Sierra Vista Hospital

Truth or Consequences, NM

SIERRA VISTA HOSPITAL AND CLINICS

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution January 28th, 2021

Dear Community Member:

Sierra Vista Hospital's history of caring for our community dates back to 1986. Our efforts to provide exceptional healthcare to the people of the greater Sierra County 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 Sierra Vista Hospital ("SVH") will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

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

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

Thank You,

Eric Stokes
Chief Executive Officer
Sierra Vista Hospital

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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Sierra Vista Hospital ("SVH" 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 Sierra County are:

1. Mental Health/Suicide
2. Drug/Substance Abuse
3. Affordability/Accessibility
4. Alcohol Abuse
5. Obesity
6. Chronic Pain Management
7. Cancer

The SVH 2020 target areas identified through the CHNA process:

In the Implementation Strategy section of the report, SVH addresses the four areas through identified programs, resources, and services provided by SVH, collaboration with other local organizations, and provides measures to track progress.

APPROACH

APPROACH

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 501(c)(3) hospitals as a condition of retaining tax-exempt status. ***While Sierra Vista Hospital ("SVH") is not a 501(c)(3) hospital, this study is designed to comply with the same standards and helps assure SVH identifies and responds to the primary health needs of its residents. This will enable SVH to focus their efforts and resources on the most significant health needs of the community.***

The goal of Quorum Health Resources ("Quorum") CHNA process is to help SVH determine priority health needs of the area and develop an implementation strategy for addressing those needs.

Project Objectives

SVH partnered with Quorum Health Resources ("Quorum") to:

- Complete a CHNA report
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

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

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

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

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.

Community Health Needs Assessment Subsequent to Initial Assessment

Quorum and SVH followed an established process for the completion of the CHNA and implementation strategy. The goal of the CHNA process is to help the hospital determine the priority health needs of an area and develop an implementation strategy for addressing those needs. The SVH CHNA report consists of the following information:

(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.

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

The 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 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 or parish 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 parish.

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:

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Sierra County compared to all New Mexico counties	February 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	February 2020	2019

http://svi.cdc.gov	To identify the Social Vulnerability Index value	February 2020	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	February 2020	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	February 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 27 Local Expert Advisors was received. Survey responses started February 18, 2020 and ended on March 11, 2020.
- Information analysis augmented by local opinions showed how Sierra County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments:
    - 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/transportation
        - Behavioral health issues

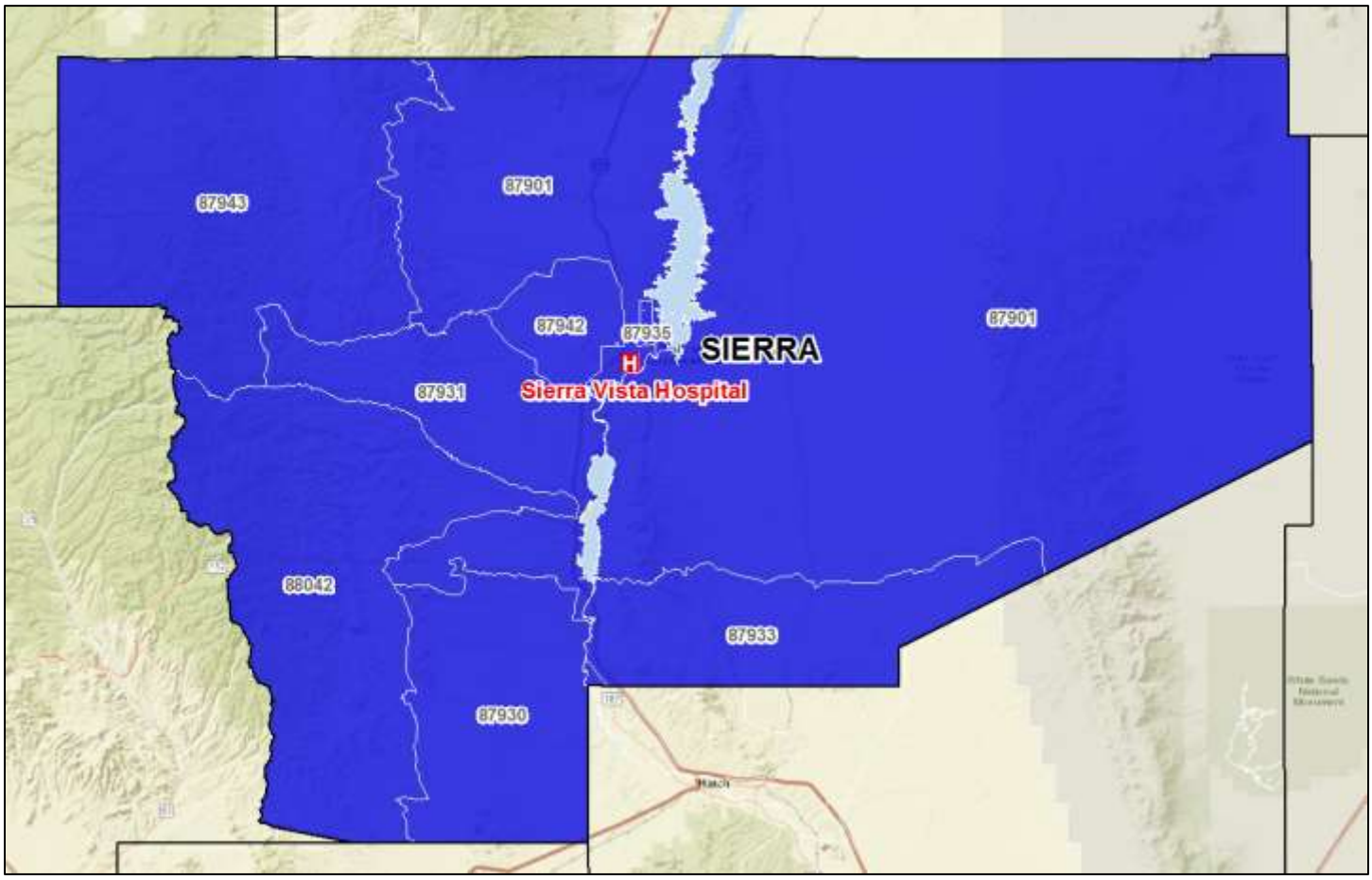
Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior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

In the SVH 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 at least 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.

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital



For the purposes of this study, Sierra Vista Hospital defines its service area as Sierra County in New Mexico, which includes the following ZIP codes:[2]

87901 – Truth or Consequences	87930 – Arrey	87931 – Caballo	87933 – Derry
87935 – Elephant Butte	87942 – Williamsburg	87943 – Winston	88042 - Hillsboro

During 2018, the Hospital received 76.6% of its Medicare inpatients from this area.

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

Demographics of the Community [3]

Variable	Sierra County			New Mexico			United States		
	2020	2025	%Change	2020	2025	%Change	2020	2025	%Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	10,798	10,440	-3.3%	2,097,660	2,115,994	0.9%	330,342,293	341,132,645	3.3%
Total Male Population	5,425	5,262	-3.0%	1,038,732	1,047,763	0.9%	162,698,834	168,065,523	3.3%
Total Female Population	5,373	5,178	-3.6%	1,058,928	1,068,231	0.9%	167,643,459	173,067,122	3.2%
Females, Child Bearing Age (15-44)	1,254	1,220	-2.7%	398,329	400,878	0.6%	64,355,395	65,121,999	1.2%
Average Household Income	$48,853			$69,538			$93,706		
POPULATION DISTRIBUTION									
Age Distribution									
0-14	1,465	1,499	2.3%	398,385	388,178	-2.6%	61,004,273	61,243,083	0.4%
15-17	268	269	0.4%	85,389	85,737	0.4%	12,813,132	13,256,890	3.5%
18-24	606	596	-1.7%	201,005	203,758	1.4%	31,228,330	32,158,942	3.0%
25-34	905	854	-5.6%	277,455	269,498	-2.9%	44,634,051	43,444,871	-2.7%
35-54	1,843	1,650	-10.5%	491,567	497,923	1.3%	83,213,897	84,462,100	1.5%
55-64	1,736	1,495	-13.9%	267,973	249,240	-7.0%	42,483,870	42,775,689	0.7%
65+	3,975	4,077	2.6%	375,886	421,660	12.2%	54,964,740	63,791,070	16.1%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	5,454	5,310	-2.6%	815,934	826,161	1.3%	125,475,973	129,798,935	3.4%
2020 Household Income									
<$15K	1,115			118,885			12,506,722		
$15-25K	791			92,515			10,771,922		
$25-50K	1,712			200,741			26,014,485		
$50-75K	892			140,085			20,994,518		
$75-100K	403			91,398			15,613,467		
Over $100K	541			172,310			39,574,859		
EDUCATION LEVEL									
Pop Age 25+	8,459			1,412,881			225,296,558		
2020 Adult Education Level Distribution									
Less than High School	394			84,841			11,743,386		
Some High School	958			116,670			15,852,334		
High School Degree	2,648			376,803			61,254,638		
Some College/Assoc. Degree	2,843			453,396			65,195,238		
Bachelor's Degree or Greater	1,616			381,171			71,250,962		
RACE/ETHNICITY									
2020 Race/Ethnicity Distribution									
White Non-Hispanic	6,831			745,780			195,988,231		
Black Non-Hispanic	71			37,370			40,865,574		
Hispanic	3,419			1,059,844			62,877,742		
Asian & Pacific Is. Non-Hispanic	82			33,127			19,739,190		
All Others	395			219,460			10,760,917		

[3] Claritas (accessed through IBM Watson Health)

Consumer Health Service Behavior[4]

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 SVH 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	112.1%	34.2%	Cancer Screen: Skin 2 yr	92.4%	9.9%
Vigorous Exercise	90.5%	51.7%	Cancer Screen: Colorectal 2 yr	98.3%	20.2%
Chronic Diabetes	117.0%	18.4%	Cancer Screen: Pap/Cerv Test 2 yr	70.0%	33.7%
Healthy Eating Habits	107.4%	25.0%	Routine Screen: Prostate 2 yr	111.3%	31.6%
Ate Breakfast Yesterday	97.2%	76.9%	**Orthopedic**		
Slept Less Than 6 Hours	109.0%	14.9%	Chronic Lower Back Pain	122.1%	37.7%
Consumed Alcohol in the Past 30 Days	73.8%	39.6%	Chronic Osteoporosis	148.2%	15.0%
Consumed 3+ Drinks Per Session	121.4%	34.2%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.7%	84.5%
Search for Pricing Info	91.0%	24.5%	NP/PA Last 6 Months	95.5%	39.6%
I am Responsible for My Health	98.5%	89.4%	OB/Gyn 1+ Visit	69.4%	26.7%
I Follow Treatment Recommendations	102.8%	79.3%	Medication: Received Prescription	105.2%	66.4%
Pulmonary			**Internet Usage**		
Chronic COPD	192.5%	10.4%	Use Internet to Look for Provider Info	74.4%	29.7%
Chronic Asthma	96.0%	11.3%	Facebook Opinions	59.5%	6.0%
Heart			Looked for Provider Rating	70.4%	16.6%
Chronic High Cholesterol	123.0%	30.0%	**Emergency Services**		
Routine Cholesterol Screening	92.9%	41.2%	Emergency Room Use	106.1%	36.8%
Chronic Heart Failure	172.5%	7.0%	Urgent Care Use	84.1%	27.7%

Conclusions from Demographic Analysis Compared to National Averages

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

- 30% less likely to receive **Cervical Cancer Screening**, affecting 34%
- 23% more likely to have **Chronic High Cholesterol**, affecting 30%
- 22% more likely to have **Chronic Lower Back Pain**, affecting 34%

[4] Claritas (accessed through IBM Watson Health)

- 21% more likely to **Consume 3+ Drinks Per Session**, affecting 34%
- 12% more likely to have a **BMI: Morbid/Obese**, affecting 34% of the population
- 10% less likely to **Vigorously Exercise**, affecting 52%
- 7% less likely to receive **Routine Cholesterol Screenings**, affecting 41%
- 6% more likely to use the **Emergency Room (for non-emergent issues)**, affecting 37%

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

- 26% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 39%
- 11% more likely to receive **Routine Prostate Screening**, affecting 31%

Leading Causes of Death[5]

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

Cause of Death			Rank among all counties in NM (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation* (Sierra County Compared to U.S.)
NM Rank	Sierra Rank	Condition		NM	Sierra	
1	1	Heart Disease	6 of 32	151.4	224.8	***Higher than expected***
2	2	Cancer	1 of 32	138.3	197.1	***Higher than expected***
4	3	Lung	1 of 32	44.1	86.8	***Higher than expected***
3	4	Accidents	6 of 32	68.2	81.9	***Higher than expected***
5	5	Stroke	6 of 32	34.7	42.7	***Higher than expected***
6	6	Diabetes	10 of 32	26.5	35.5	***Higher than expected***
9	7	Suicide	2 of 32	23.3	34.4	As expected
10	8	Flu - Pneumonia	6 of 32	13.6	22.5	***Higher than expected***
7	9	Liver	11 of 32	26.7	21.0	As expected
11	10	Kidney	10 of 32	12.8	15.3	As expected
8	11	Alzheimer's	23 of 32	22.6	13.9	***Lower than expected***
14	12	Homicide	5 of 32	8.5	13.0	***Higher than expected***
12	13	Blood Poisoning	12 of 32	9.2	10.5	As expected
13	14	Parkinson's	11 of 32	8.9	7.9	As expected
15	15	Hypertension	26 of 32	6.0	4.6	As expected

**Higher than expected = 5 or more deaths per 100,000 compared to the US; Lower than expect = 5 or more less deaths per 100,000 compared to the US*

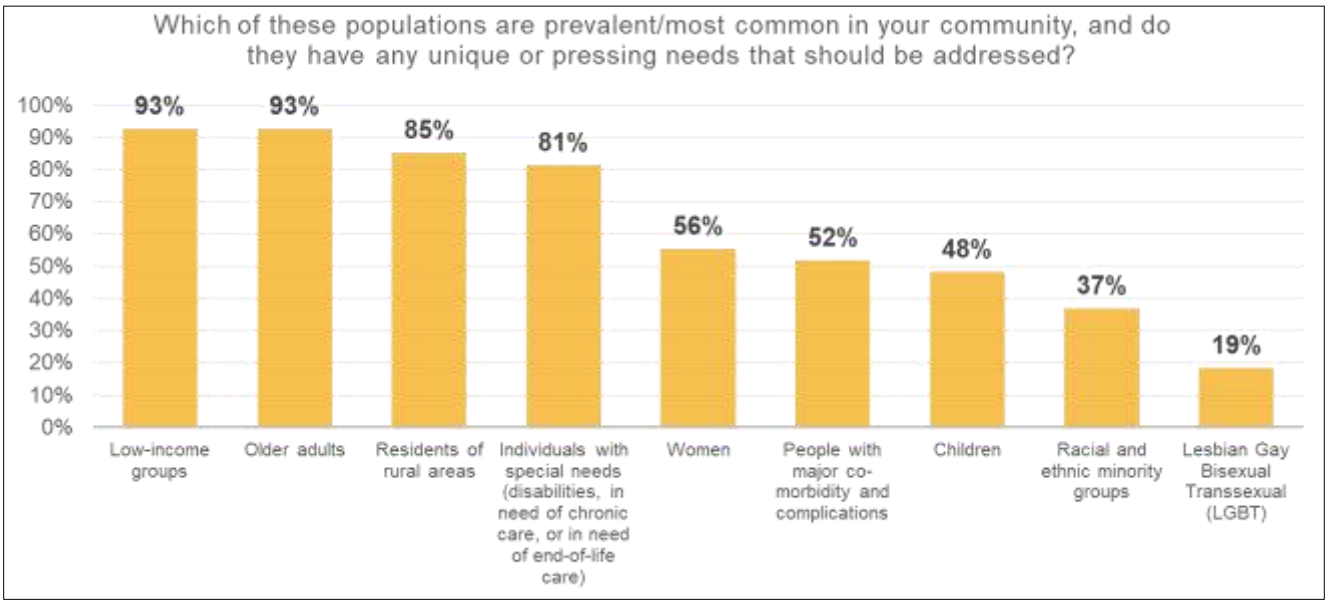
[5] www.worldlifeexpectancy.com/usa-health-rankings

Priority Populations[6]

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 B.

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:[7]



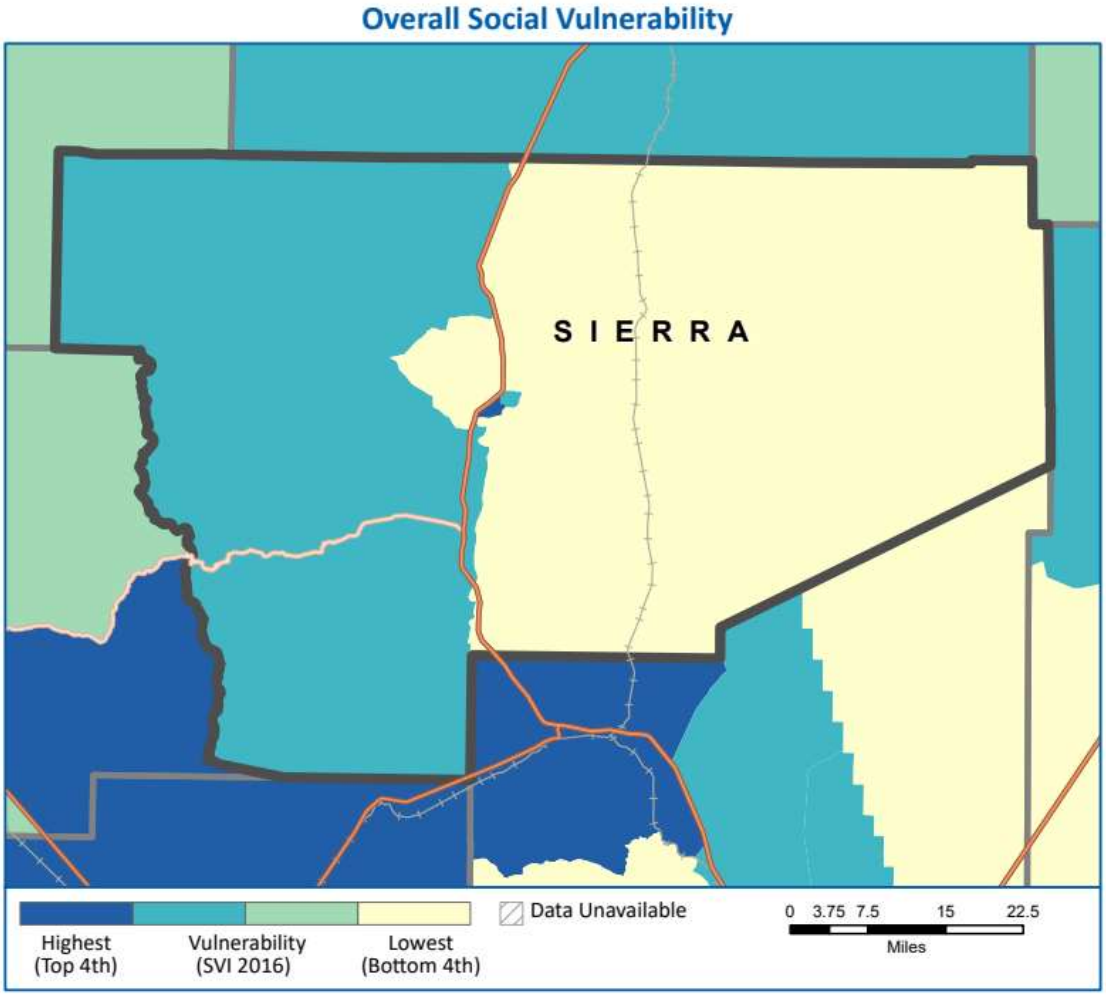
- The top three priority populations identified by the local experts were low-income groups, older adults, and residents of rural areas
- Summary of unique or pressing needs of the priority groups:
    - Access to affordable healthcare/transportation
    - Behavioral health issues

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

Social Vulnerability[8]

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.

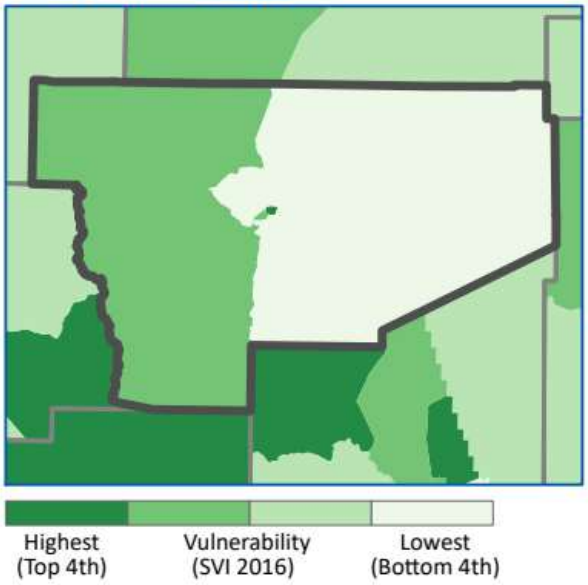
Based on the overall social vulnerability, the majority of Sierra County falls into the lowest quartile (light yellow) and the second highest (light blue) quartile of social vulnerability. There is a small portion in the central region of the county that is considered to have the highest social vulnerability (dark blue).



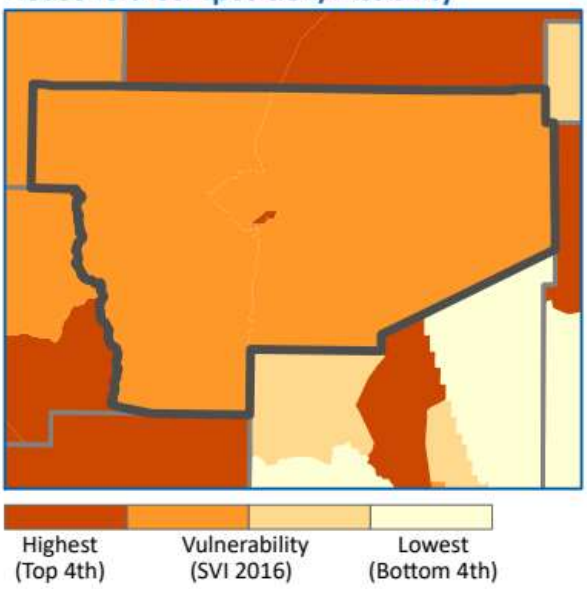
[8] http://svi.cdc.gov

SVI Themes

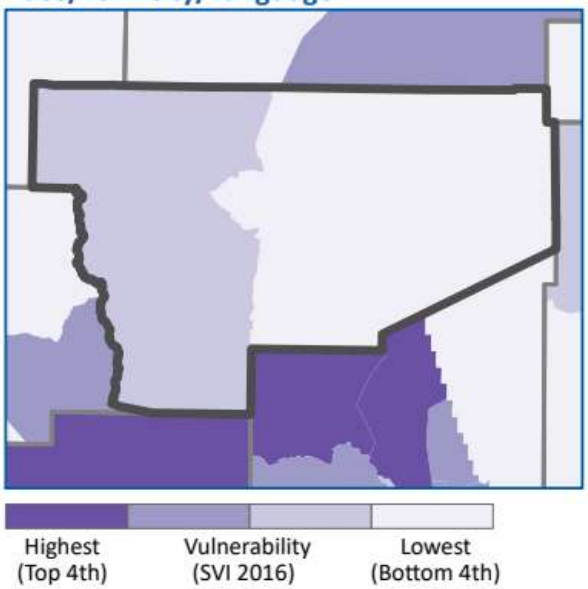
Socioeconomic Status



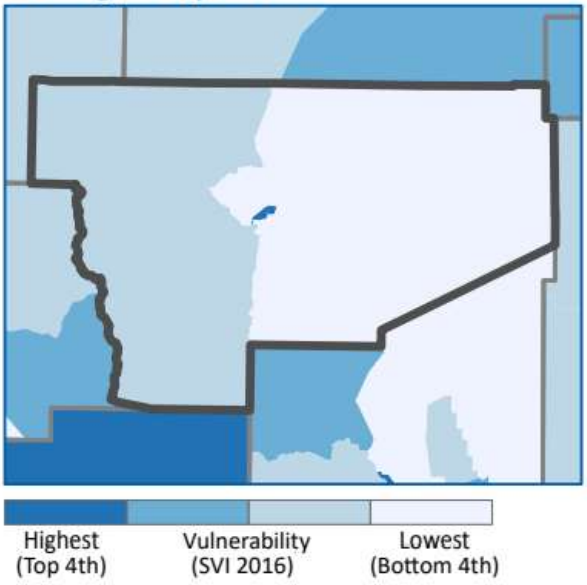
Household Composition/Disability



Race/Ethnicity/Language



Housing/Transportation



Comparison to Other State Counties[9]

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

	Sierra County	New Mexico	U.S. Median
Length of Life			
Overall Rank *(best being #1)*	**29/32**		
- Premature Death*	13,000	8,800	8,100
Quality of Life			
Overall Rank *(best being #1)*	**22/32**		
- Poor or Fair Health	22%	21%	17%
- Poor Physical Health Days Reported in Past 30 Days (average)	4.7	4.3	3.9
- Poor Mental Health Days Reported in Past 30 Days (average)	4.5	4.0	3.9
- Low Birthweight	9%	9%	8%
Health Behaviors			
Overall Rank *(best being #1)*	**12/32**		
- Adult Smoking	15%	17%	17%
- Adult Obesity	24%	26%	32%
- Physical Inactivity	24%	18%	26%
- Access to Exercise Opportunities	87%	77%	66%
- Excessive Drinking	13%	17%	17%
- Alcohol-Impaired Driving Deaths	42%	31%	28%
- Sexually Transmitted Infections*	195.0	628.6	321.7
- Teen Births *(per 1,000 female population ages 15-19)*	53	39	31
Clinical Care			
Overall Rank *(best being #1)*	**30/32**		
- Uninsured	10%	11%	10%
- Population to Primary Care Provider Ratio	2,800:1	1,340:1	2,050:1
- Population to Dentist Ratio	1,110:1	1,500:1	2,450:1
- Population to Mental Health Provider Ratio	480:1	260:1	970:1
- Preventable Hospital Stays	4,452	3,212	4,648
- Mammography Screening	25%	33%	40%
- Flu vaccinations	15%	38%	42%
Social & Economic Factors			
Overall Rank *(best being #1)*	**25/32**		
- Unemployment	7.9%	6.2%	4.4%
- Children in Poverty	43%	26%	21%
- Income Inequality**	4.6	5.2	4.4
- Children in Single-Parent Households	51%	40%	32%
- Violent Crime*	532	650	205
- Injury Deaths*	175	101	82
Physical Environment			
Overall Rank *(best being #1)*	**8/32**		
- Air Pollution - Particulate Matter	5.5 µg/m³	5.9 µg/m³	9.2 µg/m³
- Severe Housing Problems***	14%	18%	14%

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

[9] www.countyhealthrankings.org

Conclusions from Other Statistical Data[10]

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

Sierra County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Sierra County measures that are WORSE than the U.S. average and had an UNFAVORABLE change		
- Female Tracheal, Bronchus, and Lung Cancer*	48.5	39.6%
- Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	74.7	48.2%
- Female Self-Harm and Interpersonal Violence Related Deaths*	22.0	31.5%
- Male Self-Harm and Interpersonal Violence Related Deaths*	82.7	1.6%
- Female Mental and Substance Use Related Deaths*	23.9	437.3%
- Male Mental and Substance Use Related Deaths*	50.2	199.4%
- Female Liver Disease Related Deaths*	25.3	57.4%
- Male Liver Disease Related Deaths*	59.6	44.3%
UNFAVORABLE Sierra County measures that are WORSE than the U.S. average and had a FAVORABLE change		
- Male Life Expectancy	71.0	4.8%
- Female Heart Disease*	134.7	-34.8%
- Male Heart Disease*	274.7	-35.2%
- Female Transport Injuries Related Deaths*	17.2	-38.7%
- Male Transport Injuries Related Deaths*	35.2	-55.0%
DESIRABLE Sierra County measures that are BETTER than the US average and had an UNFAVORABLE change		
N/A		
DESIRABLE Sierra County measures that are BETTER than the US average and had a FAVORABLE change		
- Male Stroke*	40.6	-35.4%
AVERAGE Sierra County measures that are EQUAL to the US average and had an UNFAVORABLE change		
- Male Breast Cancer*	0.3	1.2%
- Female Skin Cancer*	2.4	4.8%
- Male Skin Cancer*	5.8	36.3%
- Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	51.3	27.5%
AVERAGE Sierra County measures that are EQUAL to the US average and had a FAVORABLE change		
- Female Life Expectancy	79.5	2.9%
- Female Stroke*	45.0	-31.1%
- Male Tracheal, Bronchus, and Lung Cancer*	68.3	-29.2%
- Female Breast Cancer*	27.4	-11.7%

*rate per 100,000 population, age-standardized

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

IMPLEMENTATION STRATEGY

Significant Health Needs

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

- Identifies goals established by the SVH Admin Team in response to the identified health issues in the community
- Establishes the implementation strategy programs and resources SVH will devote to attempt to achieve improvements
- Presents key measures tailored to the identified health needs that SVH will use to track progress
- Identifies any potential partnerships with local organizations

CHNA Implementation Plan Overview

SVH has determined that the action plan to address the health needs identified in the health needs survey (Mental Health/Suicide, Drug/Substance Abuse, Affordability/Accessibility, Alcohol Abuse, Obesity, Chronic Pain Management, and Cancer) will be worked through the following subgroups. Additional disease specific details are further described in the full report.

Behavioral Health Coordination

(Mental Health/Suicide, Drug/Substance Abuse & Alcohol Abuse)

Goal: Increase behavioral health access/coordination

Current Resources:

- Behavioral Health providers
- Licensed Suboxone prescribers
- IP and ED psych evaluations
- Transfer agreements with behavioral health hospitals
- Suboxone program with county jail

Future Implementation Plans:

- Assess additional BH programs
- Consider recruiting OP psychiatric provider
- Telepsychiatry

Accessibility

(Access to Healthcare)

Goal: Increase access to healthcare services

Current Resources:

- Access to a wide array of healthcare services, including primary and specialty care
- Patient portal access
- Transitional care program
- Medicaid transport services

Future Implementation Plans:

- Assess need for additional providers
- Explore telehealth opportunities with UNM for specialty coverage in ED and IP settings
- State grant for care coordination application submitted
- PC telehealth

Affordability

(Affordable Healthcare)

Goal: Ensure healthcare services are affordable

Current Resources:

- Financial Assistance Policy
- Implementing pricing transparency
- Slide fee scale in RHC
- Discounted flu clinics
- Discounted pharmacy rates using 340B pricing

Future Implementation Plans:

- Pricing transparency
- Evaluate SVH ancillary service cost structure
- Evaluate meds to bed program/retail pharmacy license

Chronic Disease Management

(Obesity, Chronic Pain Management & Cancer)

Goal: Promote healthy lifestyles through education and outreach

Current Resources:

- Chronic disease screenings
- Healthy lifestyle promotion events
- Physical therapy services
- Imaging capabilities
- School and community education programming

Future Implementation Plans:

- Additional community programming (cancer, Alzheimer's, health fairs)
- Implementing community Pillar
- Dept leads attend NMRHN quarterly meetings
- Assess recruitment of diabetes educator

Detailed Implementation Strategy Plan

The findings from the community health needs assessments and surveys yield valuable information in helping SVH to provide programs that address the most pressing health conditions impacting the SVH community. The following section provides a review of the current programs and partnerships as it relates to each individual health needs that make up the four subgroups.

Behavioral Health Coordination

Goal:

- Increase behavioral health access/coordination

SVH will address behavioral health access/coordination through the following services, programs, and resources:

Services currently available at SVH:

- Two Behavioral Health providers on staff
- Two Suboxone Prescribers licensed to dispense opioid medication used to treat patients with opioid addiction enabling the patient to engage in therapy, counseling and support
- Behavioral health services available in inpatient and emergency department settings
- Telepsychiatry available to assist patients with behavioral health needs in early 2021
- Suboxone program implemented in county jail to provide suboxone to recently released inmates

- Transfer agreements with receiving behavioral health hospitals

Future SVH implementation plans:

- Assessing future options for additional behavioral health programming to provide greater access and services to the community
- Exploring expansion of outpatient behavioral health services through recruitment of additional psychiatric provider

Metrics & Measures:

- Telepsychiatry visits
- Number of Suboxone prescriptions prescribed
- Drug overdose death rate
- Opioid prescribing rate
- Suicide death rate

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

Organization	Contact Name	Contact Information
The OliveTree		https://sharenm.org/the-olivetree
Local VA		

Accessibility

Goal:

- Increase access to healthcare services

SVH will address accessibility through the following services, programs, and resources:

Services currently available at SVH:

- Current hospital services offered to community:
  - General Surgery
  - Trauma Surgery
  - Cardiopulmonary
  - Rehabilitation
  - Imaging Capabilities (Mammography, MRI, CT)
  - Inpatient and Swing Bed Services
  - ED
  - Lab
  - Rural Health Clinic with primary care and specialty services
- Primary care and behavioral health telehealth services launching 2021
- Patient portal available to patients with ability to request appointments

- Transitional care program provided through EMS group that provides outreach to patients that have been recently hospitalized

Future SVH implementation plans:

- Exploration of additional primary and specialty care services/providers to meet needs of community
- Exploration of telehealth opportunity with UNM to provide additional specialty coverage in the emergency department and inpatient setting
- Application in place to receive state grant for a care coordinator in mid/late 2021

Metrics & Measures:

- Utilization of telehealth services
- Number of providers recruited
- Population to provider ratio

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

Organization	Contact Name	Contact Information
Sierra Joint Office on Aging		https://www.sierraco.org/boards/sierra-joint-office-on-aging/
Sierra County Cancer Assistance	Stephanie Ross	www.sierracountycancerassistance.org

Affordability

Goal:

- Ensure healthcare services are affordable

SVH will address affordability through the following services, programs, and resources:

Services currently available at SVH:

- Financial Assistance Program and assistance with Medicaid application
- Sliding fee scale available in the rural health clinic
- Discounted flu clinics available
- 340B partnership offers discounted rates

Future SVH implementation plans:

- Pricing transparency implemented in early 2021
- Evaluation of SVH ancillary service cost structure and patient/employee responsibility
- Evaluating meds to bed program and a retail pharmacy license utilizing 340B pricing

Metrics & Measures:

- Utilization of Financial Assistance Program
- Accounts receivable days

- Comparison of SVH prices for outpatient healthcare services relative to market

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

Organization	Contact Name	Contact Information
Local Wal-Mart		
Local Pharmacy – Davis Fleck United Pharmacy		https://www.davisfleckpharmacy.com/ (575) 894-3055 500 Broadway, Truth Or Consequences, NM 87901

Chronic Disease Management

Goal:

- Promote healthy lifestyles through education and outreach

SVH will address chronic disease management through the following services, programs, and resources:

Services currently available at SVH:

- Offers and promotes chronic disease prevention through chronic disease screenings and on-site imaging capabilities (mammography, MRI, CT)
- Participation in area outreach events to help the community choose healthier lifestyles and reduce health risk factors
- Physical therapy services available to treat and manage chronic pain without the need for invasive surgeries or potentially addictive medications
- Obesity screenings are conducted and tracked in the primary care setting to align with the 2020 MIPS indicator measure targeting preventive care and screening of BMIs
- Trauma program provides educational programs to local schools and community:
    - Stop the Bleed
    - Fall Prevention
    - Life jacket program
- Dietary director available for provider support on promoting nutrition education
- Supports Sierra County Community Council on community outreach and senior outreach program

Future SVH implementation plans:

- Opportunity to regularly promote cancer events that will aim to educate the public on the importance of early screening, testing and treatment
- Explore participation in Alzheimer's education and awareness events
- *SVH Community Pillar* launching early 2021 for managers, including the identification of organizations and resources available to the community
- Exploration of additional community programming such as health fairs and screenings to promote prevention and early detection of chronic diseases
- Beginning 2021, SVH department leaders will attend New Mexico Rural Hospital Network (NMRHN) quarterly meetings organized to leverage best practices and synergies between rural NM hospitals to improve healthcare in their communities
- Exploration of diabetes educator to address needs of diabetic patients in community

Metrics & Measures:

- Participation in education programs and community events
- Chronic disease screening rate
- Death rate associated with chronic diseases
- MIPS clinical quality indicators

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

Organization	Contact Name	Contact Information
Sierra County Community Health Council		https://sharenm.org/sierra-health-council-shc (575) 740-2206 360 W. 4th St., Truth or Consequences, NM 87901
New Mexico Rural Hospital Network		https://www.nmrhn.net/
New Mexico Hospital Association		https://www.nmhanet.org/

Other Needs Identified During CHNA Process

8. **Diabetes**
9. **Heart Disease**
10. **Physical Inactivity**
11. **Education/Prevention**
12. **Women's Health**
13. **Smoking/Tobacco Use**
14. **Accidents**
15. **Alzheimer's**
16. **Hypertension**
17. **Kidney Disease**
18. **Lung Disease**
19. **Dental**
20. **Liver Disease**
21. **Respiratory Infections**
22. **Stroke**
23. **Flu/Pneumonia**

Write-in: Behavioral Health Services

Write-in: In-home healthcare

Write-in: Emergency Medical Technicians and equipment in rural areas

APPENDIX

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

27 individuals responded to survey. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health/Suicide	300	19	13.6%	13.6%	Significant Needs
Drug/Substance Abuse	272	19	12.4%	26.0%	
Affordability/Accessibility	235	17	10.7%	36.7%	
Alcohol Abuse	195	17	8.9%	45.5%	
Obesity	122	14	5.5%	51.1%	
Chronic Pain Management	118	15	5.4%	56.5%	
Cancer	112	14	5.1%	61.5%	
Diabetes	107	13	4.9%	66.4%	Other Identified Needs
Heart Disease	100	12	4.5%	71.0%	
Physical Inactivity	92	10	4.2%	75.1%	
Education/Prevention	90	11	4.1%	79.2%	
Women's Health	72	10	3.3%	82.5%	
Smoking/Tobacco Use	62	10	2.8%	85.3%	
Accidents	48	6	2.2%	87.5%	
Alzheimer's	43	8	2.0%	89.5%	
Hypertension	40	7	1.8%	91.3%	
Kidney Disease	38	6	1.7%	93.0%	
Lung Disease	31	7	1.4%	94.4%	
Dental	29	6	1.3%	95.7%	
Liver Disease	24	5	1.1%	96.8%	
Respiratory Infections	14	4	0.6%	97.5%	
Stroke	12	4	0.5%	98.0%	
Flu/Pneumonia	12	3	0.5%	98.5%	
Write-in: Behavioral Health Services	12	1	0.5%	99.1%	
Write-in: In-home healthcare	10	1	0.5%	99.5%	
Write-in: Emergency Medical Technicians and equipment in rural areas	10	1	0.5%	100.0%	

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

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	8	13	21
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	16	8	24
3) **Priority Populations**	17	5	22
4) Representative/Member of **Chronic Disease Group** or Organization	6	13	19
5) Represents the **Broad Interest of the Community**	23	2	25
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?

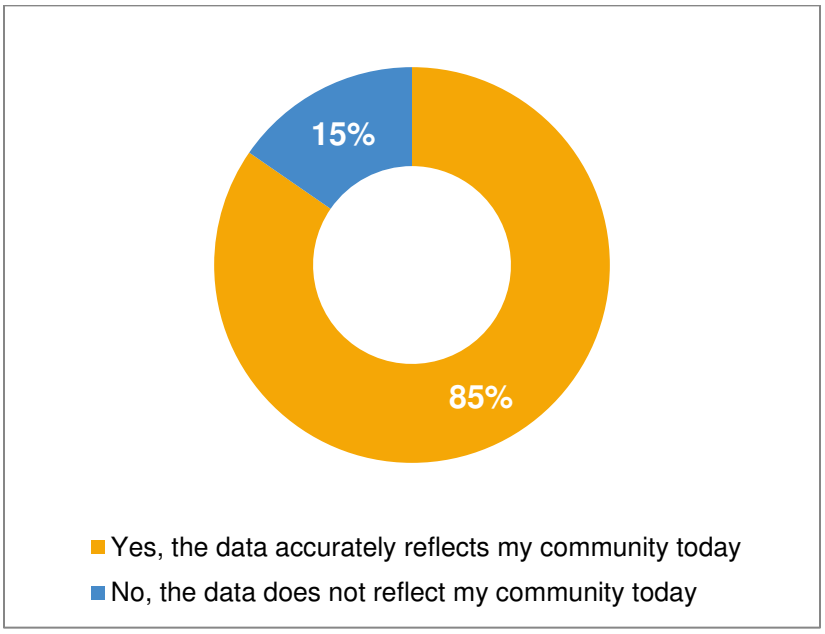
- *Information and referral to assist with access to care.*
- *Mental Health Services. Addiction Services. Geriatric Care. Kidney Dialysis, Cancer Treatment*
- *The most important issue regarding all of these patient groups and subsets of the population is access to healthcare. Specifically access to preventative services, annual exams, and healthcare maintenance. Access to specialists, within reason, in smaller communities with critical access hospitals. Continuity of care with regards to providers and the stability of the medical staff in a community is important to build trust and confidence in local health care services. Education as to services available and recommendations for preventative care based on standards within the healthcare industry.*
- *Transportation, income assistance*
- *Persons with drug addiction/alcohol use disorder and mental health (Co-Occurring diseases). Poverty, homelessness, Domestic violence and other forms of violence, high suicide rates.*
- *1) Lack of behavioral health services to address to address various disorders including: mood disorders (such as depression or bipolar disorder), anxiety disorders, personality disorders, psychotic disorders (such as schizophrenia), trauma-related disorders (such as post-traumatic stress disorder), and substance abuse disorders. 2) Additional in-home services for disabled or elderly persons, such as home health. 3) Additional emergency medical technicians in outlying areas for quick response*
- *I deal with the inmate population in detention. They have a multitude of issues including anxiety, depression, drug and alcohol abuse, high blood pressure and behavior health issues.*
- *Affordable health care. support groups for diabetes, HIV, alcoholism, drug addiction, LGBT.*
- *Need for caring, compassionate Doctors who understand their needs for good healthcare and not just push pills at them.*
- *Sierra County is economically depressed and under-served medically. There is a tremendous need to expand access to services, whether directly in the community or via provision of transportation to those services, along with active care coordination as a priority (transitions of care).*
- *Substance abuse and behavioral health treatment*
- *Sierra County has the highest percentage of people 65 and over compared to other NM counties. Many are poor living on disability or social security. All to these populations including the*

undocumented which are populations with special needs.

- *Aid understanding their medical coverage and what to do to get help necessary.*

Advice Received from Local Expert Advisors

Question: Do you agree with the comparison of Sierra County compared to New Mexico and the US?



Comments:

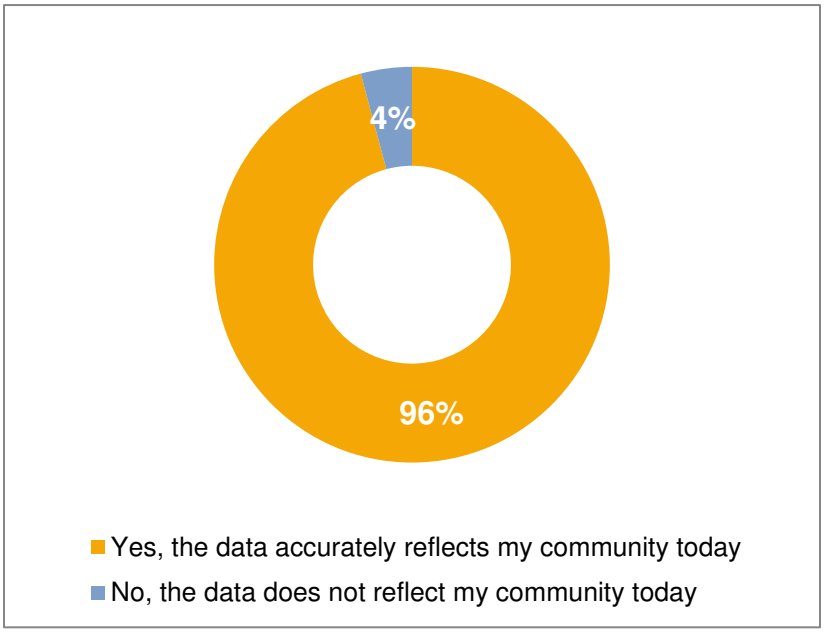
- *I believe we have higher smoker averages severe housing shortage for low income. We do not have enough dentist. We have a large number of alcohol abuse and drug abuse.*
- *I am unsure as to all of the above information as I have only been living and working here a little over 6 months. That said I have observations that I have made regarding patient populations and healthcare delivery in the community:*

  1. It seems there is a significant number of patients that I see who are lifelong smokers with ongoing tobacco addiction.
  2. Marijuana use also seems to be prevalent.
  3. There is definitely a lack of opportunities or places for people to exercise i.e. gyms or workout facilities within the community, this seems to be a very noticeable issue which I believe needs to be addressed with some type of community facility for wellness programs, exercise opportunities and physical activity class instruction etc..
  4. Certainly the number of primary providers whether physicians or midlevel providers is lacking in our community, there appears to be significant turnover, historically, and ongoing which will only lead to uncertainty and lack of confidence for the community to have healthcare provided locally

- *I find the info very interesting. Just wondering how and who gathered these stats.*

- *It appears that the issues are the same, however, the incidence of mental illness and substance use without enough treatment personnel has priority. Also, we are the 5th highest state in terms of suicide rates, which is also a priority.*
- *I don't agree with many of the percentages and unfortunately I have nothing to support that opinion at hand. I know this county is the least likely to support any industry or employment opportunity because of skill and willingness or ability to pursue gainful employment some because of disability, age and additive behavior.*
- *Our community is poor and underserved. I spent 20 years in Public Health serving the most vulnerable. At times stories broke my heart. I spent my money on critical meds for those who could not pay and utilized the food bank at St. Paul's for emergency food but there were never enough resources to fill the needs. The expansion of Medicaid has helped.*
- *Not sure the dentist ratio is correct.*
- *As far as the exercise part of this equation, I wish that we had availability to a gym like Jungle Gym use to be.*
- *Seems accurate to the best of my knowledge*

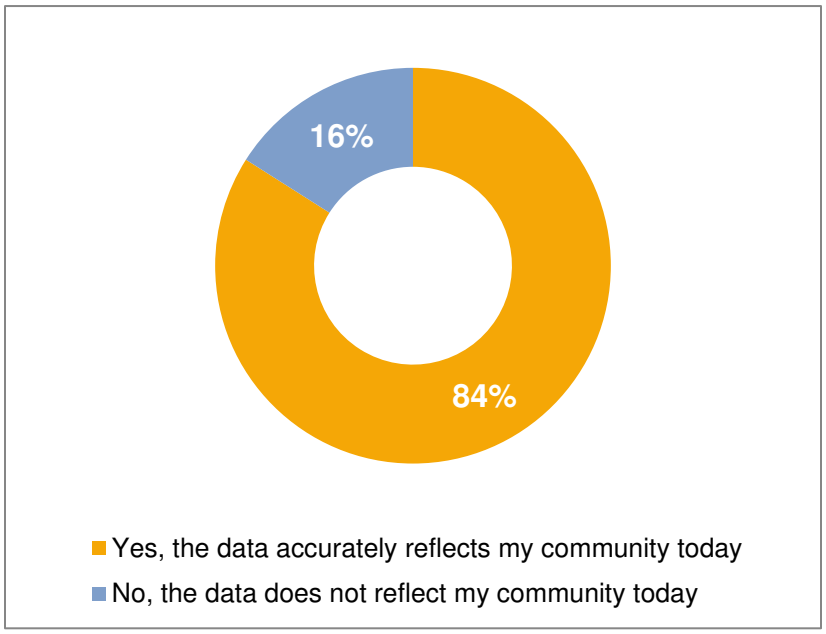
Question: Do you agree with the demographics and common health behaviors of SVH's Service Area?



Comments:

- *I disagree that the % white, non-Hispanic compared to the % Hispanic population. Are you sure it wasn't transposed?*
- *It's an assumption based on the fact that the average citizen is over 50*
- *I think that due to our lack of physicians, certain screenings are less likely to occur here.*

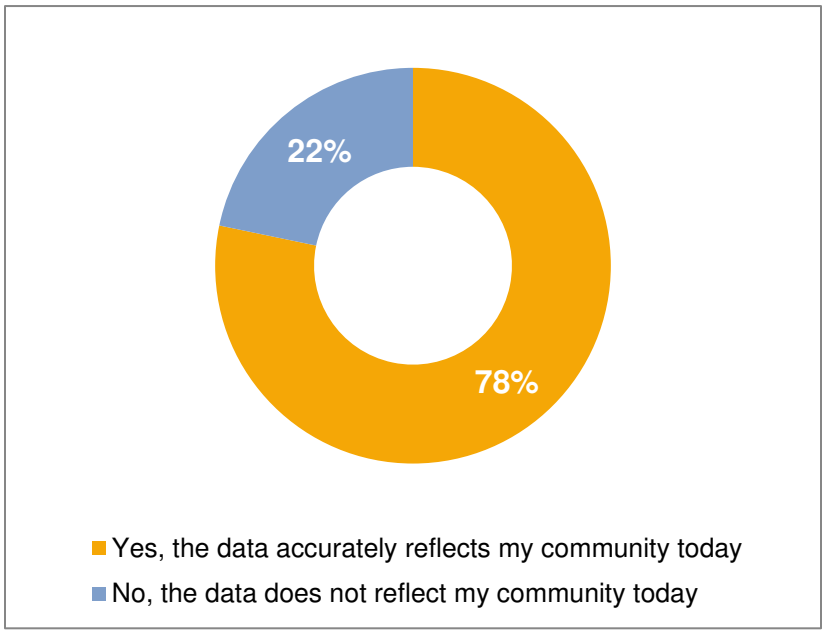
Question: Do you agree with the overall social vulnerability index for Sierra County?



Comments:

- *This is a very elderly population that live alone and are isolated. We also have a large rural community.*
- *I believe any sort of natural disaster or large scale disease outbreak would overwhelm the health care sector in very short time, and the long term effects of such events would cause significant short and long term turmoil perhaps so much so that the ongoing effects would persist indefinitely and forever change the demographic and economic makeup of the county.*
- *It's difficult to interpret your maps.*
- *I disagree that the west half of the county is more socially vulnerable. The communities of Hillsboro and Winston are not affluent, but folks neighbor well and help each other. The ranches in this area are deprived of housing nor socioeconomic condition.*
- *Seems to be a bit of general information so lacks credibility*
- *This is difficult to understand. People in the Southern half of the county with the exception of the large farmers are generally poorer with access to fewer resources. They are undocumented in many cases and have less access to care. Public Health saw many and I believe most use Ben Archer in Hatch rather than accessing care in T or C. The other issue is the fear of being picked up by the Border Patrol.*

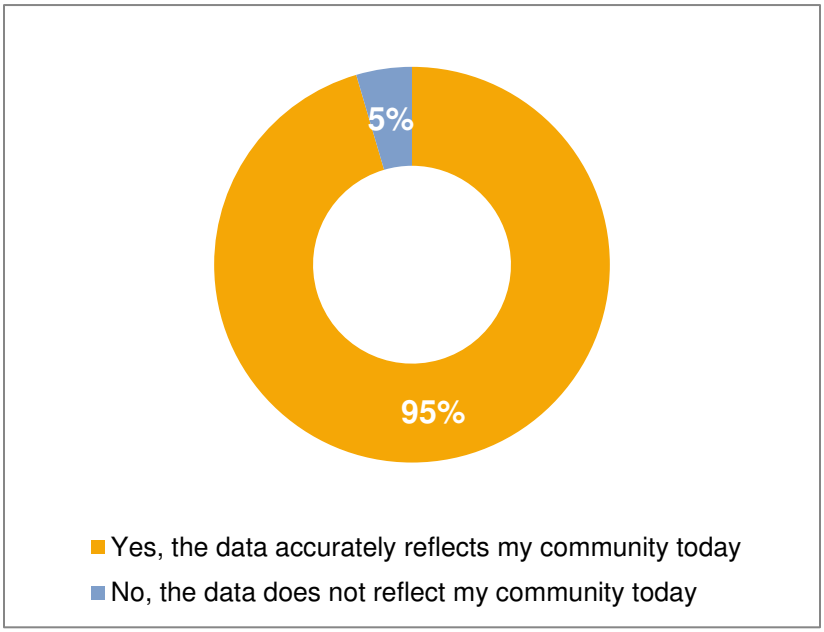
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *We have a large about of thyroid disease.*
- *With regards to suicide I believe there may be an increase on the horizon. I recently have been called in for 3 separate self-inflicted gunshots to the head over a period of 10 days.*
- *Suicide is higher than expected, 3 within the last two weeks. Does the NM Veterans home Alzheimer's rate include those at the NMSVH?*
- *I believe the suicide rate in Sierra County has risen dramatically over the past three years.*
- *The incidents of suicide has increased dramatically in recent weeks. The community needs immediate assistance to deal with this issue.*
- *I thought we had a high number of drug overdose deaths*
- *Yes, this has changed little since I left Public Health.*
- *Suicide rate seems low. There were at least 2 last year and three already this year.*
- *Suicide rates have increased significantly*

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



Comments:

- *Really hard to know how much of this is accurate.*
- *Very shocking statistics*
- *The difficulty is no real chance to decide how these fit with what I know about the financial benefits I see as a resource and how those resource choices are made*
- *I am really not sure about that information.*

Appendix B – National Healthcare Quality and Disparities Report

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.

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.[11] 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.

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,

[11] 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.

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