Spanish Peaks Regional Health Center

Walsenburg, CO

Community Health Needs Assessment and Implementation Strategy

Adopted by Board Resolution March 25, 2021[1]

Spanish Peaks Regional Health Center

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

Dear Community Member:

Spanish Peaks Regional Health Centers' history of caring for our community dates back to 1993. Our efforts to provide exceptional healthcare to the people of the greater Walsenburg region has long been in alignment with the needs of our community. The "2020 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how Spanish Peaks Regional Health Center ("SPRHC") will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

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

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

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

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

Thank You,

Kay Whitley
Chief Executive Officer
Spanish Peaks Regional Health Center

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EXECUTIVE SUMMARY

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Spanish Peaks Regional Health Center ("SPRHC" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community.

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

The 2020 Significant Health Needs identified for Huerfano County are:

1. Mental Health/Suicide – 2017 Significant Need
2. Drug/Substance Abuse
3. Education/Prevention
4. Alcohol Abuse
5. Obesity – 2017 Significant Need
6. Diabetes – 2017 Significant Need

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

APPROACH

APPROACH

Spanish Peaks Regional Health Center ("SPRHC" or the "Hospital") is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA helps the hospital identify and respond to the primary health needs of its residents.

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

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

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

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

Project Objectives

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

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

Overview of Community Health Needs Assessment

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

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

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

[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602
[3] As of the date of this report all tax questions and suggested answers relate to 2017 Draft Federal 990 Schedule H instructions i990sh—dft(2) and tax form
[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule H (Form 990) V B 6 b

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;*
>
> *(2) members of medically underserved, low-income, and minority populations in the*

[5] Section 6652

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

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

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

Assessment and Implementation Strategy efforts. The Hospital followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

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

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

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

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

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

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

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

Other (please specify)

The methodology also takes a comprehensive approach to assess community health needs, perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis. Local expert area residents were asked to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.[10]

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

Data sources include:[11]

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[8] Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) B 3 h
[9] "Local Expert" is an advisory group of at least 15 local residents, inclusive of at least one member self-identifying with each of the five Quorum written comment solicitation classifications, with whom the Hospital solicited to participate in the Quorum/Hospital CHNA process. Response to Schedule H (Form 990) V B 3 h
[10] Response to Schedule H (Form 990) Part V B 3 i
[11] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Huerfano County compared to all Colorado counties	January 2020	2012-2018
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the Hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	January 2020	2019
http://svi.cdc.gov	To identify the Social Vulnerability Index value	January 2020	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	January 2020	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	January 2020	2019

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

- A CHNA survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 17 Local Expert Advisors was received. Survey responses started August 24, 2020 and ended on September 23, 2020.
- Information analysis augmented by local opinions showed how Huerfano County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority

others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) Part V B 3 d

Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups. .[12] [13]

- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments:
    - The top three priority populations identified by the local experts were low-income groups, older adults and residents of rural areas
    - Summary of unique or pressing needs of the priority groups:
        - Access to affordable healthcare
        - Education and health programs

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

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

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

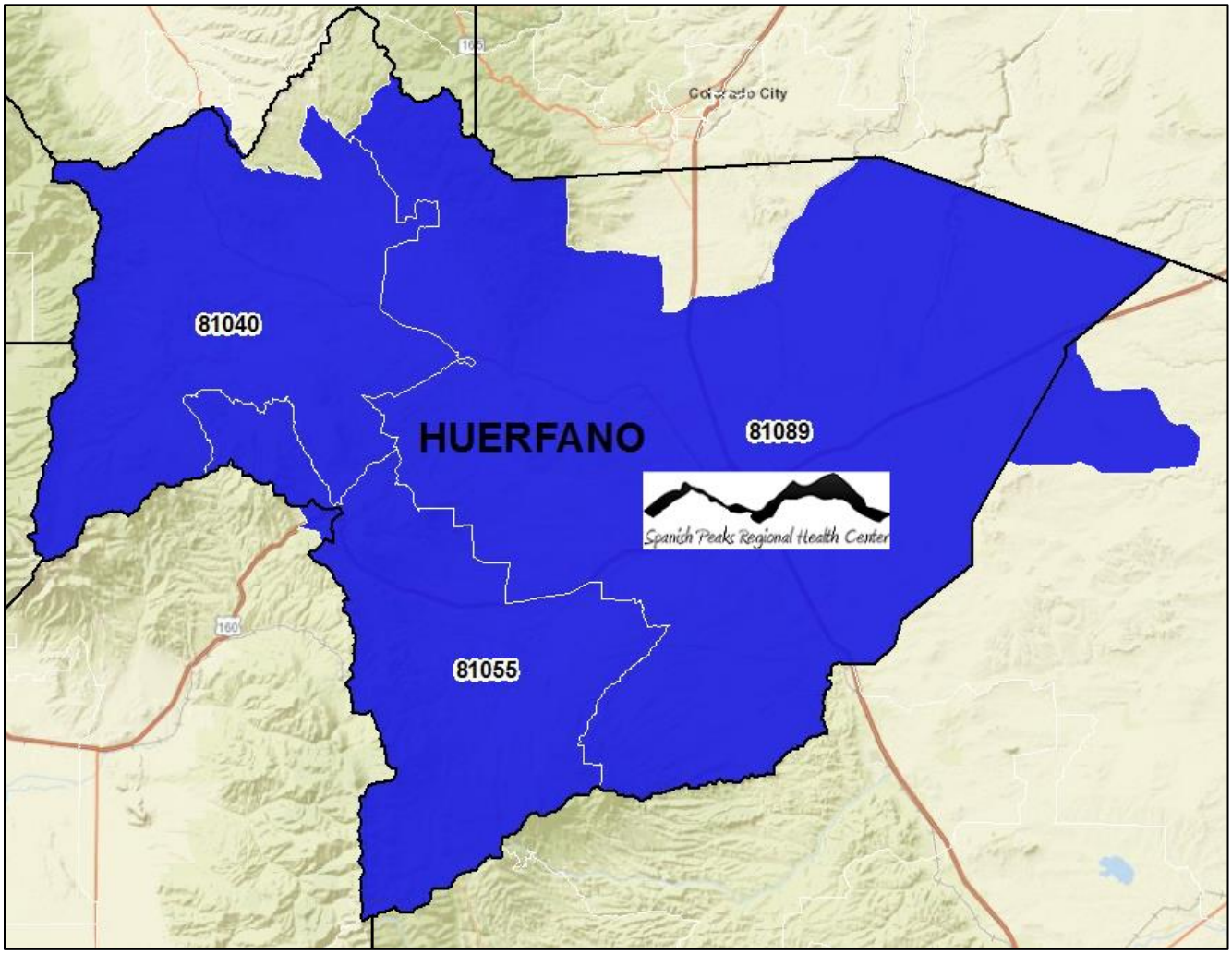
[12] Response to Schedule H (Form 990) Part V B 3 f
[13] Response to Schedule H (Form 990) Part V B 3 h
[14] Response to Schedule H (Form 990) Part V B 5
[15] Response to Schedule H (Form 990) Part V B 3 g

Overview of COVID-19 Survey Results:

- As an addition to the survey, SPRHC gathered input from Local Experts on the impacts COVID-19 has had on their community. Below you will find and overview of their feedback; See the appendix for full survey responses:
    - **Overall impact of COVID-19:** It is clear from the survey results that the community is concerned and impacted by COVID-19 personally or in their household; 50% of the surveyors reported being noticeably impacted by the pandemic and 40% reported significant daily disruption with reduced access to healthcare services or severe daily disruption, immediate needs unmet
    - **Social Determinants of Health:** Social determinants of health have been shown to have a considerable effect on COVID-19 outcomes. The top areas respondents reported as negatively impacted by the pandemic include employment, social support systems, education, childcare and access to healthcare services. As a result of this, mental health issues have increased throughout the community.
    - **Delay in Healthcare Services:** As a result of COVID-19, 80% of surveyors reported that they or someone they knew delayed accessing healthcare. Results indicate that survey respondents or individuals in their household are most likely to use the following services; 80% reported accessing emergency care; 60% reported urgent care/walk-in clinics and primary care.
    - **Community Support:** There are several ways that healthcare providers, like SPRHC, can support the community through these pressing times. Examples include offering alternatives to in-person healthcare visits, connecting with patients through digital communication channels, and serving as a trusted source of information and education.
    - **Pressing Healthcare Services/Programs:** The healthcare services/programs identified by respondents as being most important to supporting community health throughout the pandemic are mental health, primary care, and emergency care.
    - **Alternative Care Options:** Establishing alternative options to in-person care will continue to be a critical piece of the COVID response. Survey respondents believe video visits with healthcare providers would be most beneficial to the local community, virtual triage/screening options before coming to clinic/hospital, and telephone visits with a healthcare provider and video visits with healthcare providers would be most beneficial to the local community.

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[16]



For the purposes of this study, Spanish Peaks Regional Health Center defines its service area as Huerfano County in TX, which includes the following ZIP codes:[17]

81040 – Gardner 81055 – La Veta 81089 – Walsenburg

During 2018, the Hospital received 59.8% of its Medicare inpatients from this area. [18]

[16] Responds to IRS Schedule H (Form 990) Part V B 3 a
[17] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[18] IBM Watson Health MEDPAR patient origin data for the hospital; Responds to IRS Schedule H (Form 990) Part V B 3 a

Demographics of the Community [19] [20]

Variable	Huerfano County 2020	Huerfano County 2025	Huerfano County %Change	Colorado 2020	Colorado 2025	Colorado %Change	United States 2020	United States 2025	United States %Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	6,571	6,708	2.1%	9,317,568	9,701,496	4.1%	329,236,175	340,950,067	3.6%
Total Male Population	3,365	3,432	2.0%	4,628,675	4,817,974	4.1%	162,097,263	167,921,866	3.6%
Total Female Population	3,206	3,276	2.2%	4,688,893	4,883,522	4.2%	167,138,912	173,028,201	3.5%
Females, Child Bearing Age (15-44)	789	811	2.8%	1,824,664	1,863,945	2.2%	64,251,309	65,231,610	1.5%
Average Household Income	$60,111			$103,460			$89,646		
POPULATION DISTRIBUTION									
Age Distribution									
0-14	837	829	-1.0%	1,659,184	1,655,000	-0.3%	61,258,096	61,645,382	0.6%
15-17	186	188	1.1%	363,011	376,657	3.8%	12,813,020	13,319,388	4.0%
18-24	391	425	8.7%	899,805	927,346	3.1%	31,474,821	32,296,411	2.6%
25-34	541	567	4.8%	1,281,819	1,271,375	-0.8%	44,370,805	43,645,423	-1.6%
35-54	1,203	1,108	-7.9%	2,417,488	2,453,334	1.5%	83,304,733	84,255,193	1.1%
55-64	1,262	1,210	-4.1%	1,243,083	1,283,286	3.2%	42,525,512	43,333,585	1.9%
65+	2,151	2,381	10.7%	1,453,178	1,734,498	19.4%	53,489,188	62,454,685	16.8%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	3,146	3,242	3.1%	3,656,152	3,820,624	4.5%	125,018,838	129,683,911	3.7%
2020 Household Income									
<$15K	522			300,771			13,139,420		
$15-25K	514			267,199			11,333,086		
$25-50K	949			690,036			26,888,001		
$50-75K	344			604,556			21,157,116		
$75-100K	319			477,062			15,409,735		
Over $100K	498			1,316,528			37,091,480		
EDUCATION LEVEL									
Pop Age 25+	5,157			6,395,568			223,690,238		
2020 Adult Education Level Distribution									
Less than High School	199			242,063			12,173,720		
Some High School	249			338,549			16,245,471		
High School Degree	1,422			1,540,193			61,068,735		
Some College/Assoc. Degree	1,952			1,773,545			64,945,355		
Bachelor's Degree or Greater	1,335			2,501,218			69,256,957		
RACE/ETHNICITY									
2020 Race/Ethnicity Distribution									
White Non-Hispanic	4,027			6,245,253			197,594,684		
Black Non-Hispanic	49			592,250			40,877,627		
Hispanic	2,194			1,840,553			60,675,779		
Asian & Pacific Is. Non-Hispanic	51			363,327			19,327,168		
All Others	250			276,185			10,760,917		

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

Consumer Health Service Behavior[21]

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

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

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	113.6%	34.7%	Cancer Screen: Skin 2 yr	91.2%	9.8%
Vigorous Exercise	94.7%	54.1%	Cancer Screen: Colorectal 2 yr	93.0%	19.1%
Chronic Diabetes	132.8%	20.8%	Cancer Screen: Pap/Cerv Test 2 yr	75.0%	36.2%
Healthy Eating Habits	113.9%	26.6%	Routine Screen: Prostate 2 yr	89.2%	25.3%
Ate Breakfast Yesterday	99.1%	78.3%	**Orthopedic**		
Slept Less Than 6 Hours	119.0%	16.2%	Chronic Lower Back Pain	106.0%	32.7%
Consumed Alcohol in the Past 30 Days	71.7%	38.5%	Chronic Osteoporosis	136.2%	13.8%
Consumed 3+ Drinks Per Session	124.8%	35.1%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	104.2%	84.7%
Search for Pricing Info	82.0%	22.0%	NP/PA Last 6 Months	106.6%	44.2%
I am Responsible for My Health	98.4%	89.1%	OB/Gyn 1+ Visit	74.3%	28.6%
I Follow Treatment Recommendations	102.9%	79.5%	Medication: Received Prescription	105.2%	63.4%
Pulmonary			**Internet Usage**		
Chronic COPD	150.9%	8.1%	Use Internet to Look for Provider Info	65.7%	26.2%
Chronic Asthma	93.1%	11.0%	Facebook Opinions	70.1%	7.1%
Heart			Looked for Provider Rating	65.8%	15.4%
Chronic High Cholesterol	128.1%	31.3%	**Emergency Services**		
Routine Cholesterol Screening	91.8%	40.7%	Emergency Room Use	99.5%	34.5%
Chronic Heart Failure	166.1%	6.7%	Urgent Care Use	84.6%	27.9%

Conclusions from Demographic Analysis Compared to National Averages

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

- 5% less likely to **Vigorously Exercise**, affecting 54%
- 8% less likely to receive **Routine Cholesterol Screenings**, affecting 41%
- 25% less likely to receive **Cervical Cancer Screenings Every 2 Years**, affecting 36%

[21] Claritas (accessed through IBM Watson Health)

- 25% more likely to have **Consumed Alcohol in the Past 30 Days**, affecting 35%
- 14% more likely to have a **BMI: Morbid/Obese**, affecting 35%
- 6% more likely to have **Chronic Lower Back Pain**, affecting 33%
- 28% more likely to have **Chronic High Cholesterol**, affecting 31%

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

- 7% more likely to have **Routine Visit with NP/PA in Last 6 Months**, affecting 44%
- 28% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 39%

Leading Causes of Death[22]

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

Cause of Death			Rank among all counties in CO (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Huerfano County Compared to U.S.)
CO Rank	Huerfano Rank	Condition		CO	Huerfano	
2	1	Heart Disease	9 of 60	122.6	184.1	***Higher than expected***
1	2	Cancer	13 of 60	130.9	165.4	***Higher than expected***
3	3	Accidents	5 of 60	53.5	78.8	***Higher than expected***
4	4	Lung	8 of 60	45.5	69.6	***Higher than expected***
5	5	Stroke	19 of 60	35.8	41.8	***As expected***
7	6	Suicide	2 of 60	20.3	32.4	***Higher than expected***
6	7	Alzheimer's	13 of 60	34.1	30.1	***As expected***
8	8	Diabetes	20 of 60	17.2	20.3	***As expected***
10	9	Flu - Pneumonia	17 of 60	10.1	19.1	***As expected***
9	10	Liver	10 of 60	13.9	17.5	***Higher than expected***
11	11	Kidney	8 of 60	8.8	15.5	***As expected***
13	12	Blood Poisoning	6 of 60	8.4	13.0	***As expected***
15	13	Homicide	5 of 56	4.5	8.1	***As expected***
12	14	Parkinson's	14 of 60	9.3	7.6	***As expected***
14	15	Hypertension	19 of 60	5.2	5.8	***As expected***

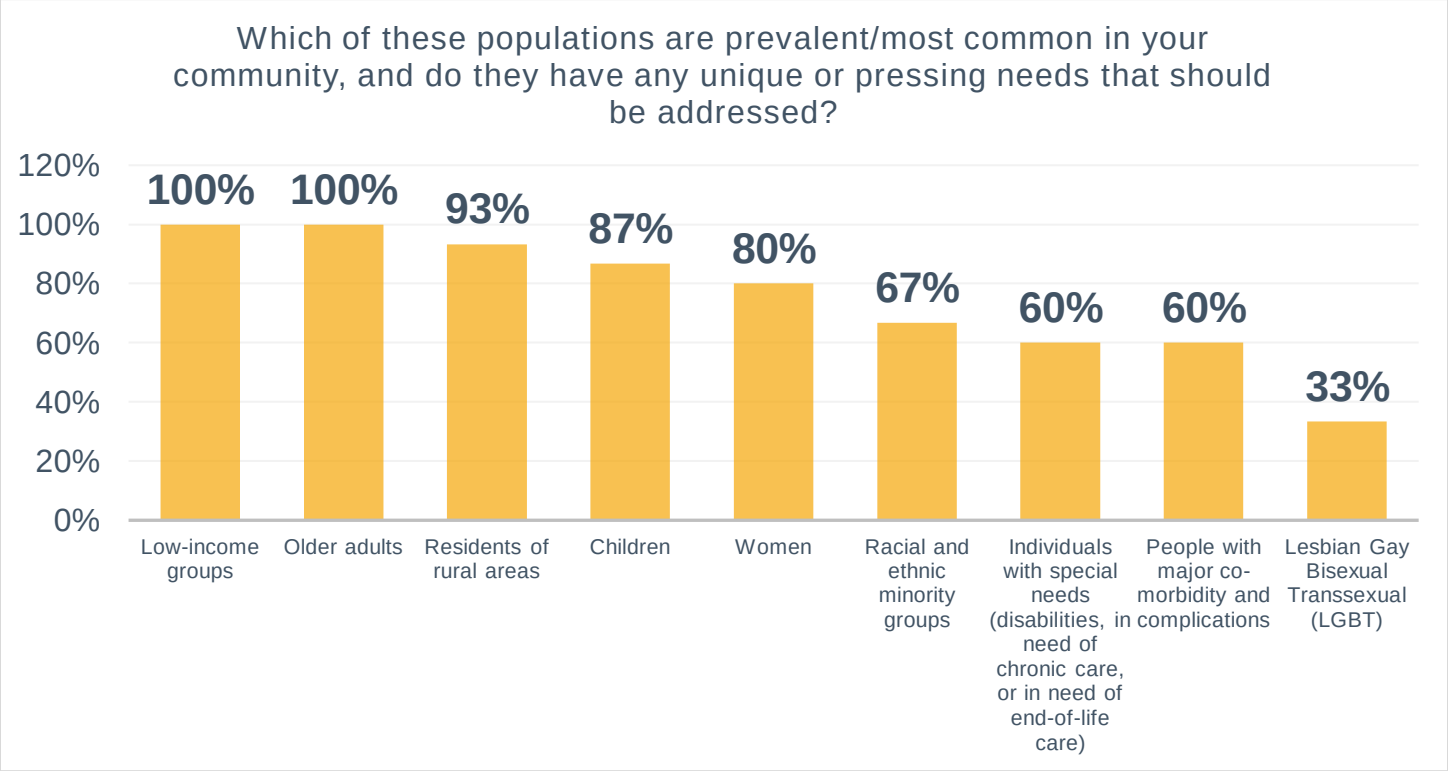
[22] www.worldlifeexpectancy.com/usa-health-rankings

Priority Populations[23]

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

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

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



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

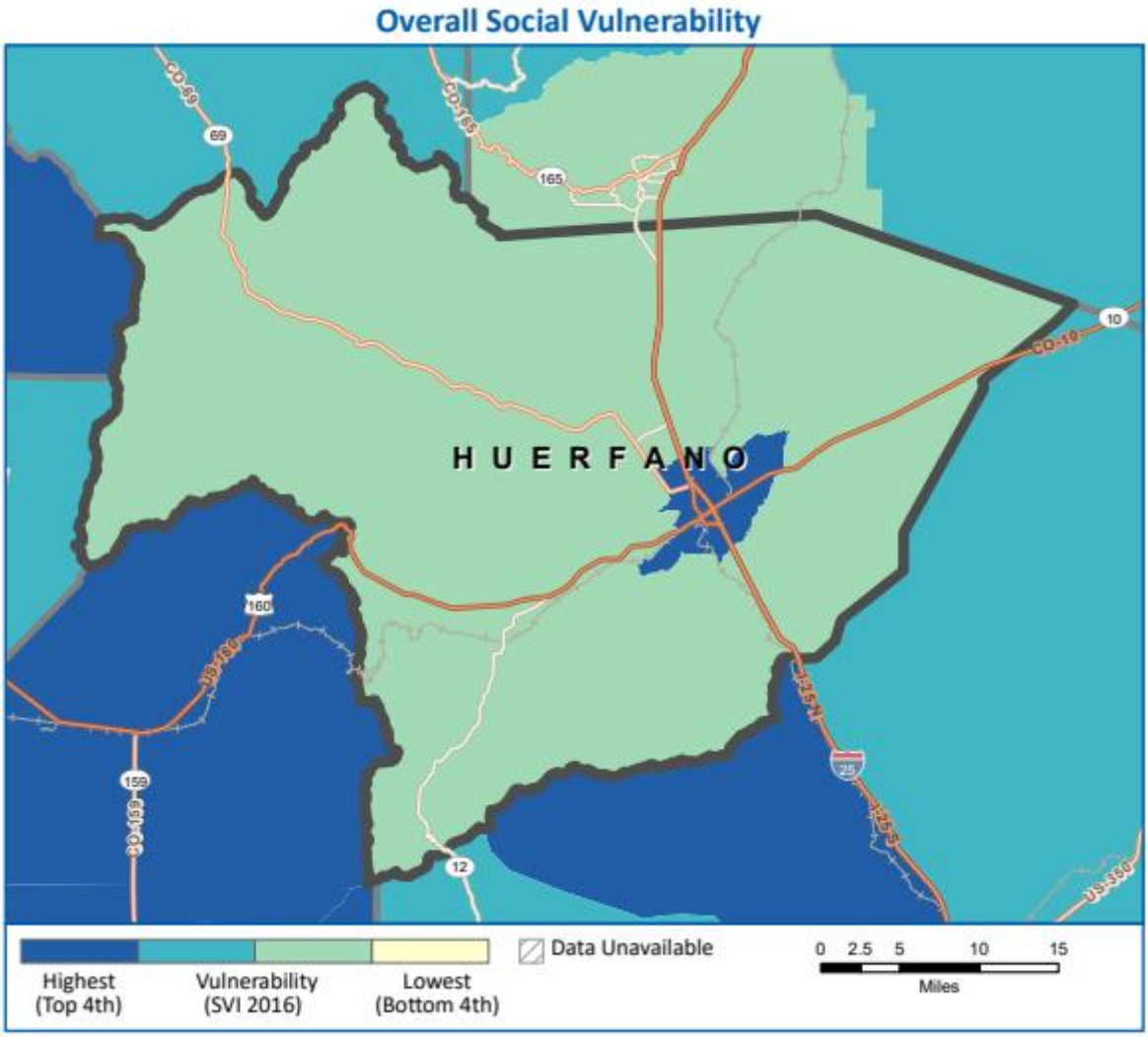
- The top three priority populations identified by the local experts were low-income groups, older adults and residents of rural areas
- Summary of unique or pressing needs of the priority groups:
    - Access to affordable healthcare
    - Education and health programs

Social Vulnerability[25]

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

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

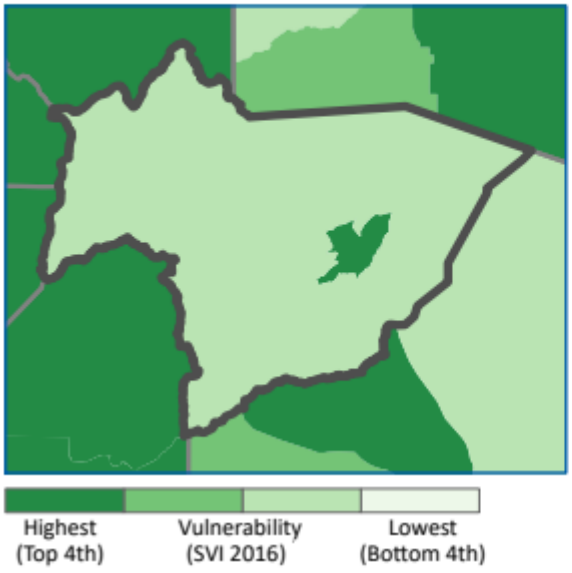
Based on the overall social vulnerability, Huerfano County falls into two quartiles of social vulnerability – the highest (dark blue) and second lowest (light green). The central region of the county in dark blue is considered to have the highest social vulnerability:



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

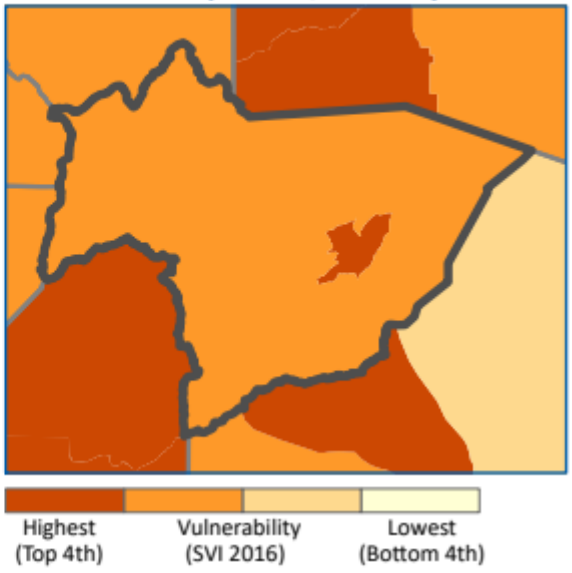
SVI Themes

Socioeconomic Status



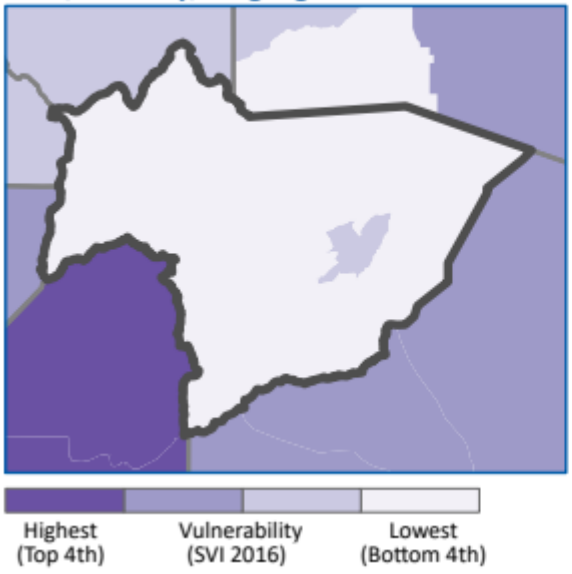
Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

Household Composition/Disability



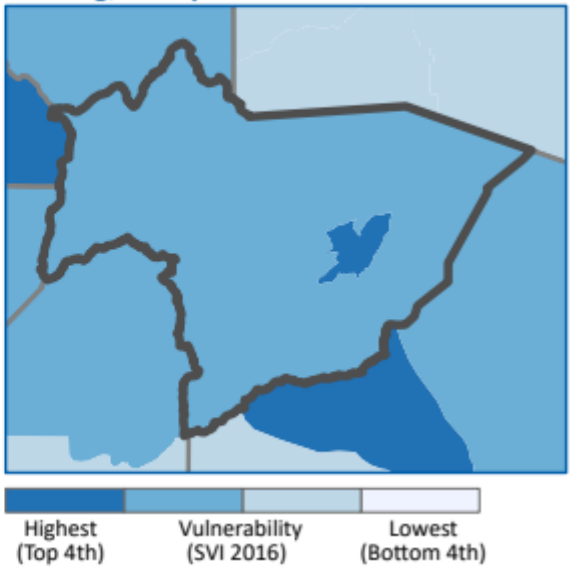
Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

Race/Ethnicity/Language



Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

Housing/Transportation



Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

Comparison to Other State Counties[26]

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

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

	Huerfano	Colorado	U.S. Median
Length of Life			
Overall Rank *(best being #1)*	**59/60**		
- Premature Death*	12,100	5,900	8,200
Quality of Life			
Overall Rank *(best being #1)*	**45/60**		
- Poor or Fair Health	17%	14%	17%
- Poor Physical Health Days	3.8	3.4	3.9
- Poor Mental Health Days	3.8	3.8	4.2
- Low Birthweight	10%	9%	8%
Health Behaviors			
Overall Rank *(best being #1)*	**24/60**		
- Adult Smoking	13%	15%	17%
- Adult Obesity	27%	22%	33%
- Physical Inactivity	21%	16%	27%
- Access to Exercise Opportunities	75%	90%	66%
- Excessive Drinking	14%	20%	18%
- Alcohol-Impaired Driving Deaths	19%	34%	28%
- Sexually Transmitted Infections*	510.4	481.4	327.4
- Teen Births *(per 1,000 female population ages 15-19)*	30	19	28
- Drug overdose deaths *(measure not included in overall ranking)*	59	18	20
Clinical Care			
Overall Rank *(best being #1)*	**24/60**		
- Uninsured	8%	9%	11%
- Population to Primary Care Provider Ratio	950:1	1,220:1	2,070:1
- Population to Dentist Ratio	3,440:1	1,260:1	2,410:1
- Population to Mental Health Provider Ratio	690:1	280:1	890:1
- Preventable Hospital Stays	2,630	2,833	4,710
- Mammography Screening	37%	41%	41%
- Flu vaccinations	27%	48%	43%
Social & Economic Factors			
Overall Rank *(best being #1)*	**60/60**		
- High school graduation	87%	81%	90%
- Unemployment	6.5%	3.3%	3.9%
- Children in Poverty	37%	12%	20%
- Income inequality**	4.8	4.4	4.4
- Children in Single-Parent Households	37%	27%	32%
- Violent Crime*	409	326	205
- Injury Deaths*	175	78	84
- Children eligible for free or reduced price lunch *(measure not included in overall*	71%	42%	52%
Physical Environment			
Overall Rank *(best being #1)*	**24/60**		
- Air Pollution - Particulate Matter	4.4 µg/m³	5.1 µg/m³	9.4 µg/m³
- Severe Housing Problems***	16%	17%	13%
- Driving to work alone	70%	75%	81%
- Long commute - driving alone	27%	36%	31%

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

[26] www.countyhealthrankings.org

Conclusions from Other Statistical Data[27]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Huerfano County's statistics to the U.S. average, and lists the change since the last date of measurement.

Huerfano County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Huerfano County measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change		
- Female Self-Harm and Interpersonal Violence Related Deaths*	**16.0**	**41.4%**
- Male Self-Harm and Interpersonal Violence Related Deaths*	**61.6**	**30.9%**
- Female Mental and Substance Use Related Deaths*	**15.7**	**440.6%**
- Male Mental and Substance Use Related Deaths*	**33.2**	**213.4%**
- Female Liver Disease Related Deaths*	**22.2**	**76.3%**
- Male Liver Disease Related Deaths*	**45.4**	**32.3%**
UNFAVORABLE Huerfano County measures that are **WORSE** than the U.S. average and had a **FAVORABLE** change		
- Male Stroke*	**57.9**	**-32.1%**
- Female Transport Injuries Related Deaths*	**19.1**	**-23.9%**
- Male Transport Injuries Related Deaths*	**34.4**	**-44.3%**
DESIRABLE Huerfano County measures that are **BETTER** than the US average and had an **UNFAVORABLE** change		
- Female Tracheal, Bronchus, and Lung Cancer*	**28.8**	**46.2%**
- Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	**53.8**	**18.8%**
DESIRABLE Huerfano County measures that are **BETTER** than the US average and had a **FAVORABLE** change		
- Female Stroke*	**36.5**	**-31.1%**
- Male Tracheal, Bronchus, and Lung Cancer*	**61.8**	**-5.2%**
AVERAGE Huerfano County measures that are **EQUAL** to the US average and had an **UNFAVORABLE** change		
- Male Breast Cancer*	**0.3**	**2.4%**
- Female Skin Cancer*	**2.2**	**11.7%**
- Male Skin Cancer*	**4.7**	**65.5%**
- Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	**44.5**	**8.6%**
AVERAGE Huerfano County measures that are **EQUAL** to the US average and had a **FAVORABLE** change		
- Female Life Expectancy	**81.2**	**3.8%**
- Male Life Expectancy	**74.2**	**5.1%**
- Female Heart Disease*	**121.2**	**-45.1%**
- Male Heart Disease*	**193.0**	**-52.3%**
- Female Breast Cancer*	**22.6**	**-20.2%**

**rate per 100,000 population, age-standardized*

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

IMPLEMENTATION STRATEGY

Significant Health Needs

SPRHC used the priority ranking of the area health needs by the Local Expert Advisors as the primary input to develop the response and implementation plans for the community health needs.[28] The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies SPRHC current efforts responding to the need
- Establishes the Implementation Strategy programs and resources SPRHC will devote to attempt to achieve improvements
- Documents the Leading Indicators SPRHC will use to measure progress
- Presents the Lagging Indicators SPRHC believes the Leading Indicators will influence in a positive fashion, and
- Identifies any potential partnerships with local organizations.

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

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

1. Mental Health/Suicide – 2017 Significant Need

- Huerfano County's population to mental health care provider ratio is worse than the state average
- Suicide is the #6 leading cause of death in Huerfano County and the death rate is worse than the national average
- Huerfano County's mental and substance use related deaths significantly increased from 1980-2014 and the statistics were worse than the U.S. average in 2014

Public comments received on previously adopted implementation strategy:

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

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

- Employee Assistance Program (HUD) available to hospital staff and families that includes counseling for a variety of health and social issues
- Integrated Behavioral Health services including telepsych services are available in the rural health clinic through Health Solutions
- Referrals to Health Solutions for inpatient treatment programs
- PQ9 depression screenings are administered during annual visits and for every patient in the emergency department and if patient has had life changing experiences

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

- Training in identifying mental health issues through SBIRT (Screening, Brief Intervention and Referral to Treatment)
- Open discussions with law enforcement on how to address mental health issues/patients in the community
- Explore opportunities for implementing telepsych treatment in the emergency department
- SPRHC participates in the Communities That Care (CTC) program that addresses the root causes of substance abuse in hopes to reduce levels of youth problems before they start

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

- Implementation of Integrated Behavioral Health for Medicaid Patients

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

- Number of behavioral health interactions per month

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

- Poor mental health days in Huerfano County
- Suicide death rate in Huerfano County

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

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

Organization	Contact Name	Contact Information
Health Solutions	Teresa Keller	(719) 545-2746 41 Montebello Rd, Pueblo, CO 81001
Huerfano County Sheriff's Department	Sheriff Bruce Newman	(719) 738-1600 500 S. Albert, Walsenburg, CO 81089
Spanish Peaks Ambulance	Nicholas Brown	(719) 738-4517 326 Main St., Walsenburg, CO 81089
Parkview Medical Center		(719) 584-4000 400 West 16th St., Pueblo, CO 81003

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

- Family Resource Center
- Health Solutions-Youth and Family Services

Anticipated results from SPRHC Implementation Strategy

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

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

6. Otherwise would become responsibility of government or another tax-exempt organization	**X**	
7. Increases knowledge; then benefits the public	**X**	

2. Drug/Substance Abuse – Local expert concern

5. Alcohol Abuse – Local expert concern

- Huerfano County's mental and substance use related deaths significantly increased from 1980-2014 and the statistics were worse than the U.S. average in 2014
- Huerfano County's drug overdose deaths rate is worse than the state average and U.S. median
- Huerfano County's excessive drinking rate and alcohol-impaired driving deaths rate are similar to the state averages and U.S. median
- Residents of Huerfano County are more likely to consume 3+ drinks per session when compared to the U.S. average

Due to the similar services, programs, and resources available to respond to this need, only one implementation strategy has been developed.

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

- Medicated Assisted Treatment (MAT) program
- SPRHC participates in the Colorado Opioid Solution: Clinicians United to Resolve the Epidemic (CO's CURE) to reduce the administration of opioids while still treating pain appropriately through the use of ALTO (Alternative to Opioids Project)
- SPRHC participates in the Communities That Care (CTC) program that addresses the root causes of substance abuse in hopes to reduce levels of youth problems before they start
- Hospital is a tobacco-free campus
- Providers and staff trained in Tobacco Cessation through the American Lung Association
- Employee Assistance Program available to hospital staff and families that includes counseling for a variety of health and social issues
- Tobacco surveys conducted at annual visits
- Respiratory therapy provided to inpatients as part of discharge planning

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

- Researching having emergency providers speak in school on the dangers of substance abuse and how they can lead to motor vehicle accidents
- Through the Hospital Transformation Program SPRHC is actively working towards reducing substance use in Huerfano County by exploring best practices around breaking the multi-generational cycle of drug use, developing a communication plan to ensure resources on substance use are updated and shared among community members, and improving access to comprehensive treatment for substance use disorders
- In the process of offering all the providers the opportunity to get certified to administer Suboxone through One Health grant
- Explore options for participating in drug take back events

The strategy to evaluate SPRHC intended actions is to monitor change in the following Leading

Indicator:

- Number of opioid prescriptions
- Patients referred and engaged in treatment programs

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

- Drug overdose deaths
- Detox relapse rate

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

Organization	Contact Name	Contact Information
Alcoholics/Narcotics Anonymous	N/A	(718) 546-1173 www.puebloaa.org
Huerfano Las Animas Health Department	Kim Gonzales, ED Glenn Miers, MAT Marsy Key, CTC	(719) 738-2650 119 East 5th St., Walsenburg, CO 81089 www.la-h-health.org
Colorado Hospital Association	N/A	https://cha.com/
American Lung Association	N/A	https://www.lung.org/
One Health	Kelly Means	(208) 206-7632 www.onehealthinsights.com

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

- Spanish Peaks Mental Health Center
- Narcotics Anonymous
- La Veta School District
- Sangre de Cristo Center for Youth

Anticipated results from SPRHC Implementation Strategy

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

3. Education/Prevention – Local expert concern

- Huerfano County's preventable hospital stays rate is worse than the state average and U.S. median
- Huerfano County's mammography screening rate is slightly than the state average and U.S. median
- Huerfano County's flu vaccination rate is worse than the state average and U.S. median

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

- SPRHC participates in the Communities That Care (CTC) program that addresses the root causes of substance abuse in hopes to reduce levels of youth problems before they start
- PQ9 depression screenings are administered during annual visits and for every patient in the emergency department and patients with life changing events
- Actively addressing education and prevention through Practice Transformation, Quality Improvement Plans, and the Hospital Transformation Program
- Tobacco surveys conducted at annual visits
- Providers and staff trained in Tobacco Cessation through the American Lung Association
- SPRHC's Wellness Committee promotes wellness throughout the organization; The committee launched the Wellness Wednesday campaign which highlights a healthy meal every Wednesday in the cafeteria and those who participate are entered into a drawing to win prizes every quarter
- Marketing teams promotes health and wellness education through social media platforms and distribute flyers out to all Huerfano residents
- Participate in annual county-wide health fair
    - Lab work performed for $25 (discounted rate) beforehand and patients receive results via primary care provider at health fair
- Host 65+ drive thru flu clinics and provide flu vaccine in the clinics

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

- Will take steps through marketing and one on one patient education to emphasize the importance of early screening and vaccinations
- Utilize EMR to pull reports that will measure and identify SPRHC impact on key indicators of improvement
- Continue to request funds to support case manager and patient navigator tasked with education of the community and patients

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

- Mammography screening rate
- Participation in Wellness Wednesday campaign

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

- Preventable hospital stays

- Obesity, Diabetes, and Heart Disease rates

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

Organization	Contact Name	Contact Information
SOCO Advertising	Trapper Collova	(719) 735-5005
Outreach Clinic	Patient Navigator (TBD)	ewhite@sprhc.com; ataylor@sprhc.org (719) 738-5200

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

- Las Animas Huerfano Counties Health Department

Anticipated results from SPRHC Implementation Strategy

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

5. **Obesity – 2017 Significant Need**
6. **Diabetes – 2017 Significant Need**

- Huerfano County's obesity rate and physical inactivity rates are slightly worse than the state average, but better than the U.S. median
- Diabetes is the #8 leading cause of death in Huerfano County
- Huerfano County's diabetes, urogenital, blood, and endocrine disease deaths increased from 1980-2014

Due to the similar services, programs, and resources available to respond to this need, only one implementation strategy has been developed.

Public comments received on previously adopted implementation strategy:

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

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

- CCPD – free heart risk assessment with biometric screening, triglycerides, glucose
- Participate in annual county-wide health fair
    - Lab work performed for $25 (discounted rate) beforehand and patients receive results via primary care provider at health fair
- Free lifestyle coaching – provides nutrition education, healthy lifestyle choices, blood-pressure monitoring
- 'Shopping Matters' classes teaching how to shop for healthy foods and read nutrition labels
- Hospital teams participate in local runs/races
- SPRHC's Wellness Committee promotes wellness throughout the organization; The committee launched the Wellness Wednesday campaign which highlights a healthy meal every Wednesday in the cafeteria and those who participate are entered into a drawing to win prizes every quarter

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

- Continue offering current programs and resources

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

- Contracted an RN who is leading the diabetes prevention program and diabetes self-management program free to the public; Participates have the option of virtual or in-person classes where they will learn healthy eating, active lifestyle tips, blood sugar monitoring techniques, medications, and more

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

- Participation in the diabetes prevention program, diabetes self-management program, and lifestyle coaching

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

- Obesity rate

- Diabetes rate

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

Organization	Contact Name	Contact Information
Spanish Peaks Healthcare Foundation		https://www.sprhc.org/ (719) 738-5100 23500 U.S. Highway 160, Walsenburg, CO 81089
La Veta School District, Huerfano School District RE-1		http://www.laveta.k12.co.us/ (719) 742-3562 126 East Garland, La Veta, CO 81055 http://huerfano.k12.co.us/ (719) 738-1520 201 E 5th St, Walsenburg, CO 81089
Las Animas/Huerfano Counties District Health Department		www.la-h-health.org **Las Animas County** (719)846-2213 412 Benedicta Avenue Trinidad, CO 81082 **Huerfano County** (719) 738-2650 119 E 5th Street Walsenburg, CO 81089

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

- Local fitness centers

Anticipated results from SPRHC Implementation Strategy

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

Other Needs Identified During CHNA Process

7. **Affordability/Accessibility – 2017 Significant Need**
8. **Women's Health**
9. **Cancer**
10. **Heart Disease**
11. **Hypertension**
12. **Physical Inactivity**
13. **Chronic Pain Management**
14. **Social Factors – 2017 Significant Need**
15. **Accidents**
16. **Lung Disease**
17. **Smoking/Tobacco Use**
18. **Alzheimer's**
19. **Kidney Disease**
20. **Pharmacy**
21. **Stroke**
22. **Flu/Pneumonia**
23. **Live Disease**
24. **Dental**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[31]

1. Mental Health/Suicide – 2016 Significant Need
2. Mental Health/Suicide – 2017 Significant Need
3. Drug/Substance Abuse
4. Education/Prevention
5. Alcohol Abuse
6. Obesity – 2017 Significant Need
7. Diabetes – 2017 Significant Need

Significant needs where hospital did not develop implementation strategy[32]

1. Mental Health/Suicide – 2016 Significant Need
2. Mental Health/Suicide – 2017 Significant Need
3. Drug/Substance Abuse
4. Education/Prevention
5. Alcohol Abuse
6. Obesity – 2017 Significant Need
7. Diabetes – 2017 Significant Need

Other needs where hospital developed implementation strategy

1. N/A

Other needs where hospital did not develop implementation strategy

1. N/A

[31] Responds to Schedule h (Form 990) Part V B 8
[32] Responds to Schedule h (Form 990) Part V Section B 8

APPENDIX

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

Hospital solicited written comments about its 2017 CHNA.[33] 17 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.[34]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	6	9	15
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	4	9	13
3) **Priority Populations**	7	7	14
4) Representative/Member of **Chronic Disease Group** or Organization	1	10	11
5) Represents the **Broad Interest of the Community**	13	1	14
Other			4

Congress defines "Priority Populations" to include:

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

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

- *The median age in the county is 55.1 years of age. We have a high senior population. We a rural county, are also one of the poorest and least healthy counties in the state.*
- *Multi-generational trauma and stigma surrounding seeking help; an under educated cohort over many years has created an overwhelmingly high-risk rural population*

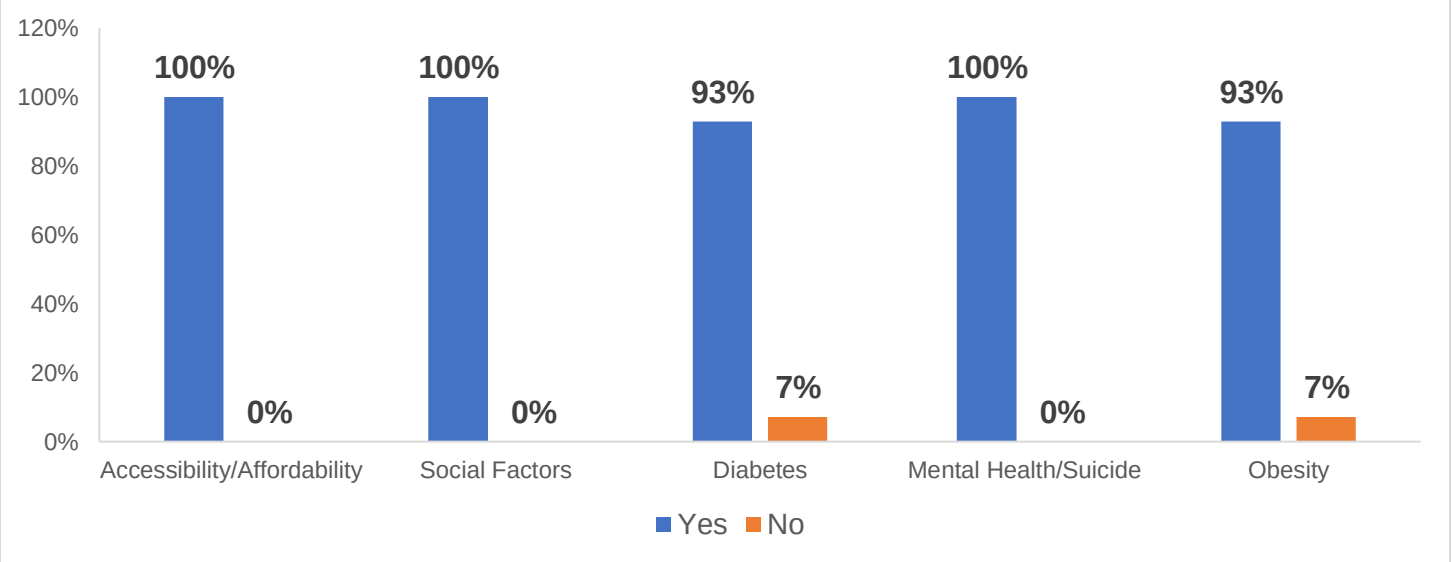
[33] Responds to IRS Schedule H (Form 990) Part V B 5
[34] Responds to IRS Schedule H (Form 990) Part V B 3 g

- *Drug abuse, Diabetes, Obesity*
- *Many of those listed above do have mental health needs that are intensified due to the struggles of race, poverty, gender, age, etc.*
- *Universal health care, better education system, improved broadband, more economic opportunities.*

In the 2017 CHNA, there were five health needs identified as "significant" or most important:

1. Accessibility/Affordability
2. Social Factors
3. Diabetes
4. Mental Health/Suicide
5. Obesity

3. Should the hospital continue to consider and allocate resources to help improve the needs identified in the 2017 CHNA?



Comments:

- *Health Solutions works to help identify clients who are at risk of self harm. We work with the Medicaid and indigent population and assist persons who may struggle with anxiety or depression related to a serious healthcare issue. Due to COIVD we find that people's mental health issues are often made worse due to the fears and isolation they have related to COVID as well as the staggering violence they see on the news taking place in the larger cities. This is a trigger for those who have trauma histories.*
- *Stigmas on mental health and substance use (or those in MAT services)*

4. Please share comments or observations about the actions SPRHC has taken to address Accessibility/Affordability & Social Factors.

- *Mental health remains to have issues no good resources locally.*

- *Agree with initiatives.*
- *Why do you only want to add a Urgent Care center in Walsenburg? What about Gardner or La Veta?*
- *Health Solutions has a person on site weekly, also able to do psych-telehealth. Program for bi-county referrals is active.*
- *After hours clinic in downtown area is part of the 2020 strategic plan. Live Well Colorado is no longer in Huerfano County. Diabetes educator in place, Health Solutions is on site for clinic appointments.*
- *Health Solutions is providing telehealth for therapy and prescriber services. Hugh Keating has been the provider on site. We are looking to do a Mental Health First Aide Class for Community health and law enforcement providers. We offer crisis services 24/7.*
- *Several of those objectives have not been met.*
- *Telehealth option has been a nice add, maybe in some diagnosis that can remain, at least for follow ups.*

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

- *Agree with initiatives.*
- *LiveWell is gone, and part-time wellness coordinator quit because the LiveWell executive director insisted on micromanaging. LiveWell did not live well.*
- *Hired a diabetic educator/nutritionist and are DSME up and running.*
- *Educator in place - continuing to develop the program. Working with UCH on Tele-Endocrinology.*
- *The diabetes education courses have been nice, I just wish more people took advantage of the class.*

6. **Please share comments or observations about the actions SPRHC has taken to address Mental Health/Suicide.**

- *Mental health remains to have issues no good resources locally.*
- *Agree with initiatives.*
- *Mental Health, tele-psych health available in our community will be a great resource and need in this community. There presently no mental health care available in this community and when one is in need of mental health they are being transferred all the way to Fort Morgan up North.*
- *Health Solutions is in Walsenburg. Do not center everything in the county in one area.*
- *Health Solutions is on site weekly in the clinic. A partnership is ongoing and increasing in services.*
- *Health Solutions has an office in our main clinic*
- *You have worked with Health Solutions by having an on-site provider in the clinic.*

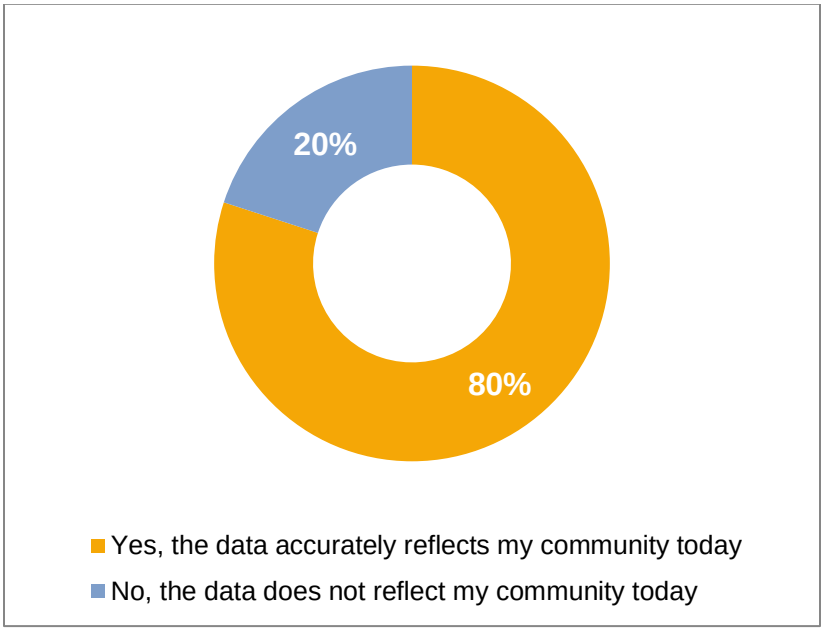
Appendix B – Identification & Prioritization of Community Needs (Local Expert Survey)

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health/Suicide*	220	10	20.0%	20.0%	Significant Needs
Drug/Substance Abuse	130	8	11.8%	31.8%	
Education/Prevention	105	6	9.5%	41.4%	
Alcohol Abuse	70	8	6.4%	47.7%	
Obesity*	68	5	6.2%	53.9%	
Diabetes*	58	6	5.3%	59.2%	
Affordability/Accessibility*	48	5	4.4%	63.5%	Other Identified Needs
Women's Health	40	6	3.6%	67.2%	
Cancer	35	4	3.2%	70.4%	
Heart Disease	35	5	3.2%	73.5%	
Hypertension	35	6	3.2%	76.7%	
Physical Inactivity	35	4	3.2%	79.9%	
Chronic Pain Management	33	4	3.0%	82.9%	
Social Factors*	32	3	2.9%	85.8%	
Accidents	30	3	2.7%	88.5%	
Lung Disease	30	5	2.7%	91.3%	
Smoking/Tobacco Use	30	4	2.7%	94.0%	
Alzheimer's	20	3	1.8%	95.8%	
Kidney Disease	15	2	1.4%	97.2%	
Pharmacy	10	1	0.9%	98.1%	
Stroke	8	2	0.7%	98.8%	
Flu/Pneumonia	5	1	0.5%	99.3%	
Liver Disease	5	1	0.5%	99.7%	
Dental	3	1	0.3%	100.0%	
Respiratory Infections	0	0	0.0%	100.0%	

** = 2017 Significant Needs*

Advice Received from Local Expert Advisors

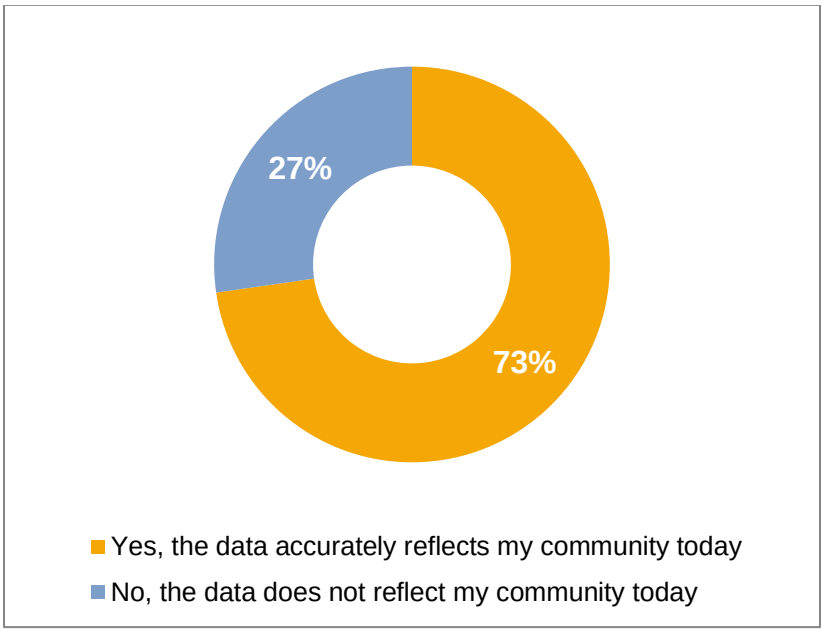
Question: Do you agree with the comparison of Huerfano County compared to Colorado and the US?



Comments:

- *Do not believe numbers are current.*
- *I would need more study to answer this question.*
- *I am not sure how the data was collected, I do not feel comfortable answering this question as I do not know if it is correct or not.*
- *I don't see anything that's gotten better in the past 4 years.*
- *Severe housing problems should include our areas lack of access to housing options - rents are high outside of housing authority and housing authority availability is not sufficient. High poverty levels do not allow residents to afford housing options*
- *The lack of vaccinating is highly concerning, as is violence, alcohol related deaths, overdoses, and sexually transmitted disease.*
- *As much as I know, this still seems reasonable.*

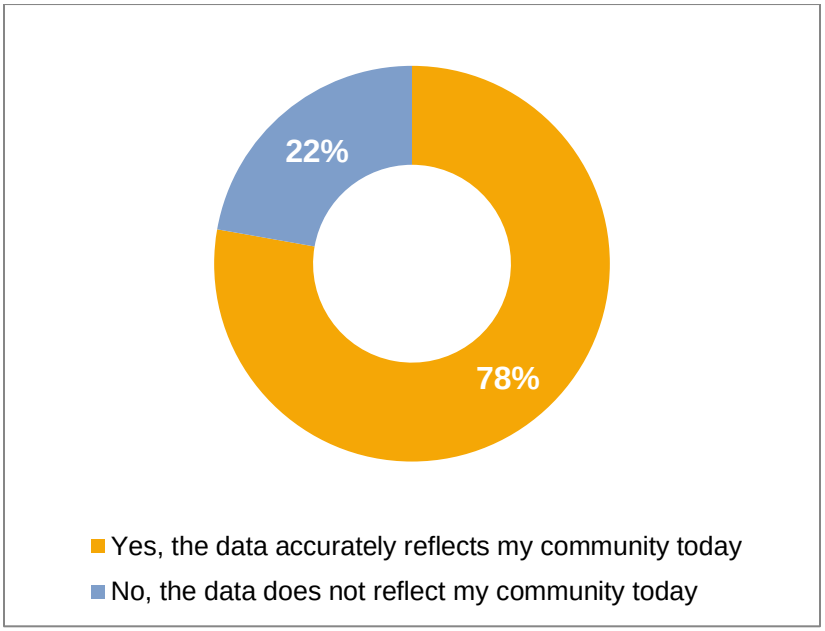
Question: Do you agree with the demographics and common health behaviors of SPRHC's Service Area?



Comments:

- *As far as I know. Whether I believe it or not doesn't make it accurate or not accurate.*
- *Don't feel comfortable answering this question.*
- *I don't believe the median age is quite up to 55.9, according to datausa.*
- *I do feel that rural has attracted more people especially since COVID.*
- *Always interesting to see the comparisons.*

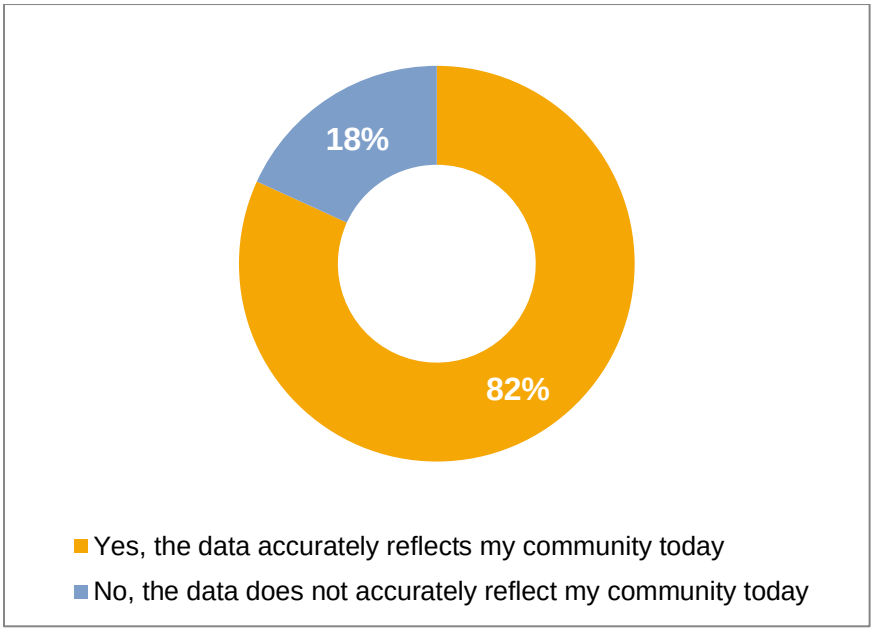
Question: Do you agree with the overall social vulnerability index for Huerfano County?



Comments:

- *Again I would have to be privy to the details of the studies. To ask me whether I believe or don't believe in the data doesn't really make sense to me.*
- *Not able to answer without researching data for myself.*
- *The whole county is having disasters. In 2018 La Veta was almost destroyed by fire. Areas outlying La Veta and in the 81055 zip code were destroyed. In 2019 we were told we were going to drown in debris flow and flash floods. In 2020 we're told we're all going to die if we don't wash our hands, stay 6 feet away, and wear masks. The entire economy was shut down - you can't turn that back on like a light switch. We live for tourist season each year - its the only time most shop owners have income. The last 3 seasons there has been no tourist season. How long do you think we can survive?*
- *I really don't know about the accuracy of this information.*

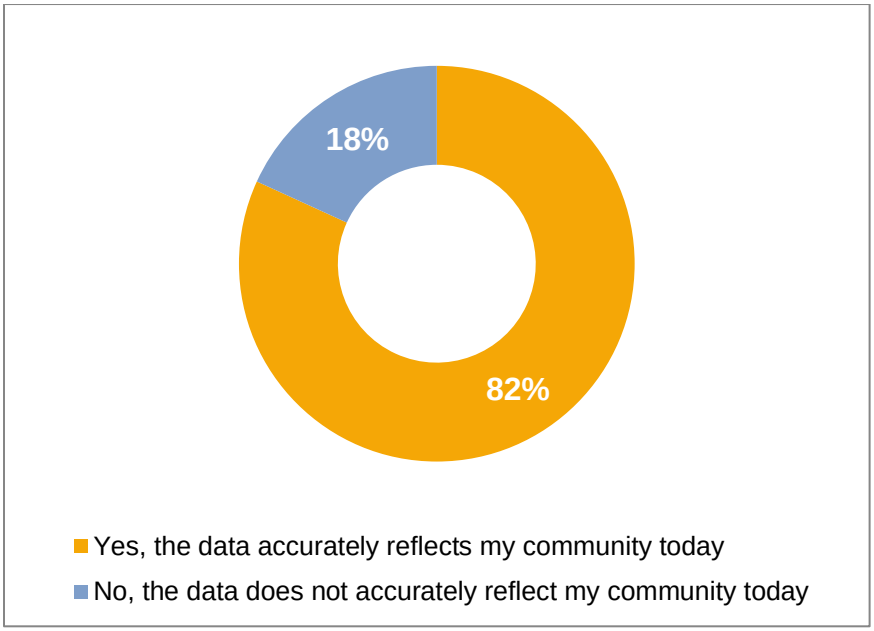
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *I believe new data needs to be collected as I believe the population has changed from 5 years ago.*
- *I expected hypertension would be higher.*

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



Comments:

- *I believe new data needs to be obtained*
- *Mental health is down precipitously by not letting anyone socialize and telling us to all stay in our homes. We've all been frightened to death.*
- *We have made some strides regarding health. This data seems dated.*
- *I don't really have any reason not to believe this information*

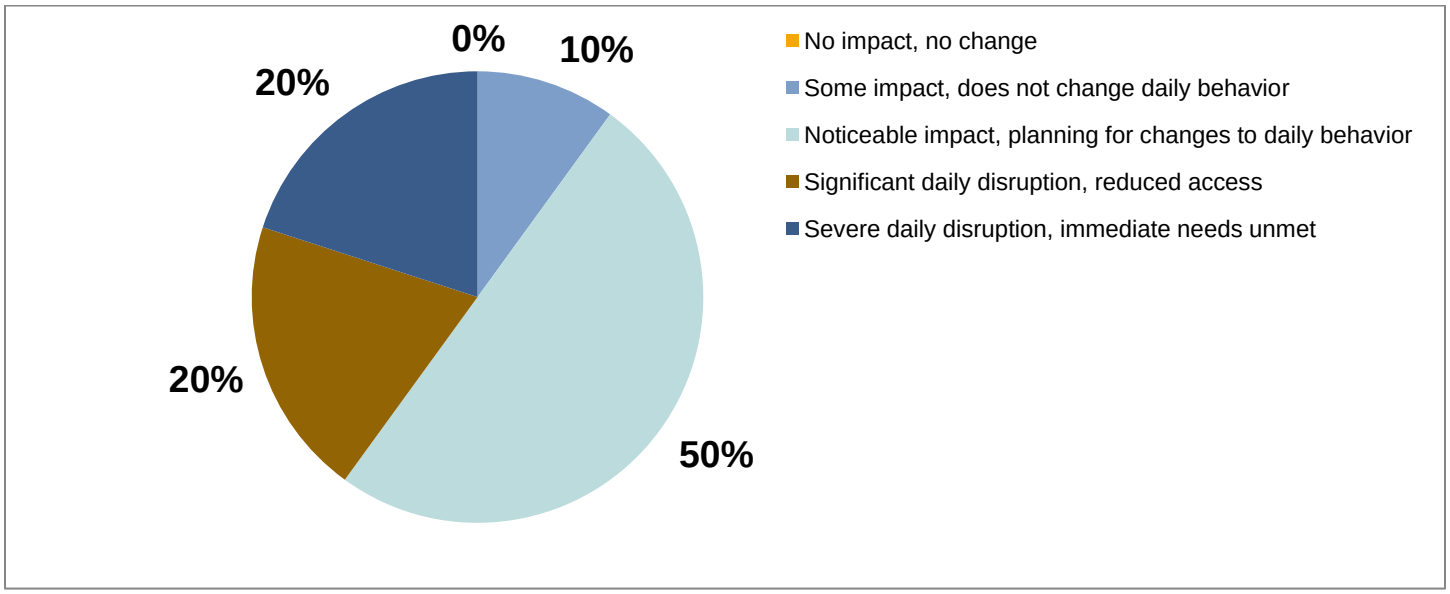
Question: Please add any additional information you would like us to understand.

Comments:

- *By women's health I am referring to domestic violence.*

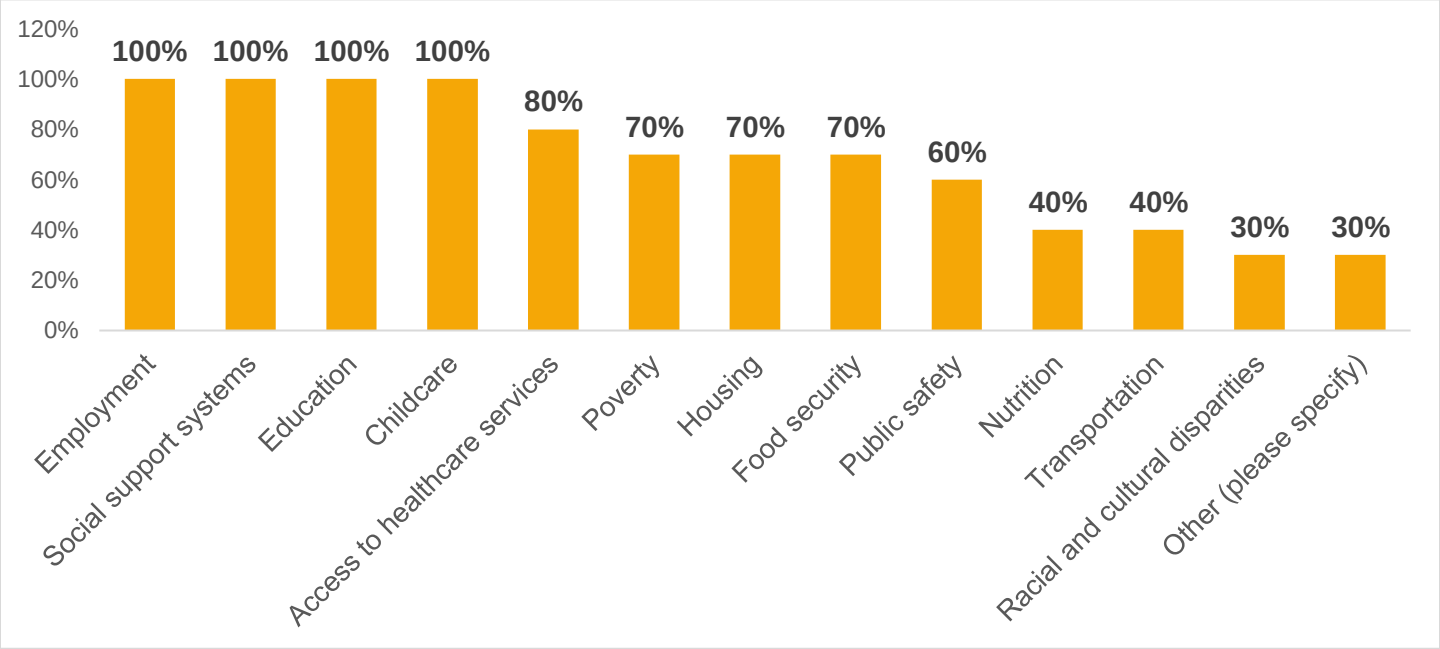
Local Expert COVID-19 Impacts

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



Note: No impact, no change had no responses (0%)

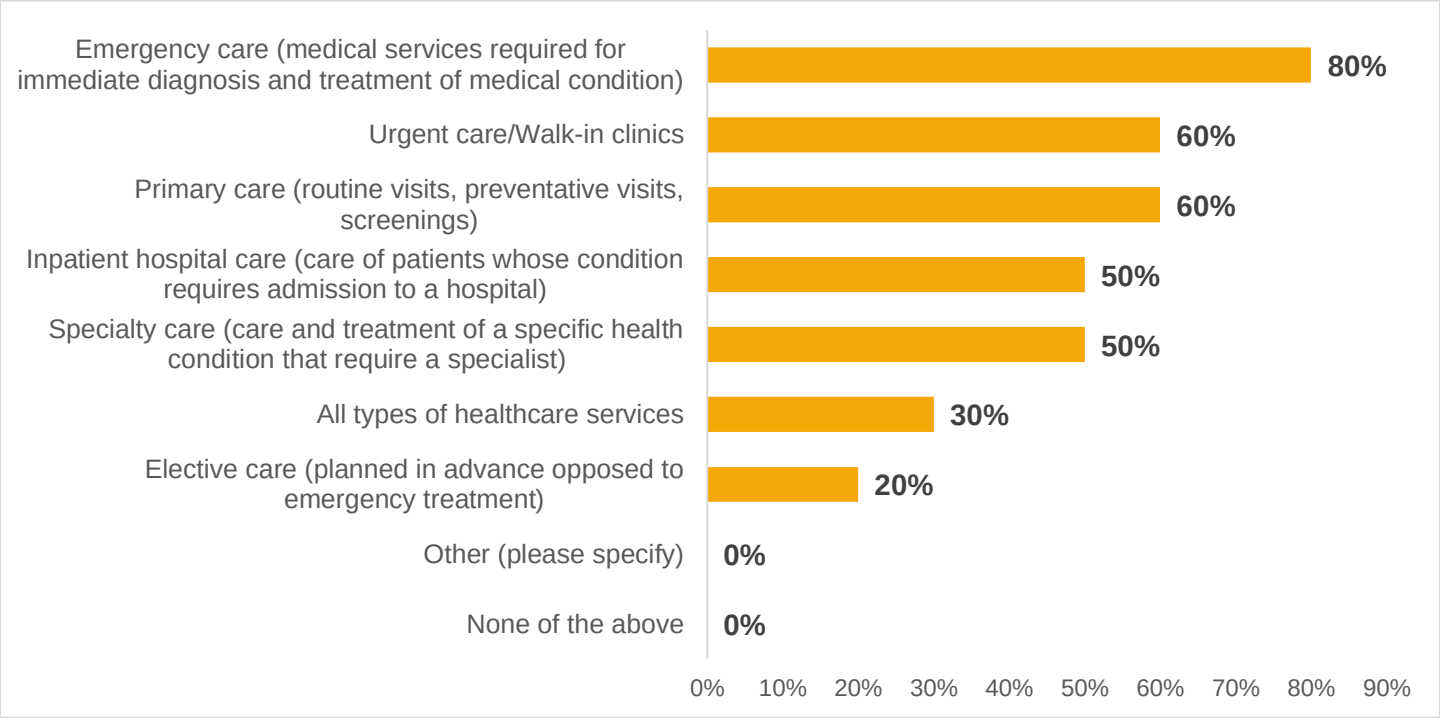
Question: Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. Please select the key social determinants that have been negatively impacted by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



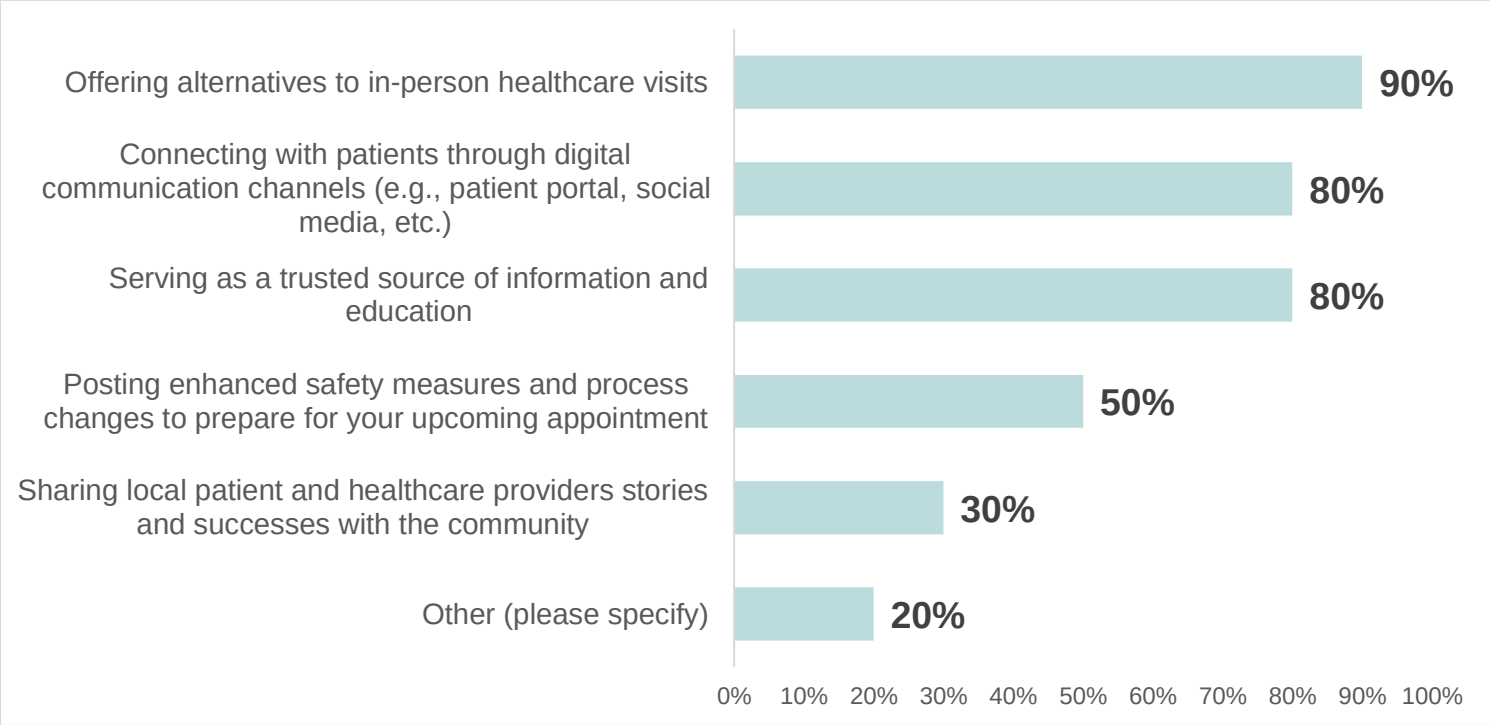
Comments:

- *Stores and restaurants not open*
- *Mental health*
- *Mental health - fear and isolation*

Question: As the COVID-19 crisis continues, community members may delay accessing healthcare services. What healthcare services are community members most likely to use in the current environment? (please select all that apply)



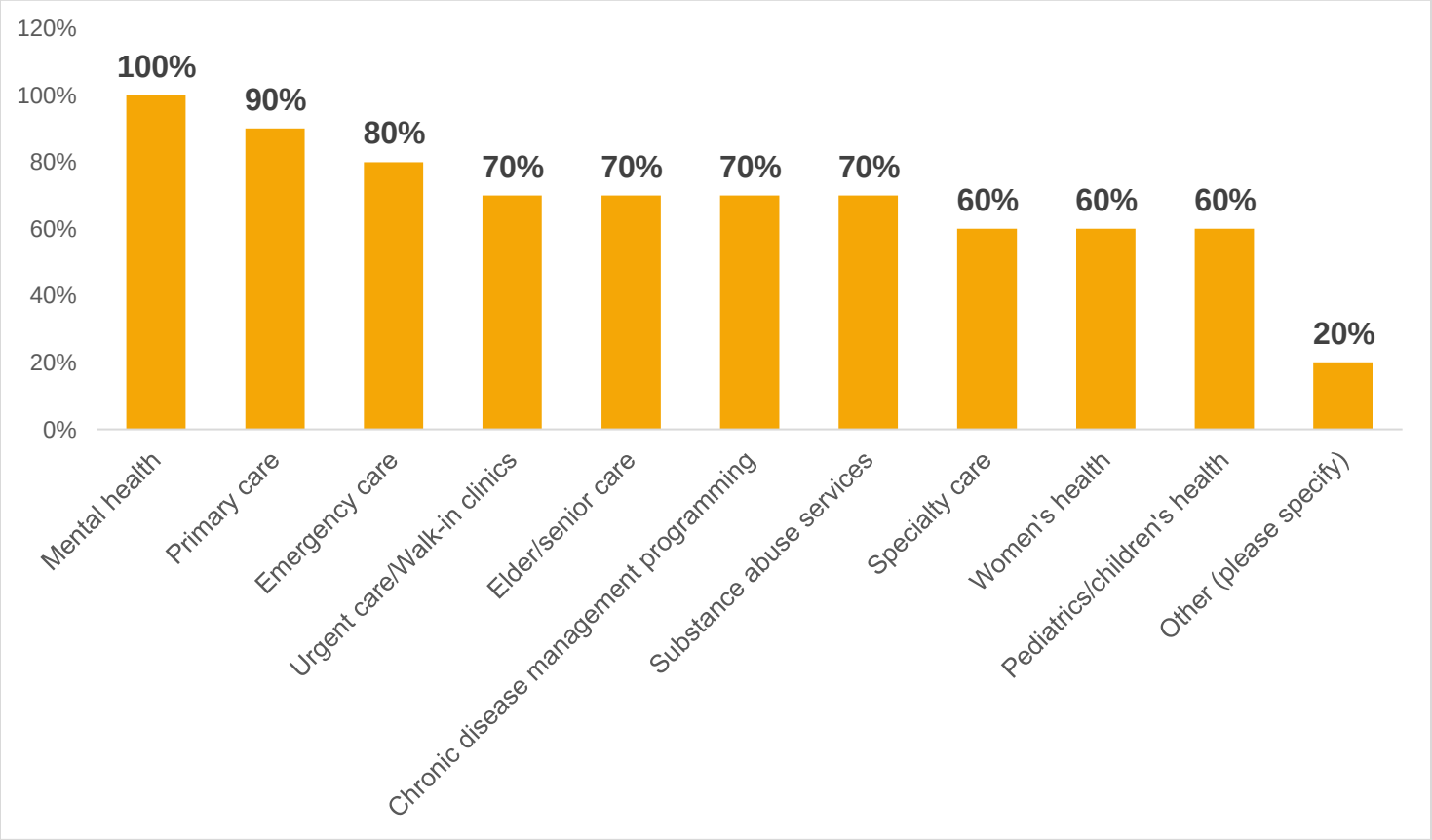
Question: How can healthcare providers, including Spanish Peaks Regional Health Center, continue to support the community through the challenges of COVID-19? (please select all that apply)



Comments:

- *Stop scaring us*
- *Education at schools regarding the pandemic*

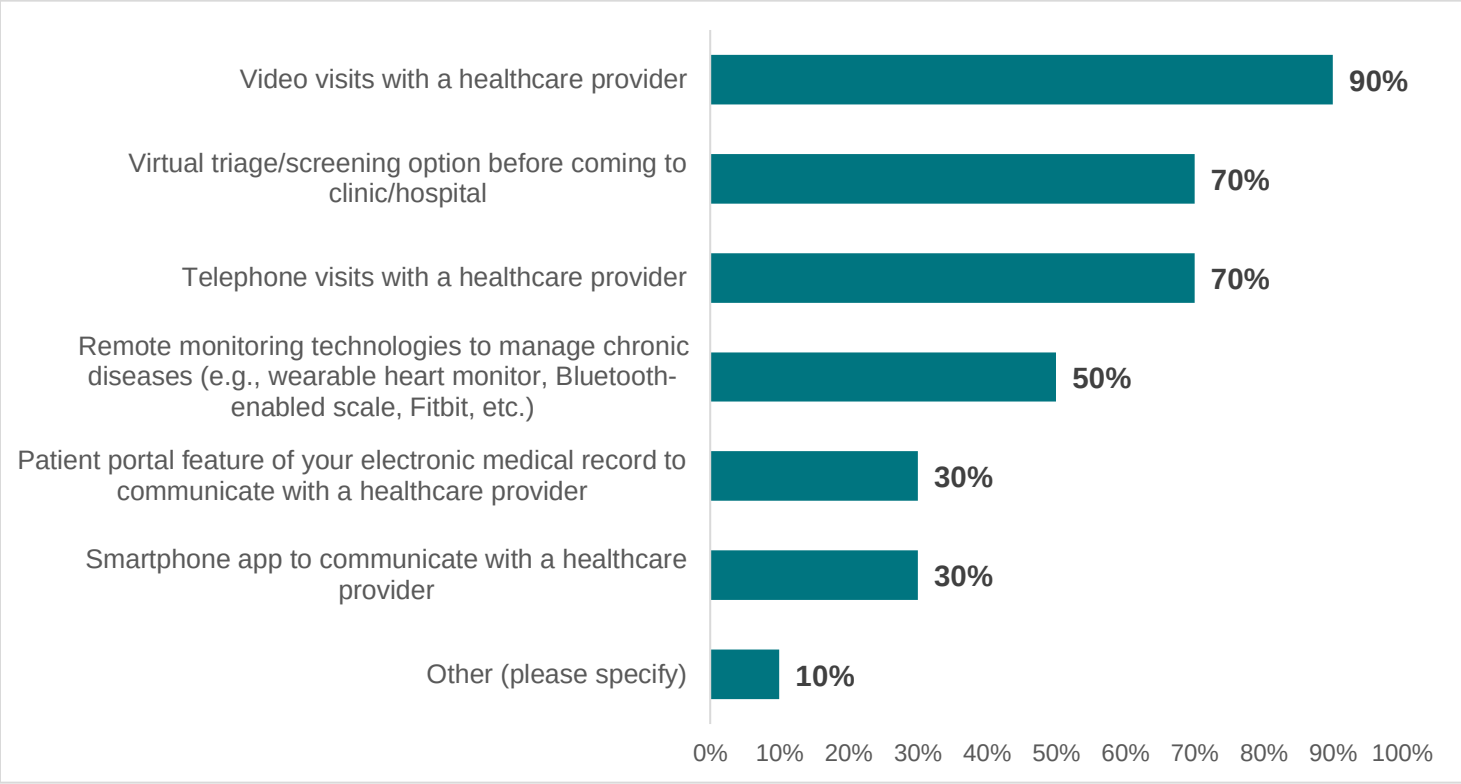
Question: What healthcare services/programs will be most important to supporting community health as the pandemic continues to unfold? (please select all that apply)



Comments:

- *Stop scaring us*
- *All are very important to the person needing them*

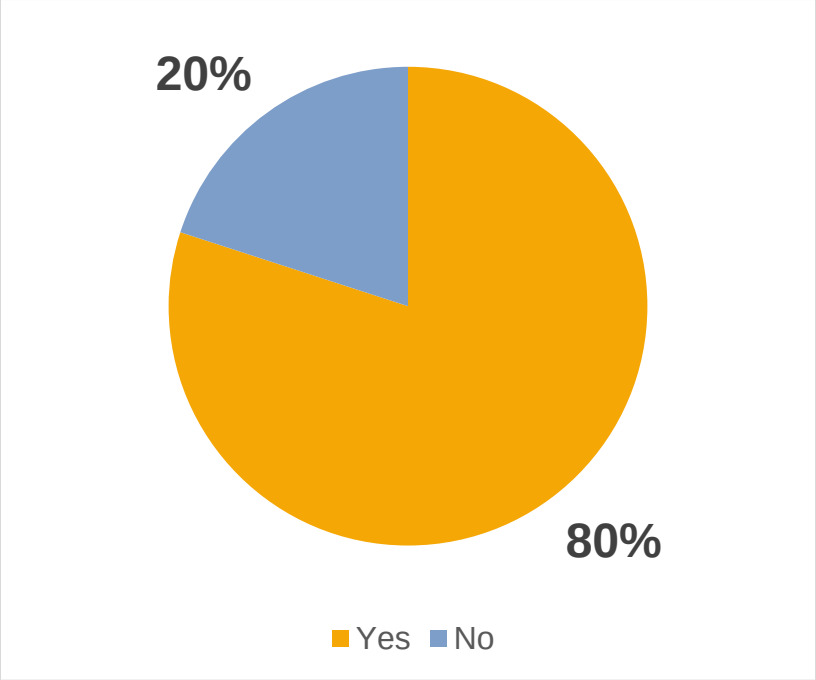
Question: COVID-19 has led to an increase in virtual and at-home healthcare options, including telemedicine, telephone visits, remote monitoring, etc. What alternative care options do you believe would benefit the community most? (please select all that apply)



Comments:

- *I think in-person works better*

Question: As a result of COVID-19, have you or someone you know delayed accessing healthcare?



Comments:

- *Health care provider*
- *For months no care was allowed unless it was COVID-19 related.*
- *It is not safe to risk contracting covid-19*
- *At doctor's recommendation - surgeries delayed, even serious ones*
- *Didn't want to go out. Certainly focused on COVID not other annoyances*

Appendix C – National Healthcare Quality and Disparities Report[35]

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

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

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

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

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

Key Findings

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

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

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

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

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

Trends

- Trends show that about 55% percent of quality measures are improving overall for Blacks.[36] However, most recent data in 2014-2015 show that about 40% of quality measures were worse for Blacks compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Asians. However, most recent data in 2014-2015 show that 20% of quality measures were worse for Asians compared with Whites.
- Trends show that almost 35% of quality measures are improving overall for American Indians/Alaska Natives (AI/ANs). However, most recent data in 2014-2015 show that about 30% of quality measures were worse for AI/ANs compared with Whites.
- Trends show that approximately 25% of quality measures are improving overall for Native Hawaiians/Pacific Islanders (NHPIs). However, most recent data in 2014-2015 show that nearly 33% of quality measures were worse for NHPIs compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Hispanics, but in 2014-2015, nearly 33% of quality measures were worse for Hispanics compared with non-Hispanic Whites.
- Variation in care persisted across the urban-rural continuum in 2014-2016, especially in access to care and care coordination.

Looking Forward

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

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

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

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

Link to the full report:

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

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

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

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnote 16 on page 12

   b. **Demographics of the community**

      See footnote 19 on page 13

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

      See footnote 29 on page 25 and footnote 30 on page 26

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 28 on page 24

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

      See footnote 12 on page 9

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

      See footnote 15 on page 9

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

      See footnotes 13 on page 9

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

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

See footnote 10 on page 8, footnotes 14 on page 9, and footnote 23 on page 17

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

N/A

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

2017

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

Yes, see footnote 14 on page 9 and footnote 34 on page 39

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

No

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

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

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

Yes

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

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

https://sprhc.org/

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

No other website

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

Yes

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

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

Yes

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

   2017

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

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

       https://sprhc.org/community-health-needs-assessment.html

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

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

    See footnote 29 on page 25

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

    None incurred

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

    Nothing to report

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

    Nothing to report