other opportunities for physical exercise in the services area and 28% of the service area being physically inactive versus 24% in the state of Texas. Motor vehicle deaths are much higher in the service area as compared to the state of Texas at 37 per 10,000 population compared to 13 per 10,000 population. The number of preventable hospital days, which measures outpatient sensitive hospital admissions is higher in the service area at 58 per 1,000 versus 53 per 1,000 in the state of Texas. The infant mortality rate, which represents death of children within one year of birth per 1,000 live births, is higher at 10 versus 6 for the state of Texas. Deaths of children under the age 18 are higher in the service area at 86.1 per 100,000 population versus 67 per 100,000 population in the state of Texas.

Health Status Synopsis

After reviewing secondary data for the service area, it was noted that the Health Outcomes ranking is in the upper half of the 237 counties at 128. The median county ranking in Texas is 118. The Health Factors ranking for the service area is below the median at 75. On average, the national and state benchmark data is better than the service area. (See Attachment B).

	Gray County	Service Area (Average)	State of Texas
Health Outcomes			
Length of Life			
Premature Death	9.3%	8.5%	6.7%
Quality of Life			
Poor physical health days	3.7	3.5	3.7
Low birth weight	7%	7%	8%
Health Factors			
Health Behaviors			
Adult smoking	17%	15%	14%
Adult obesity	30%	29%	28%
Physical inactivity	27%	28%	24%
Alcohol impaired driving deaths	19%	24%	33%
Sexually transmitted infections	330	436	524
Teen births	72	48	41
Clinical Care			
Uninsured adults	22%	21%	19%
Primary care physicians*	2,900:1	3,086:1	1,670:1
Preventable hospital stays	51	59	53
Diabetic screening	82%	82%	84%
Mammography screening	47%	50%	58%

Key:

Worse than the State of Texas

Better than the State of Texas

Equal to the State of Texas

Note: See definitions on pages 44-47.

Source: www.countyhealthrankings.org

CONCLUSION

COMMUNITY RESOURCESIDENTIFIED

The assessment identified few community assets (See Attachment A) including the Hospital and its community benefit programs.

In addition to the Hospital, community resources identified were numerous religious congregations, primary care physicians, and a public school system with active home and school associations.

OVERALL OBSERVATION

Priorities for the key areas will be assessed by the Hospital's Board of Directors and documented in the implementation strategy report.

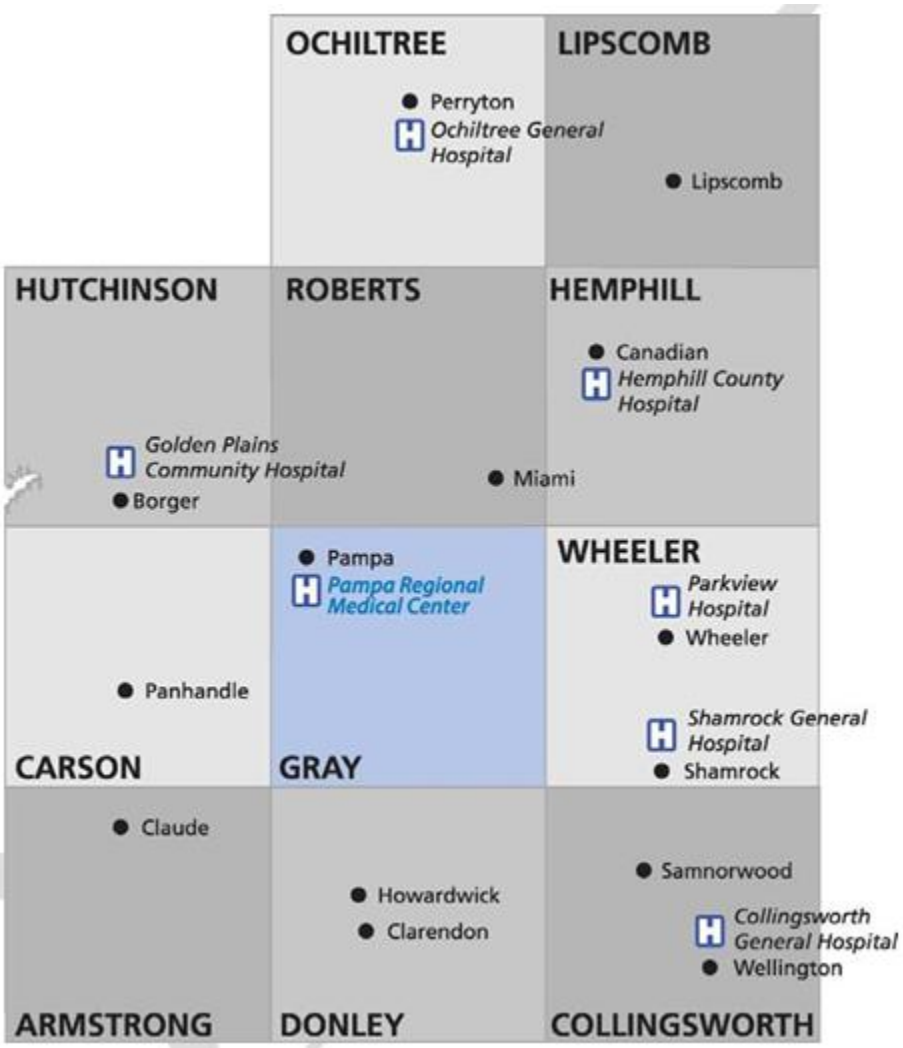
Overall priorities determined to be significant:

- Increasing primary care physicians,
- Increasing educational awareness programs,
- Increasing the number of mental healthcare providers and professionals, especially focusing on adolescents,
- Increasing substance abuse prevention,
- Expanding transportation services to/from treatment services, and
- Increasing access to pain management services for treatment.

CONTACT

This assessment summary is published on the website of Pampa Regional Medical Center, www.prmctx.com. Additionally, a copy may be obtained by contacting the Hospital's Administration office at (806) 665-3721 or in writing to the Hospital's mailing address: Attn: Administration, One Medical Plaza, Pampa, TX 79065.

ATTACHMENT A:
AVAILABLE COMMUNITYRESOURCES



(Gray County) Pampa, Texas

- Accolade Home Care
- Albracht Chiropractic of Pampa
- Anytime Fitness
- BSA Hospice
- CASA of the High Plains
- Department of Family Services
- Family Care Clinic of Pampa
- Ford Chiropractic
- Harvester Health and Wellness
- Interim Healthcare
- Graycares Living at Home
- Good Samaritan Christian services
- HealthMart Pharmacy
- Jazzercise of Pampa
- Keyes Pharmacy
- Lukner Medical Clinic
- Massage Therapy – Cathy Potter
- New Life Wellness Center – Chiropractors
- Nguyen Pediatric and Internal Medicine Clinic
- Pampa Dental Association
- Pampa Heart Group
- Pampa Meals on Wheels
- Pampa Medical Group
- Pampa Nursing Center
- Pampa Youth & Community Center
- Pampa United Way
- Panhandle Community Services
- Pregnancy Support Center & Hope House of Pampa
- Shepard's Crook Nursing Agency
- Shepard's Helping Hand
- Southside Senior Citizens Center
- Texas Panhandle Center Behavioral and Development Health
- The Brown Alliance for Children – The Bridge
- Tralee Crisis Center for Women
- United Supermarkets – pharmacy and dietitians

(Ochiltree County) Perryton, Texas

- Panhandle Community Services
- Texas Panhandle Center Perryton Center – Rural Behavioral Health Services

(Hutchinson County) Borger, Texas

- Borger Healthcare Center
- Caprock Nursing and rehabilitation Center
- Department of Family & Protective Services

(Carson County) Whitedeer, Texas

- Safety Advisors & Consultants
- Panhandle Community Services
- Texas Panhandle Center Borger Center – Rural Behavioral Health Services

(Donley County) Clarendon, Texas

- Panhandle Community Services
- Texas Panhandle Center Clarendon Services Center – Rural Behavioral Health Services

(Wheeler County) Shamrock,Texas

- Panhandle Community Services

(Collingsworth County) Wellington, Texas

- Panhandle Community Services

ATTACHMENT B: DEMOGRAPHIC DATA

EXPLANATIONS & DEFINITIONS FOR SELECTED CHARTS/GRAPHS THAT FOLLOW

TITLE OF CHART/GRAPH	EXPLANATIONS & DEFINITIONS
Health Outcomes	Health Outcomes ranking is based upon the length of life and quality of life rates.
Length of Life	Length of Life ranking is based on the premature death rate.
Premature Death	Years of potential life lost before age 75 per 100,000 population (age adjusted)
Quality of Life	Indicates poor health and the prevalence of disease in 4 separate categories which include poor or fair health, poor physical health days, poor mental health days and low birth weight.
Poor or Fair Health	Percent of adults reporting fair or poor health (age adjusted) by county.
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age adjusted).
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 Days (age adjusted).
Low Birth Weight	Percent of live births with low birth weights (<2,500 grams).
Health Factors	Weighted measures of health behaviors, clinical care, social and economic and physical environment factors within each county.
Health Behaviors	An aggregate of a number of variables that include adult smoking, adult obesity, food environment index, physical inactivity, access to exercise opportunities, excessive drinking, alcohol-impaired driving deaths, sexually transmitted infections and teen births.
Adult Smoking	Percent of adults who report smoking >= 100 cigarettes and are currently smoking.
Adult Obesity	Percent of adults who report a Body Mass Index (BMI) >= 30.
Food Environment Index	Index of factors that contribute to a healthy food environment by weighing two indicators equally, one being the access to healthy foods by of low income and the other being the food insecurity of the population.
Physical Inactivity	Percent of adults 20 years or older reporting no leisure time physical activity.
Access to Exercise Opportunities	Percent of the population with adequate access locations where they can engage in physical activity.
Excessive Drinking	Includes both binge and heavy drinking.
Alcohol-Impaired Driving Deaths	Percent of driving deaths caused by alcohol
Sexually Transmitted Infections	Chlamydia rate per 100,000 population.

Source: www.countyhealthrankings.org

TITLE OF CHART/GRAPH	EXPLANATIONS & DEFINITIONS
Teen Birth Rate	Teen birth rate per 1,000 female population, ages 15 to 19.
Clinical Care	Aggregate of several variables including percentage of uninsured, primary care physicians-to-population, preventable hospital days; diabetic screening, and mammography screening.
Uninsured	Percentage of the population under age 65 used in the clinical care factors ranking.
Primary Care Physicians	Ratio of population to Primary Care Physicians.
Dentists	Ratio of population to Dentists.
Mental Health Providers	Ratio of population to Mental Health Provider.
Preventable Hospital Stays	Hospital rate for ambulatory-sensitive conditions per 1,000 Medicare enrollees.
Diabetic Monitoring	Percent of diabetic Medicare enrollees who receive HbA1c monitoring.
Mammography Screening	Percent of female Medicare enrollees who receive mammography screening.
Social & Economic Factors	Aggregate of factors including education level, unemployment rate, children in poverty, inadequate social support, children in single parent households, and violent crime rate.
High School Graduation	Percent of ninth graders who graduate in 4 years.
Some College	Percent of adults age 25 to 44 years with some post-secondary education.
Unemployment	Percent of population 16+ unemployed but seeking work.
Children in Poverty	Percent of children under age 18 in poverty.
Income Inequality	Ratio of income at the 80th percentile to the 20th percentile.
Children in Single-Parent Households	Percent of children who live in a household headed by a single parent.
Social Associations	Number of membership associations per 10,000 population.
Violent Crime Rate	Annual crimes per 100,000 in population.
Injury Deaths	Number of deaths caused from injuries per 100,000 population.
Physical Environment	Aggregate of several weighted variables including air pollution, drinking water violations, severe housing problems, driving alone to work and long commute - driving alone.
Air Pollution - Particulate Matter	Average density of fine particulate matter in micrograms per cubic meter per day.
Drinking Water Violations	Percent of population who may be exposed to water that does not meet safe drinking water standards.
Severe Housing Problems	Percent of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen or plumbing.

Source: www.countyhealthrankings.org

TITLE OF CHART/GRAPH	EXPLANATIONS & DEFINITIONS
Driving Alone to Work	Percent of workforce that drives to work alone
Long Commute - Driving Alone	Percent of the workforce whose commute exceeds 30 minutes.
Additional Measures	Additional parameters identified in each category. These parameters are included as a valuable source of data to help gain a better understanding of the community. These measures are not used to determine the ranking of each category unless no other data is available.
Population	Number of individuals who reside in a county.
% Below 18 Years of Age	Percentage of the population who are younger than 18 years of age.
% 65 and Older	Percentage of the population who are 65 or older.
% Non-Hispanic AfricanAmerican	Percentage of the population who are not Hispanic African American.
% American Indian & Alaskan Native	Percentage of the population who are of American Indian and Alaskan Native descent.
% Asian	Percentage of the population who are of Asian descent.
% Native Hawaiian/Other Pacific Islander	Percentage of the population who are of Native Hawaiian or other Pacific Island descent.
% Hispanic	Percent of the population who are Hispanic.
% Non-Hispanic White	Percent of the population who are white and not of Hispanic descent.
% Not Proficient in English	Percent of the population, age 5 or older, who report as not speaking English “well”.
% Females	The percent of the population that are female.
% Rural	Percentage of the population living in a rural area.
Diabetes	Percentage of adults aged 20 or older who have been diagnosed with having diabetes.
HIV Prevalence	Number of people per 100,000 population diagnosed with HIV.
Premature Age-Adjusted Mortality	Number of deaths under 75 years old per 100,000 population (age-adjusted).
Infant Mortality	Number of babies who died within 1 year of birth per 1,000 live births.
Child Mortality	Number of children (under age 18) who died per 100,000.
Food Insecurity	Percent of population who lack adequate access to food.
Limited Access to Healthy Foods	Percent of population who are low income and do not live close to a grocery store.
Motor Vehicle Crash Deaths	Number of deaths caused by motor vehicle crashes per 100,000 population.
Drug Poisoning Deaths	Number of deaths caused by drug overdose per 100,000 population.
Uninsured Adults	Percent of the population under age 65 without health insurance.

Source: www.countyhealthrankings.org

TITLE OF CHART/GRAPH	EXPLANATIONS & DEFINITIONS
Uninsured Children	Percent of the population under the age of 18 without health insurance.
Healthcare Costs	The amount of price-adjusted Medicare reimbursements per enrollee.
Could Not See Doctor Due to Cost	Percent of the population who were unable to see a doctor because of cost.
Other Primary Care Providers	Ratio of population per primary care providers other than physicians.
Median Household Income	The income at which half the households earn more and half earn less.
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free lunch.
Homicides	Number of deaths caused by assault per 100,000 population.

Source: www.countyhealthrankings.org

SERVICE AREA ANALYSIS

	Texas	Gray		Armstrong	Carson	Collingsworth	Donley	Hemphill	Hutchinson	Lipscomb	Ochiltree	Roberts	Wheeler
Health Outcomes		142		53	16	171	133	15	220	10	117	NR	168
Length of Life		183		112	50	186	163	28	222	26	170	NR	227
Premature death	6,700	9,300			6,900	9,500	9,100	6,100	10,500	6,000	9,200		10,900
Quality of Life		82		19	6	149	85	22	175	3	64	NR	47
Poor or fair health	18%	19%		12%	13%	22%	16%	16%	17%	16%	20%	12%	17%
Poor physical health days	3.5	3.7		3.0	3.1	4.2	3.6	3.5	3.7	3.4	3.8	3.0	3.7
Poor mental health days	3.4	3.7		3.3	3.3	3.9	3.6	3.5	3.7	3.4	3.6	3.2	3.7
Low birthweight	8%	7%		8%	7%	7%	8%	6%	10%	5%	7%		6%
Health Factors		162		18	11	140	44	16	142	17	139	NR	91
Health Behaviors		171		68	37	162	48	38	194	81	109	NR	72
Adult smoking	14%	17%		13%	13%	17%	15%	15%	16%	14%	15%	13%	15%
*Adult obesity***	28%	30%		29%	30%	28%	29%	28%	30%	28%	29%	27%	29%
*Food environment index***	6.0	7.3		6.3	7.7	7.8	6.7	8.4	7.0	5.9	8.8	7.0	7.8
*Physical inactivity***	24%	27%		26%	28%	26%	27%	27%	32%	27%	32%	25%	28%
Access to exercise opportunities	81%	93%		3%	67%	83%	18%	85%	69%	16%	88%	76%	77%
Excessive drinking	19%	19%		20%	21%	16%	18%	19%	19%	20%	20%	21%	18%
Alcohol-impaired driving deaths	28%	19%		29%	0%	60%	13%	10%	36%	33%	11%	13%	39%
*Sexually transmitted infections***	523.6	329.8		1,688.0	515.5	331.5	169.3	143.5	436.3	197.0	306.7		140.0
Teen births	41	72		37	27	44	39	62	56	51	68		44
Clinical Care		127		152	43	220	46	48	113	68	241	NR	216
Uninsured	19%	22%		18%	16%	33%	21%	22%	19%	22%	26%	11%	23%
Primary care physicians	1,670:1	2,900:1		1,950:0		3,040:1	3,500:1	1,070:1	2,720:1		2,690:1	920:0	2,830:1
Dentists	1,790:1	2,270:1		1,880:0	6,060:1	3,020:0	3,410:1		2,690:1	3,490:0	2,580:1	920:0	2,770:1
Mental health providers	1,010:1	4,550:1			6,060:1			4,130:1	7,170:1		5,150:1	920:0	2,770:1
Preventable hospital stays	53	51			51	50	30	57	63	34	95		93
Diabetes monitoring	84%	82%		83%	86%	74%	88%	85%	87%	86%	64%		81%
Mammography screening	58%	47%			54%	58%	54%	58%	45%		43%		41%
Social & Economic Factors		180		10	5	64	123	42	129	14	73	NR	54
*High school graduation***	89%	95%		96%	99%	100%	94%	89%	93%	100%	93%	100%	96%
Some college	60%	49%		71%	73%	44%	59%	49%	59%	52%	47%	68%	53%
Unemployment	4.6%	7.0%		2.8%	3.4%	3.5%	4.3%	3.8%	5.6%	4.6%	5.4%	4.7%	5.0%
Children in poverty	22%	24%		16%	12%	31%	34%	15%	19%	16%	17%	8%	21%
Income inequality	4.9	4.5		4.5	3.7	3.7	4.5	3.5	5.1	4.0	4.4	2.9	4.1
Children in single- parent households	33%	32%		18%	31%	31%	45%	33%	36%	21%	22%	33%	27%
Social associations	7.6	16.8		20.5	25.1	26.3	25.7	21.1	20.2	33.6	17.7	21.8	28.3
*Violent crime***	408	598		136	167	11	315	312	709	105	196	282	122
Injury deaths	55	81		165	76	131	97	72	97	91	88		117
Disconnected youth	15%	17%											
Median household income	$56,600	$47,800		$54,900	$62,600	$37,400	$38,800	$74,900	$53,900	$54,200	$61,200	$75,800	$47,500
Children eligible for free or reduced price lunch	59%	61%		44%	31%	60%	62%	43%	48%	60%	56%	26%	51%
*Residential segregation - black/white***	54	61					45		37				56
*Residential segregation - non-white/white***	40	37					39		35	23	6		8
Homicides	5												
Firearm fatalities	11	17							16				

SERVICE AREA ANALYSIS (continued)

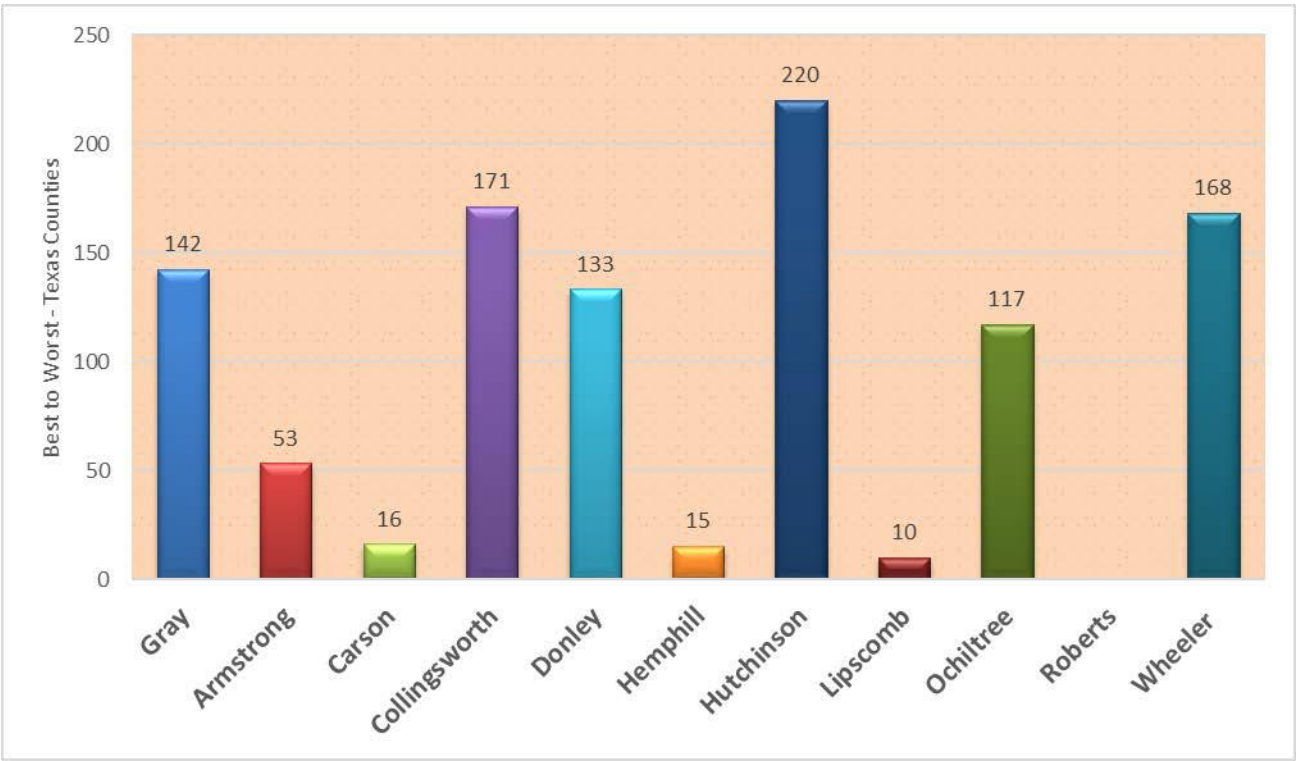
	Texas	Gray		Armstrong	Carson	Collingsworth	Donley	Hemphill	Hutchinson	Lipscomb	Ochiltree	Roberts	Wheeler
Physical Environment		52		8	46	72	16	14	41	20	27	NR	108
Air pollution - particulate matter	8.0	7.0		6.8	7.1	7.0	6.9	6.9	7.1	7.1	7.1	6.8	7.1
Drinking water violations		No		No	No	Yes	No	No	No	No	No	No	Yes
Severe housing problems	18%	13%		7%	7%	12%	11%	8%	11%	7%	13%	4%	9%
Driving alone to work	80%	85%		70%	89%	78%	73%	79%	86%	84%	81%	69%	88%
Long commute - driving alone	37%	22%		47%	32%	21%	29%	15%	18%	19%	12%	31%	24%
Length of Life													
Premature age- adjusted mortality	340	520		580	350	460	510	310	530	290	420		450
Child mortality	50	60							60				
Infant mortality	6	10											
Quality of Life													
Frequent physical distress	11%	12%		9%	9%	13%	11%	11%	11%	10%	12%	9%	11%
Frequent mental distress	11%	11%		10%	10%	13%	11%	11%	11%	10%	11%	10%	11%
Diabetes prevalence**	10%	11%		11%	12%	11%	12%	10%	11%	10%	9%	11%	11%
HIV prevalence	369	116							102				109
Health Behaviors													
Food insecurity**	16%	16%		15%	14%	15%	19%	12%	16%	13%	10%	15%	15%
Limited access to healthy foods	9%	7%		20%	6%	3%	6%	2%	10%	28%	2%	12%	3%
Drug overdose deaths	10												
Drug overdose deaths - modeled	10.1	14-15.9		2-3.9	20-21.9	18-19.9	18-19.9	16-17.9	16-17.9	16-17.9	8-11.9	2-3.9	20-21.9
Motor vehicle crash deaths	13	23			33			45	37		40		41
Insufficient sleep	33%	32%		29%	29%	32%	30%	31%	31%	31%	32%	29%	31%
Clinical Care													
Uninsured adults	23%	26%		19%	17%	38%	24%	24%	23%	24%	30%	11%	25%
Uninsured children	10%	13%		15%	12%	24%	15%	18%	13%	20%	20%	11%	18%
Health care costs**	$11,121	$10,716		$11,442	$10,544	$12,758	$10,625	$9,047	$10,879	$7,298	$9,354	$9,111	$12,128
Other primary care providers	1,497:1	2,066:1		1,876:1	1,010:1	1,005:1	681:1	4,129:1	3,073:1	3,487:1	10,306:1	916:0	2,773:1
Demographics													
Population	27,862,596	22,725		1,876	6,057	3,016	3,405	4,129	21,511	3,487	10,306	916	5,546
% below 18 years of age	26.2%	25.6%		23.4%	25.4%	27.2%	20.6%	32.3%	25.9%	26.9%	32.0%	23.9%	26.1%
% 65 and older	12.0%	15.3%		21.5%	16.7%	18.0%	23.4%	13.9%	15.7%	15.6%	10.8%	19.0%	18.3%
% Non-Hispanic African American	11.8%	4.9%		1.0%	0.8%	5.0%	5.3%	0.2%	2.4%	0.9%	0.5%	0.0%	2.6%
% American Indian and Alaskan Native	1.0%	1.6%		1.4%	1.5%	2.9%	0.8%	2.0%	2.2%	2.2%	1.6%	0.8%	1.8%
% Asian	4.8%	0.6%		0.1%	0.5%	0.5%	0.5%	0.9%	0.7%	0.6%	0.7%	0.3%	0.9%
% Native Hawaiian/Other Pacific Islander	0.1%	0.0%		0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%	0.1%	0.0%	0.0%
% Hispanic	39.1%	28.9%		9.2%	10.1%	34.0%	10.7%	33.0%	22.9%	33.8%	53.1%	11.2%	26.7%
% Non-Hispanic white	42.6%	63.4%		87.7%	85.8%	57.9%	81.3%	64.3%	70.6%	61.8%	44.1%	85.7%	67.7%
% not proficient in English	8%	4%		0%	0%	8%	1%	6%	2%	4%	11%	0%	5%
% Females	50.4%	46.9%		49.8%	50.0%	51.5%	50.7%	50.9%	49.6%	47.9%	49.5%	49.5%	50.0%
% Rural	15.3%	19.4%		100.0%	95.2%	100.0%	100.0%	27.0%	22.6%	100.0%	13.9%	100.0%	100.0%

** Compare across states with caution

Note: Blank values reflect unreliable or missing data

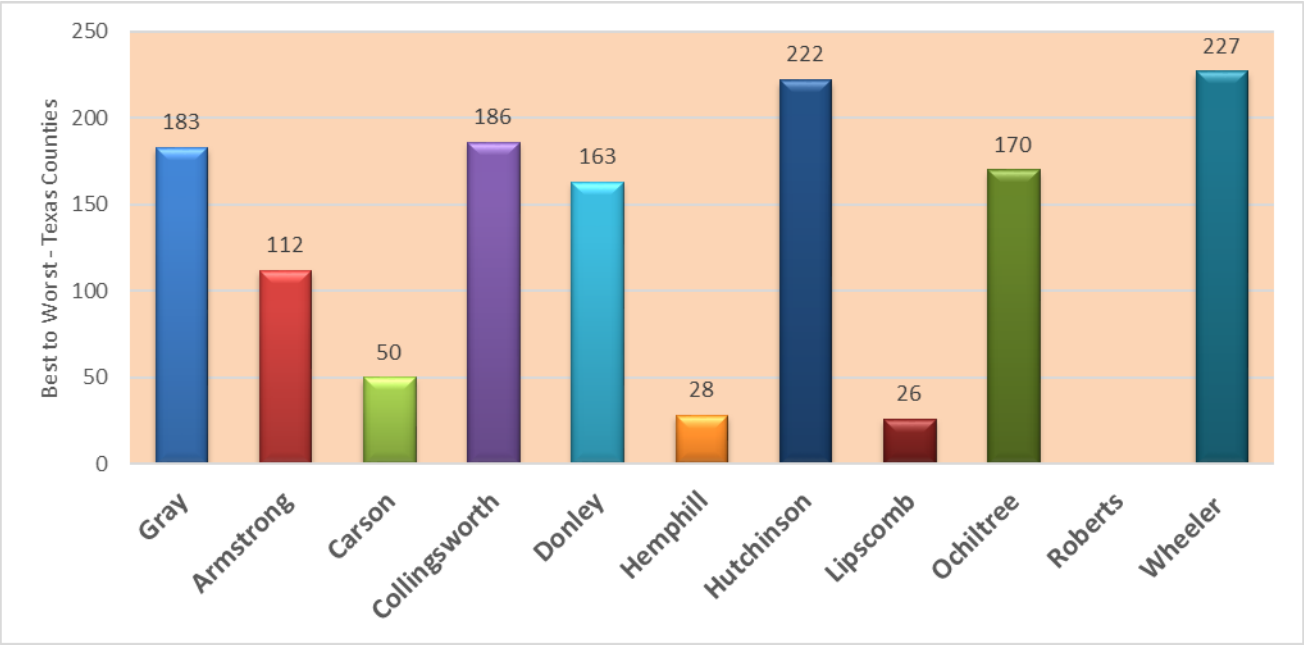
http://www.countyhealthrankings.org/app/texas/2018/compare/snapshot?counties=48_011%2B48_179%2B48_065%2B48_087%2B48_129%2B48_211%2B48_233%2B48_295%2B48_357%2B48_393

2018 HEALTH OUTCOMES



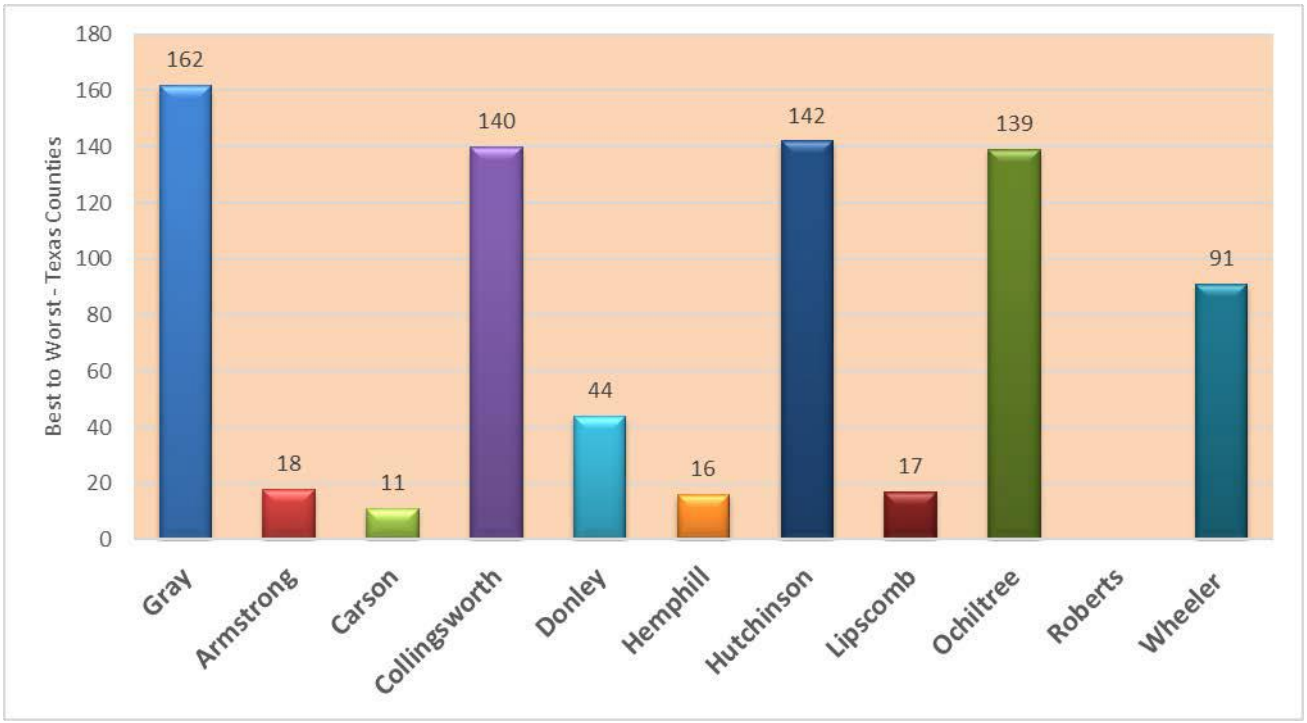
Health Outcomes is a Counties Health Ranking representing how long people live and how healthy people feel while alive. The health outcomes represent the health of the county by measuring the length and quality of life within each county. 242 counties in Texas have been ranked from 1 to 242, with 1 representing the best and 242 representing the least healthy county. Roberts County did not data for 2018. Refer to page 38 for additional health status synopsis for the service area. (Source: www.countyhealthrankings.org)

2018 Length of Life



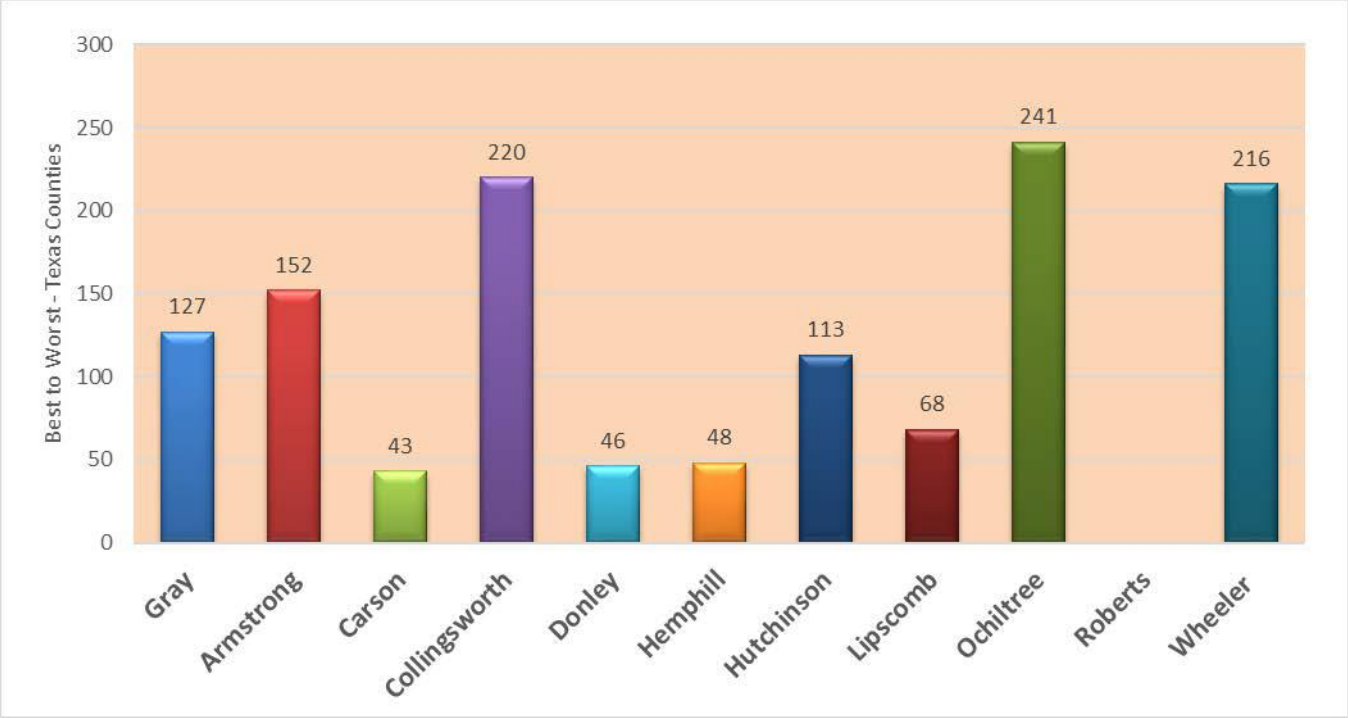
The length of life ranking representing how long people live is based on the premature death rate in the county. 242 counties in Texas have been ranked from 1 to 242, with 1 representing the best and 242 representing the least length of life by county. Roberts County did not data for 2018. Refer to page 38 for additional health status synopsis for the service area. (Source: www.countyhealthrankings.org)

2018HEALTH FACTORS



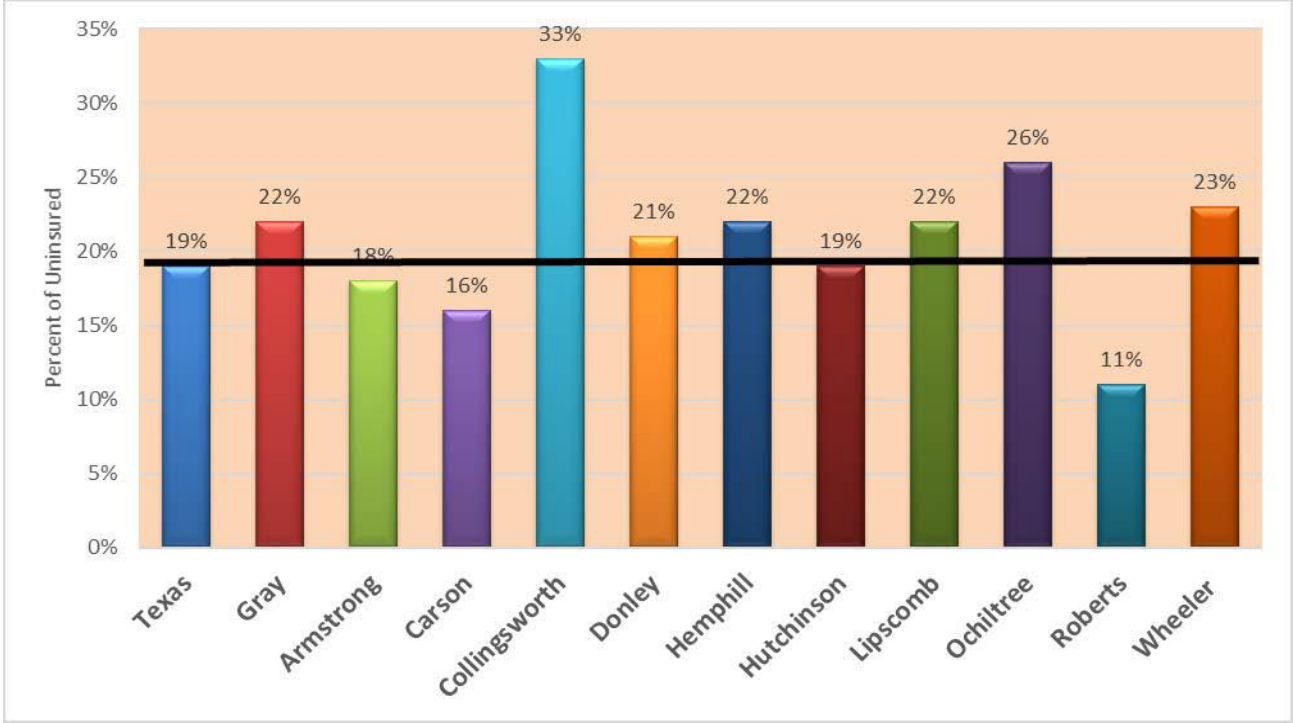
Health Factors is a County Health Ranking representing what influences the health of a county. The health factors are weighted measures of health behaviors, clinical care, social and economic, and physical environment factors within each county. The 242 counties in Texas have been ranked from 1 to 242, with 1 representing the best health factors and 242 representing the lowest composite score. Roberts County did not data for 2018. (Source: www.countyhealthrankings.org)

2018 Clinical Care



Clinical care is comprised of two weighted factors for each county: access to care and quality of care. 242 counties in Texas have been ranked from 1 to 242, with 1 representing the highest and 242representing the lowest composite score. The clinical care score is a factor in calculating a county's overall health factor ranking. Roberts County did not data for 2018. (Source: www.countyhealthrankings.org)

2018 Uninsured



Uninsured represents a significant barrier to accessing needed health care due to lack of health insurance coverage that continues to increase. The value reported for each county is the estimated percent of the population under age 65 without health insurance coverage. The uninsured percentage is a factor in calculating a county's overall clinical care ranking. (Source: www.countyhealthrankings.org)

ATTACHMENT C:
PHYSICIAN NEEDS ASSESSMENT

Physician Specialties: GMENAC Goodman Hicks & Glenn Solucient

Population of 100,000

SPECIALTIES	CURRENT NUMBER OF PHYSICANS WITHIN PRIMARY SERVICE	SURPLUS (SHORTAGE) IN PRIMARY SERVICE	GMENA	GOODMA	HICKS & GLENN	SOLUCIE	AVERAG	ESTIMATED 2017 POPULATION UPON HOSPITAL PRIMARY AREA: POPULATION OF 22,962
Primary Care								
Family Practice	0.00	(4.89)	25.20	N/A	16.20	22.53	21.31	4.89
Internal Medicine	5.00	0.48	28.80	N/A	11.30	19.01	19.70	4.52
Pediatrics	1.00	(1.63)	12.80	N/A	7.60	13.90	11.43	2.63
Total Primary Care	6.00	(6.04)	66.80	N/A	35.10	55.44	52.45	12.04
Medical Specialties								
Allergy/Immunology	0.00	(0.29)	0.80	1.30	N/A	1.72	1.27	0.29
Cardiology	2.00	1.26	3.20	3.60	2.60	3.41	3.20	0.74
Dermatology	0.00	(0.50)	2.90	1.40	2.10	2.38	2.20	0.50
Endocrinology	0.00	(0.18)	0.80	N/A	N/A	0.80	0.80	0.18
Gastroenterology	0.00	(0.50)	2.70	1.30	N/A	2.50	2.17	0.50
Hematology/Oncology	0.00	(0.53)	3.70	1.20	N/A	1.99	2.30	0.53
Infectious Disease	0.00	(0.21)	0.90	N/A	N/A	0.90	0.90	0.21
Nephrology	0.00	(0.23)	1.10	N/A	N/A	0.92	1.01	0.23
Neurology	0.00	(0.44)	2.30	2.10	1.40	1.90	1.93	0.44
Psychiatry	0.00	(2.02)	15.90	7.20	3.90	8.18	8.80	2.02
Pulmonology	0.00	(0.33)	1.50	1.40	N/A	1.40	1.43	0.33
Rheumatology	0.00	(0.15)	0.70	0.40	N/A	0.81	0.64	0.15
Physical Medicine & Rehab	0.00	(0.31)	1.30	N/A	N/A	1.40	1.35	0.31
Other Medical Specialties	1.00	0.54	N/A	N/A	N/A	2.01	2.01	0.46
Surgical Specialties								
General Surgery	1.00	(0.69)	9.70	9.70	4.10	6.01	7.38	1.69
Cardio/Thoracic Surgery	0.00	(0.16)	N/A	0.70	N/A	N/A	0.70	0.16
Neurosurgery	0.00	(0.21)	1.10	0.70	N/A	N/A	0.90	0.21
OB/GYN	2.00	(0.09)	9.90	8.40	8.00	10.17	9.12	2.09
Ophthalmology	0.00	(0.93)	4.80	3.50	3.20	4.71	4.05	0.93
Orthopedic Surgery	1.00	(0.29)	6.20	5.90	4.20	6.12	5.61	1.29
Otolaryngology	0.00	(0.65)	3.30	2.40	N/A	2.8	2.83	0.65
Plastic Surgery	0.00	(0.39)	1.10	1.10	2.30	2.22	1.68	0.39
Urology	1.00	0.39	3.20	2.60	1.90	2.86	2.64	0.61
Other Surgical Specialties	0.00	(0.51)	N/A	N/A	N/A	2.20	2.20	0.51
Hospital-based								
Emergency	1.00	(0.81)	8.50	2.70	N/A	12.40	7.87	1.81
Anesthesiology	0.00	(1.76)	8.30	7.00	N/A	N/A	7.65	1.76
Radiology	1.00	(0.94)	8.90	8.00	N/A	N/A	8.45	1.94
Pathology	0.00	(1.11)	5.60	4.10	N/A	N/A	4.85	1.11
Pediatric Cardiology	0.00	(0.05)	N/A	N/A	N/A	0.20	0.20	0.05
Pediatric Neurology	0.00	(0.03)	N/A	N/A	N/A	0.12	0.12	0.03
Pediatric Psychiatry	0.00	(0.10)	N/A	N/A	N/A	0.45	0.45	0.10
Other Pediatric Subspecialties	0.00	(0.20)	0.89	N/A	N/A	N/A	0.89	0.20
TOTALS	16.00	-18.45						34.45

Physician Needs Assessment Analysis

A quantitative physician needs assessment analysis was completed for a portion of the service area considered to be the primary service area, specifically for Gray County only. The physician needs assessment analysis uses a nationally-recognized quantitative methodology to determine the need for physicians by physician specialty for a given geographic population area being assessed. This need for physicians by specialty is then compared to the current supply of physicians practicing in that given geographic population. For purposes of this CHNA, the Gray County population of 22,962 specifically, were analyzed by physician need vs. supply by physician specialty. Gaps of physician supply vs. needs were then identified.

It should be noted there are a myriad of qualitative factors that impact the need, supply and gaps for physicians by specialty in any particular geographic region. These needs include, but are not limited to, the age of current practicing physicians; quality or service issues with a given physician or practice; the number of practicing mid-level providers; full time vs. part time availability expressed in terms of a full time equivalent (FTE); hospital emergency department coverage; coverage for vacations, continuing medical education, or personal time off; patient outmigration; the geographical referral area for the given specialty; waiting times for appointments; insurance plans accepted by the physician practice; the growing national shortage of physicians; the length of time it can take to successfully recruit a physician to the community and begin practicing; and other important qualitative factors.

For purposes of additional analysis, the physician needs assessment analysis of Gray County only reveals a need for physicians in a variety of specialties, and are discussed below. The primary qualitative factor accounted for in this analysis was the age of the practicing physicians in Gray County, and the identification of any physician considered to be in the “retirement zone”, or 63 years of age or older. It was assumed that any physician in the retirement zone could retire from his/her medical practice at any time and therefore that position must be considered as one possibly needing to be replaced and part of any physician recruitment plan for the future.

Based on the quantitative physician needs assessment analysis completed, the top six physician needs in Gray County by specialty are as follows:

- Family Practice – 4.89 FTEs
- Pediatrics – 1.63 FTEs
- Psychiatrist – 2.02
- Ophthalmologist - .93 FTEs
- Anesthesiology – 1.76 FTEs
- Pathology – 1.11 FTEs

Qualitative Factors to be Assessed

1. Age of current physicians practicing in service area—by specialty. For those at age 60 and above it should be assumed they are in the possible retirement zone and their position should be accounted for in recruitment planning. This is especially true given the length of time successful recruitment can take.
2. Quality or service issues that may cause the physician to be asked to leave or be replaced.
3. Waiting times for new patientappointments.
4. Full-time vs. part-time status (FTE count).
5. Emergency department call coverage and any gaps that may exist.
6. Coverage for vacations, continuing medical education time off, personal time off, etc.
7. The specialty of “Hospitalist” is a newer specialty, and therefore the four national physician need models do not account for this specialty.
8. Patient outmigration by specialty.
9. Patient satisfaction by physician.
10. Size of individual physician practices/approximate patient counts and patients seen per day on average.

ATTACHMENT D: SURVEYS

COMMUNTIY ON-LINE SURVEY

* 1. Please enter the following information:

Name

County of Residence

Number of Years Lived in the County

* 2. Identify the top three most significant health care prevention, treatment, and awareness needs in the community.

Affordable health insurance	Health promotion services lacking
Affordable health care prices	Mental health education lacking
Mental health services availability	Places to exercise lacking
Addiction care service availability	Food and nutrition education
Primary care provider availability	General health education lacking
Specialty care provider Availability	Community events lacking
Healthy food availability	Lack of community interests
Financial issues	Other

* 3. Are you aware of the health care services available in your community?

Completely aware

Somewhat aware

Not aware

* 4. How do you generally describe the health status of your community?

Excellent

Good

Fair

Poor

* 5. Are the health care needs currently being met in your community?

Completely agree

Somewhat agree

Somewhat disagree

Completely disagree

COMMUNTIY ON-LINE SURVEY (continued)

* 6. Please share any health care needs of the community that are not being met.

* 7. Health care providers work well together and coordinate care in this community.

Completely agree

Somewhat agree

Somewhat disagree

Completely disagree

* 8. There are barriers that exist in government, the general community, public health community, or health care provider community that prevents us from creating a healthier community.

Completely agree

Somewhat agree

Somewhat disagree

Completely disagree

* 9. Please share any barriers that exist in government, the general community, public health community, or health care provider community that prevents creating a healthier community.

* 10. Please share any general comments about the Health Needs in the Community.

FOCUS GROUP AND PERSONAL INTERVIEWS: STRUCTURED QUESTIONS

1. Describe access to healthcare services in this community.
2. Does access to healthcare vary between primary care and specialty care service? If so, how?
3. Does access to healthcare vary between medical care and mental health care? If so, how?
4. What are the biggest healthcare needs in this community?
5. What are the obstacles to people accessing needed medical, mental health and other types of healthcare in this community?
6. Are their manpower issues impacting access to healthcare services?
7. Are there any other barriers that exist in the general community, public health community, or healthcare provider community that prevents us from creating a healthier community?
8. What healthcare needs are currently being met and what healthcare needs are currently not being met adequately? For those needs that are unmet, what reasons exist for them not being met?
9. What are the biggest health education or prevention needs in this community? What unmet needs should be targeted with health education and prevention?
10. Are there unmet social service needs impacting access to healthcare services in the community? If so, what are they?
11. What types of communication mediums do you find the most credible for hospital information and education on healthcare topics?

    - Television
    - Direct mail
    - Community-based programs
    - Radio
    - Newsletter
    - Internet
    - Newspaper
    - Seminars
    - Brochures
    - Other

12. Describe your perception of how well healthcare providers work together and coordinate care across the continuum in this community.
13. Describe your perception of how well healthcare providers and organizations work together with social service organizations in the community.
14. Are there any special one-time projects that exist where one-time funding would help meet a healthcare or related need that is currently unmet?
15. Name 2 or 3 improvements you would like to see made in healthcare services in this community and why.
16. Is this community adequately prepared to prevent injury, as well as prevent disease & epidemics, and prevent or respond to environmental hazards and emergency situations? If not, how could the community infrastructure be improved so that we are more adequately prepared?
17. Do you have any other thoughts, comments or suggestions about healthcare, mental health, addiction care, or health education and prevention that we have not discussed today?

ATTACHMENT E: CITATIONS

2018 REPORT

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