Greeley County Health Services

Tribune, KS

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution August 28th, 2019[1]

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

Dear Community Member:

Greeley County Health Services (GCHS) has been providing care to our community for over 60 years. Our efforts to provide exceptional healthcare to the people of the greater Greeley and Wallace counties region has long been in alignment with the needs of our community. The “2019 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how GCHS 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.

GCHS 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,

Burke Kline, DHA
Chief Executive Officer
Greeley County Health Services

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EXECUTIVE SUMMARY

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Greeley County Health Services ("GCHS" 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 2019 Significant Health Needs identified for Greeley and Wallace Counties are:

1. Obesity – 2016 Significant Need
2. Access to Primary Care and Specialty Care Physicians – 2016 Significant Need
3. Aging Population/Elder Wellness – 2016 Significant Need
4. Mental Health/Behavior Health – 2016 Significant Need
5. Health Education/Prevention – 2016 Significant Need
6. Alcoholism and Drug Abuse – 2016 Significant Need

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

APPROACH

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Greeley County Health Services ("GCHS" 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

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

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

Overview of Community Health Needs Assessment

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

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

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

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

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

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

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

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other (please specify)

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

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

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

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

existed in their portion of the county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Greeley and Wallace counties compared to all Kansas counties	February 1, 2019	2012-2016
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 1, 2019	2017-2018
http://svi.cdc.gov	To identify the Social Vulnerability Index value	February 4, 2019	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	February 4, 2019	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	February 1, 2019	2016

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

[10] Response to Schedule H (Form 990) Part V B 3 i

[11] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) Part V B 3 d

- A CHNA survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 35 Local Expert Advisors was received. Survey responses started March 22, 2019 and ended with the last response on April 5, 2019.
- Information analysis augmented by local opinions showed how Greeley and Wallace Counties relate to their peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12] [13]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
    - The top three priority populations identified in the area are residents of rural areas, low-income groups and older adults
    - Elderly community, requiring more care and a need for transportation
    - Lack of available resources for low-income families and overall access to specialty services

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]

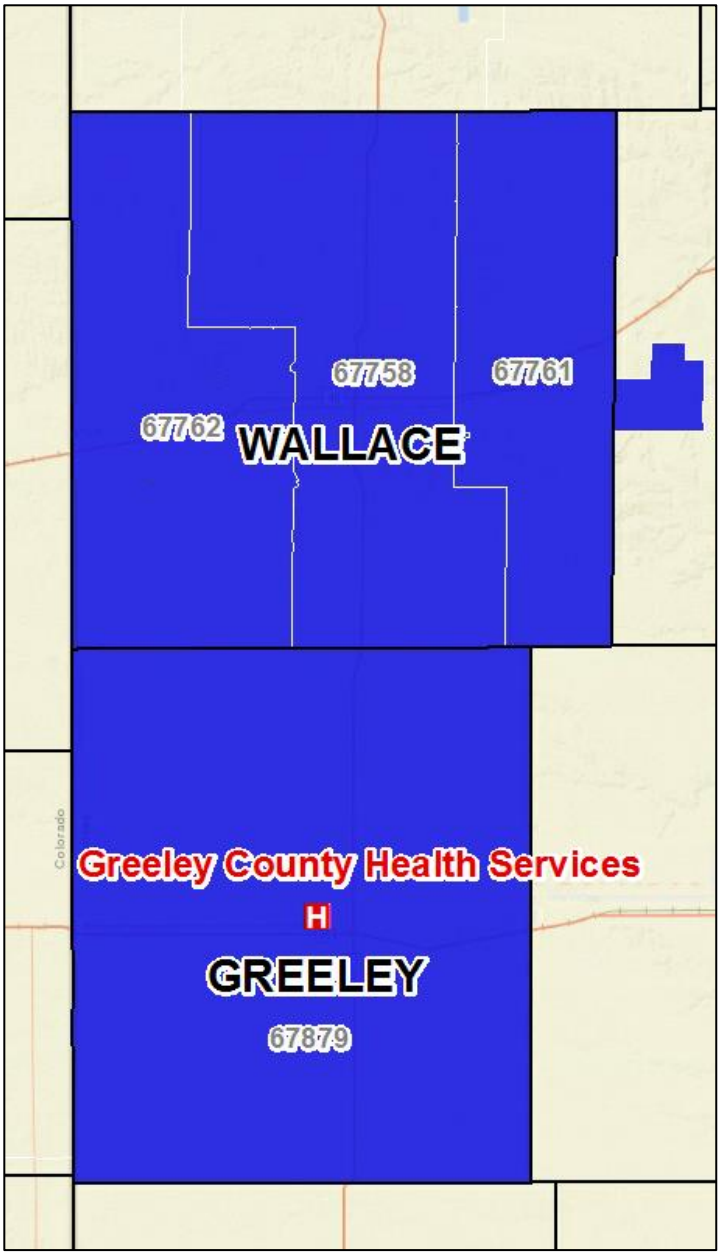
In the GCHS process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A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

The ranked needs were divided into two groups: "Significant" and "Other Identified Needs." The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least 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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[16]



For the purposes of this study, Greeley County Health Services defines its service area as Greeley and Wallace Counties in Kansas, which includes the following ZIP codes:[17]

67758 – Sharon Springs 67761 – Wallace 67762 – Weskan 67879 - Tribune

During 2016, the Hospital received 64.2% 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	GCHS Service Area 2019	GCHS Service Area 2024	GCHS Service Area %Change	Kansas 2019	Kansas 2024	Kansas %Change	United States 2019	United States 2024	United States %Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	2,864	2,872	0.3%	2,914,922	2,954,668	1.4%	326,533,070	337,947,912	3.5%
Total Male Population	1,393	1,404	0.8%	1,454,899	1,474,762	1.4%	160,763,625	166,448,475	3.5%
Total Female Population	1,471	1,468	-0.2%	1,460,023	1,479,906	1.4%	165,769,445	171,499,437	3.5%
Females, Child Bearing Age (15-44)	467	489	4.7%	560,559	566,030	1.0%	63,920,735	64,819,726	1.4%
Average Household Income	$69,431			$78,684			$86,278		
POPULATION DISTRIBUTION									
Age Distribution									
0-14	610	632	3.6%	592,419	585,967	-1.1%	61,041,209	61,251,924	0.3%
15-17	115	116	0.9%	120,369	124,298	3.3%	12,768,680	13,285,276	4.0%
18-24	232	251	8.2%	308,466	315,111	2.2%	31,582,678	32,239,015	2.1%
25-34	285	293	2.8%	374,921	366,977	-2.1%	43,889,724	43,505,348	-0.9%
35-54	563	517	-8.2%	696,653	690,996	-0.8%	83,269,718	83,715,341	0.5%
55-64	430	380	-11.6%	367,715	353,975	-3.7%	42,204,839	43,372,785	2.8%
65+	629	683	8.6%	454,379	517,344	13.9%	51,776,222	60,578,223	17.0%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	1,227	1,242	1.2%	1,140,018	1,157,189	1.5%	123,942,877	128,512,554	3.7%
2018 Household Income									
<$15K	106			119,888			13,504,093		
$15-25K	127			107,939			11,746,600		
$25-50K	389			271,456			27,363,648		
$50-75K	212			211,821			21,179,900		
$75-100K	142			143,905			15,192,390		
Over $100K	251			285,009			34,956,246		
EDUCATION LEVEL									
Pop Age 25+	1,907			1,893,668			221,140,503		
2018 Adult Education Level Distribution									
Less than High School	118			72,911			12,391,997		
Some High School	71			111,902			16,363,756		
High School Degree	603			502,871			61,028,690		
Some College/Assoc. Degree	634			608,035			64,253,906		
Bachelor's Degree or Greater	481			597,949			67,102,154		
RACE/ETHNICITY									
2018 Race/Ethnicity Distribution									
White Non-Hispanic	2,418			2,196,012			197,066,325		
Black Non-Hispanic	10			172,955			40,402,616		
Hispanic	379			352,678			59,581,510		
Asian & Pacific Is. Non-Hispanic	5			90,160			18,958,063		
All Others	52			103,117			10,524,556		

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

Consumer Health Service Behavior[21]

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

Where the GCHS 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
Lifestyle			**Cancer**		
BMI: Morbid/Obese	116.1%	35.5%	Cancer Screen: Skin 2 yr	90.7%	9.7%
Vigorous Exercise	96.4%	55.1%	Cancer Screen: Colorectal 2 yr	100.9%	20.7%
Chronic Diabetes	116.3%	18.2%	Cancer Screen: Pap/Cerv Test 2 yr	80.7%	38.9%
Healthy Eating Habits	103.3%	24.1%	Routine Screen: Prostate 2 yr	97.8%	27.7%
Ate Breakfast Yesterday	100.6%	79.5%	**Orthopedic**		
Slept Less Than 6 Hours	113.5%	15.5%	Chronic Lower Back Pain	109.5%	33.8%
Consumed Alcohol in the Past 30 Days	77.3%	41.5%	Chronic Osteoporosis	123.4%	12.5%
Consumed 3+ Drinks Per Session	113.7%	32.0%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.5%	84.1%
Search for Pricing Info	88.7%	23.8%	NP/PA Last 6 Months	108.0%	44.8%
I am Responsible for My Health	99.9%	90.3%	OB/Gyn 1+ Visit	80.4%	30.9%
I Follow Treatment Recommendations	104.0%	80.3%	Medication: Received Prescription	103.9%	63.0%
Pulmonary			**Internet Usage**		
Chronic COPD	141.0%	7.6%	Use Internet to Look for Provider Info	70.3%	28.0%
Chronic Asthma	100.4%	11.9%	Facebook Opinions	81.7%	8.3%
Heart			Looked for Provider Rating	69.4%	16.3%
Chronic High Cholesterol	119.9%	29.3%	**Emergency Services**		
Routine Cholesterol Screening	96.3%	42.7%	Emergency Room Use	105.3%	34.0%
Chronic Heart Failure	168.2%	6.8%	Urgent Care Use	84.4%	27.8%

[21] Claritas (accessed through IBM Watson Health)

Conclusions from Demographic Analysis Compared to National Averages

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

- 16.1% more likely to have a **BMI: Morbid/Obese**, affecting 35.5%
- 13.7% more likely to have **Consumed Alcohol in the Past 30 Days**, affecting 32.0%
- 19.3% less likely to receive **Cervical Cancer Screenings Every 2 Years**, affecting 38.9%
- 9.5% more likely to have **Chronic Lower Back Pain**, affecting 33.8%
- 19.6% less likely to receive **Routine OB/Gyn Visit**, affecting 30.9%
- 5.3% more likely to use the **Emergency Room** (for non-emergent issues), affecting 34.0%

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

- 22.7% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 41.5%
- 8.0% more likely to receive **Routine NP/PA Visit in Last 6 Months**, affecting 44.8%

Leading Causes of Death[22]

The Leading Causes of Death are determined by official Centers for Disease Control and Prevention (CDC) final death total. Kansas's Top 15 Leading Causes of Death are listed in the tables below in Greeley and Wallace County's rank order. Greeley and Wallace Counties were compared to all other Kansas counties, Kansas 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 KS (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Greeley County Compared to U.S.)
KS Rank	Greeley Rank	Condition		KS	Greeley	
2	1	Cancer	49 of 105	158.5	177.1	Higher than expected
1	2	Heart Disease	105 of 105	159.1	128.7	Lower than expected
4	3	Accidents	3 of 105	45.7	91.4	Higher than expected
3	4	Lung	1 of 105	48.3	91.2	Higher than expected
7	5	Diabetes	7 of 105	21.2	40.5	Higher than expected
10	6	Suicide	4 of 105	17.9	24.9	Higher than expected
8	7	Kidney	10 of 105	14.9	23.9	Higher than expected
5	8	Stroke	105 of 105	38.5	17.5	Lower than expected
9	9	Flu - Pneumonia	90 of 105	14.3	16.0	As expected
11	10	Blood Poisoning	42 of 105	10.3	10.0	As expected
6	11	Alzheimer's	99 of 105	23.0	8.2	Lower than expected
12	12	Parkinson's	70 of 104	10.1	6.2	As expected
15	13	Homicide	13 of 91	5.3	5.3	As expected
13	14	Liver	103 of 105	9.8	2.5	Lower than expected
14	15	Hypertension	97 of 104	6.0	1.8	Lower than expected

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

Cause of Death			Rank among all counties in KS (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Wallace County Compared to U.S.)
KS Rank	Wallace Rank	Condition		KS	Wallace	
1	1	Heart Disease	84 of 105	159.1	168.4	As expected
2	2	Cancer	102 of 105	158.5	148.1	Lower than expected
4	3	Accidents	27 of 105	45.7	64.3	Higher than expected
3	4	Lung	19 of 105	48.3	58.5	Higher than expected
5	5	Stroke	100 of 105	38.5	29.8	Lower than expected
7	6	Diabetes	57 of 105	21.2	21.6	As expected
11	7	Blood Poisoning	4 of 105	10.3	15.7	Higher than expected
6	8	Alzheimer's	89 of 105	23.0	11.8	Lower than expected
12	9	Parkinson's	7 of 104	10.1	10.3	As expected
8	10	Kidney	101 of 105	14.9	9.2	As expected
10	11	Suicide	102 of 105	17.9	7.1	Lower than expected
9	12	Flu - Pneumonia	105 of 105	14.3	3.7	Lower than expected
13	13	Liver	102 of 105	9.8	2.5	Lower than expected
14	14	Hypertension	99 of 105	6.0	1.4	Lower than expected
15	N/A	Homicide	N/A	5.3	N/A	N/A

Priority Populations[23]

It can be difficult to obtain information about Priority Populations in a hospital's community. The object is to understand the general trends of issues impacting Priority Populations and to interact with the Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

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

A specific question was asked to the GCHS'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, GCHS places great importance on the commentary received from the Local Expert Advisors to identify unique population needs to which GCHS should respond. Specific opinions from the Local Expert Advisors are summarized below:[24]

- The top three priority populations identified in the area are residents of rural areas, low-income groups and older adults
- Elderly community, requiring more care and a need for transportation
- Lack of available resources for low-income families and overall access to specialty services

[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

Comparison to Other State Counties[25]

To better understand the community, Greeley and Wallace Counties have been compared to all 103 counties in the state of Kansas across five areas available: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

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

	Greeley County	Wallace County	Kansas	U.S. Median
Health Outcomes				
Overall Rank *(best being #1)*	42/103	N/A		
- Premature death*	N/A	N/A	6,800	7,800
- Poor or fair health	14%	13%	15%	17%
- Poor mental health days	3.1	3.1	3.3	3.9
Health Behaviors				
Overall Rank *(best being #1)*	48/103	N/A		
- Adult Smoking	14%	14%	17%	17%
- Adult Obesity	32%	34%	32%	32%
- Physicial Inactivity	27%	29%	25%	27%
- Access to Exercise Opportunities	0%	39%	81%	66%
- Alcohol-impaired driving deaths	100%	33%	25%	29%
Clinical Care				
Overall Rank *(best being #1)*	81/103	N/A		
- Uninsured	15%	11%	10%	11%
- Population to Primary Care Provider Ratio	1,330:1	1,520:1	1,320:1	2,040:1
- Population to Dentist Ratio	1,300:1	1,500:1	1,760:1	2,520:1
- Population to Mental Health Provider Ratio	N/A	1,500:1	560:1	1,050:1
- Preventable Hospital Stays	95	123	51	56
- Diabetes monitoring	91%	89%	86%	86%
- Mammography screening	N/A	N/A	63%	61%
Social & Economic Factors				
Overall Rank *(best being #1)*	15/103	N/A		
- High school graduation	N/A	N/A	86%	88%
- Unemployment	2.3%	2.9%	4.2%	5.0%
- Children in poverty	18%	12%	14%	21%
- Children in single-parent households	35%	7%	29%	32%
- Violent Crimes*	77	0	348	198
- Injury deaths*	169	N/A	70	79
Physical Environment				
Overall Rank *(best being #1)*	24/103	N/A		
- Severe housing problems	7%	5%	14%	14%

Per 100,000 Population

[25] www.countyhealthrankings.org

Conclusions from Other Statistical Data[26]

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 Greeley and Wallace County statistics to the U.S. average, as well as the trend in each measure over a 34-year span (1980-2014).

Greeley County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Greeley county measures that are WORSE than the U.S. average and had an UNFAVORABLE change		
- Female skin cancer*	2.8	19.3%
- Male skin cancer*	4.8	20.0%
- Female diabetes, urogenital, blood, and endocrine disease deaths*	74.8	68.6%
- Male diabetes, urogenital, blood, and endocrine disease deaths*	78.9	48.8%
- Male self-harm and interpersonal violence related deaths*	39.1	7.9%
- Male mental and substance use related deaths*	19.7	179.4%
UNFAVORABLE Greeley county measures that are WORSE than the U.S. average and had an FAVORABLE change		
- Female life expectancy	80.8	2.6%
- Male life expectancy	75.8	8.2%
- Female breast cancer*	27.1	-12.1%
- Female transport injuries related deaths*	22.5	-6.2%
- Male transport injuries related deaths*	54.6	-16.5%
DESIRABLE Greeley county measures that are BETTER than the US average and had an UNFAVORABLE change		
- Female trachel, bronchus, and lung cancer*	37.5	74.4%
- Female self-harm and interpersonal violence related deaths*	8.8	8.0%
- Female mental and substance use related deaths*	5.7	342.8%
- Male liver disease related deaths*	21.6	7.6%
DESIRABLE Greeley county measures that are BETTER than the US average and had an FAVORABLE change		
- Female heart disease*	112.1	-48.4%
- Female stroke*	37.9	-34.1%
- Male stroke*	38.9	-50.7%
- Male tracheal, bronchus, and lung cancer*	60.9	-33.2%
- Female liver disease related deaths*	9.9	-26.9%
- Male liver disease related deaths*	15.1	-40.5%
AVERAGE Greeley county measures that are EQUAL than the US average and had an FAVORABLE change		
- Male heart disease*	191.5	-62.7%
- Male breast cancer*	0.3	-15.7%
AVERAGE Greeley county measures that are EQUAL than the US average and had an UNFAVORABLE change		
- Female liver disease related deaths*	11.8	23.0%

*rate per 100,000 population, age-standardized

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

Wallace County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Wallace county measures that are WORSE than the U.S. average and had an UNFAVORABLE change		
- Female skin cancer*	2.8	22.8%
- Male skin cancer*	4.9	25.0%
UNFAVORABLE Wallace county measures that are WORSE than the U.S. average and had an FAVORABLE change		
- Female trachel, bronchus, and lung cancer*	37.5	79.2%
- Female transport injuries related deaths*	21.1	-10.8%
- Male transport injuries related deaths*	46.9	-19.7%
DESIRABLE Wallace county measures that are BETTER than the US average and had an UNFAVORABLE change		
- Female diabetes, urogenital, blood, and endocrine disease deaths*	48.6	31.1%
- Male diabetes, urogenital, blood, and endocrine disease deaths*	61.3	35.8%
- Female self-harm and interpersonal violence related deaths*	8.1	1.5%
- Female mental and substance use related deaths*	4.1	243.9%
- Male mental and substance use related deaths*	14.7	119.9%
- Female liver disease related deaths*	10	7.5%
DESIRABLE Wallace county measures that are BETTER than the US average and had an FAVORABLE change		
- Female life expectancy	81.7	3.3%
- Male life expectancy	77.5	8.3%
- Female heart disease*	107.4	-48.1%
- Male heart disease*	165.8	-59.1%
- Female stroke*	38.5	-33.9%
- Male stroke*	35.4	-50.6%
- Male tracheal, bronchus, and lung cancer*	51.8	-37.6%
- Female breast cancer*	25.8	-16.0%
- Male self-harm and interpersonal violence related deaths*	25.4	-1.4%
- Male liver disease related deaths*	16.7	-0.4%
AVERAGE Wallace county measures that are **EQUAL** than the US average and had an FAVORABLE change		
- Male breast cancer*	0.3	-16.9%

*rate per 100,000 population, age-standardized

Community Benefit

Worksheet 4 of Form 990 h can be used to report the net cost of community health improvement services and community benefit operations.

> *"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.*
>
> *"Community benefit operations" means:*
>
> - *activities associated with community health needs assessments, administration, and*
> - *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following:

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

Activities reported by the Hospital in its implementation efforts and/or its prior year tax reporting (FY2018) included:

Greeley County Health Services Charitable Donations

DATE	LOCATION / COUNTY	ACTIVITY	STAFF	STAFF IDENTIFIED	QUANTITY	ESTIMATED DONATION	
	Greeley County	Tribune grade school, high school physicals-95	9		3 hrs	$ 670.00	
	Wallace County	SS and Weskan grade school and high school physicals - 94	8		3 hrs	$ 670.00	
Aug	Wallace County	Helped to run a ride	12			$ -	staff donated time, no pay
Aug	Greeley County	help with fair swings	20			$ -	staff donated time, no pay
Aug	Greeley County	serve fair barbecue	6			$ -	staff donated time, no pay
	Wallace County	Free skin check days	2 midlevels, 2 support staff @ 4 hours			$ 560.00	
	Greeley County	Free skin check days	2 midlevels, 2 support staff @ 4 hours			$ 560.00	
	Regional	Rural Health Best Practices	4-5 staff members	Chrysanne, Drew, Kieran, Dr. Ellis		$ 1,737.12	
	Sharon Springs	Medical student presents in library	1 volunteer				Med Student Donated time
June 5th	Sharon Springs	Healthy Pork recipe demo at retirement village	student	Chrysanne and Regan Stramel	2	$ 75.00	
	Regional	point guard university-medical student outreach to regional basketball camp	medical student				Med Student Donated time
January 10th	Leadership Wallace County	tour GCHS hospital and WCFPC		Chrysanne	1 day	$ 236.80	
		Meals on Wheels				$ 35,975.81	diff in actual meal cost vs charges
		Greeley County Community Development Donation				$ 100.00	
		2018 National Child Safety Council Sponsor				$ 187.50	
		Scholorship Gold Tournament Sponsor				$ 800.00	
		High School Sponsorship				$ 503.00	
		Total				$ 42,075.23	

IMPLEMENTATION STRATEGY

Significant Health Needs

GCHS used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by GCHS.[27] The Implementation includes the following:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies GCHS current efforts responding to the need including any written comments received regarding prior GCHS implementation actions
- Establishes the Implementation Strategy programs and resources GCHS will devote to attempt to achieve improvements
- Documents the Leading Indicators GCHS will use to measure progress
- Presents the Lagging Indicators GCHS believes the Leading Indicators will influence in a positive fashion, and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

GCHS is a primary hospital in its service area. GCHS is an 18-bed, acute care medical facility located in Tribune, Kansas. The next closest facilities are outside the service area and include:

- Wichita County Health Center, Leoti, KS; 22.8 miles (26 minutes)
- Hamilton County Hospital, Syracuse, KS; 35.8 miles (37 minutes)
- Keefe Memorial Hospital, Cheyenne Wells, CO; 57.8 miles (59 minutes)
- Scott County Hospital, Scott City, KS; 47.9 miles (51 minutes)
- Kearny County Hospital, Lakin, KS; 62.5 miles (62 minutes)

All statistics analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the GCHS 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.

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

1. **Obesity – Also a 2016 Significant Need; Physical Inactivity and Access to Exercise Opportunities rates are worse in Greeley and Wallace Counties compared to the state average**

Public comments received on previously adopted implementation strategy:

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

GCHS services, programs, and resources available to respond to this need include:[28]

- Wellness programs for hospital employees
    - Quarterly weight loss challenges
    - Hospital-sponsored discounts for membership at the wellness facilities in Tribune and Sharon Springs
- Funding through the HRSA Small Health Care Provider Quality Improvement Grant includes covers chronic disease management, wellness, and education efforts - Includes Health Coach visits which include wellness and activity planning
- Ongoing lifestyle education for residents from rotating medical students
- Community-sponsored InBody machine at the Wallace County Clinic
    - Provides a comprehensive metabolic analysis, including BMI measurement
    - Machine is made available to clinic patients, employees, and health fair attendees

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

- Build on weight loss challenge success
    - Potential county/county challenge
- Grocery store – bountiful baskets – healthy options and recipes and displays in store
- Clinicians prescribe exercise
- Expand telehealth offerings
    - Exploring options dietary and complex diabetes management – available through Freestate telemedicine programs
- Cardio and Diabetes risk screening clinics

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

- Community weight loss challenges have engaged the community and yielded positive health outcomes
- BMI management is an ongoing goal, though it is difficult to measure and manage
- Community members are increasingly taking responsibility for healthcare as reported by survey
- GCHS Health Coach Program redesigns the office visit for patients with diabetes, cardiovascular disease and

[28] 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

obesity.

Anticipated results from GCHS Implementation Strategy

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

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

- Total participation count for weight loss programs or challenges
- Clinician referral volume for obesity-related activities
- Clinician prescription volume for obesity-related activities
- Obesity screening volumes

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

- Improved Body Mass Index (BMI) scores
- Decrease in diabetes diagnoses relative to the overall population
- Improvement in Hemoglobin A1c (HbA1c) scores
- Growth in community adoption of fitness and wellness programs

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

Organization	Contact Name	Contact Information
Greeley County Health Department	Lisa Moritz	Nurse04@sunflowertelco.com 620-376-4200
Wallace County Health Department	Aften Gardner	wcountyhealth@fairpoint.net 785-852-4272
Greeley County Extension Office	Todd Schmidt	620-376-4284
Wallace County Extension Office	Melinda Daily	mdaily@ksu.edu 785-852-4285
Greeley County Recreation Board CYAT Center	April Sherer	(618) 616-4280
Wallace County Recreation Board Mt Sunflower Recreation Center	Amber Fischer	Amberfischer13@hotmail.com 785-821-1837
Gooch's Foods (Greeley County)	Josh Gooch	

Other local resources identified during the CHNA process that are believed available to respond to this need:[29]

Organization	Contact Name	Contact Information
The General Store (Wallace County)	Judi Selzer	
Miller's Food Store (Wallace County)	Scott and Katrina Miller	Katrina 785-673-3349
Community Walking Trails		Greeley and Wallace Counties

2. Access to Primary Care and Specialty Care Physicians – Also a 2016 Significant Need; Population to Primary Care Provider Ratio is worse in Greeley and Wallace Counties compared to the state average

Public comments received on previously adopted implementation strategy:

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

GCHS services, programs, and resources available to respond to this need include:[30]

- GCHS Primary Care Clinics in both Greeley and Wallace counties
- Telemedicine program recently expanded to include nine new specialties

[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 and Schedule H (Form 990) Part V Section B 11

[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

- Mentorship programs for medical students and PA Students and local students interested in healthcare
- Southwest Kansas Mission-based Recruiting Group organizes practitioners around regional health needs
- Visiting specialists include a general surgeon, a cardiologist, and behavioral health counselor
- GCHS Long-term Care Unit hosts "360 Care" for patients
    - Includes visiting podiatry, audiology, dentistry, and optometry services

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

- Expand clinic hours to improve appointment availability
- Expansion of services available at GCHS
    - New infusion center opening June 2019
    - Visiting podiatry clinic
- Improvement of the telemedicine program to enhance the patient experience
    - In-person "Nurse Champion" enhances the face-to-face experience
    - New facility Includes an improved room and space for telehealth visits
- Ongoing specialty recruitment/outreach
    - Renovated facility will enhance procedural capabilities
    - Local clinician outreach to referring physicians in the region
    - Collaboration with area hospitals such as Lakin OB/GYN for deliveries. Improved pre-natal and post-natal care services at GCHS.
- Educating and assisting patients with upcoming changes to insurance and healthcare coverage
- Develop alternatives for loan repayment options since the HPSA re-scoring program is likely to eliminate ability to use National Health Services Corps or even Kansas State Loan Repayment

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

- Successfully recruited a new physician to the medical staff
- Strong participation with Southwest Kansas Missions-based recruiting group
- Successfully contracted with Colorado Medicaid
- Began offering, and subsequently expanded, telemedicine services
- Started a new infusion center
- Collaborates with other state organizations such as University of Kansas and Kansas Recruitment Center

Anticipated results from GCHS Implementation Strategy

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

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

- Visit volumes for chronic vs. acute diagnoses
- Clinic volumes for scheduled services and telemedicine visits vs. walk-ins and emergency room visits
- Provider referral volumes for telemedicine
- Count of visiting specialists and specialty clinics hosted per month

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

- Increase in scheduled visit volumes
- Increased volumes for chronic and acute visit volumes
- Improved utilization of clinic versus Emergency Dept. visits

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

Organization	Contact Name	Contact Information
FreeState Healthcare	Elisha Yaghami	eyaghmai@freestatehealthcare.com
Compass Mental Health	Max Meschberger	mmeschberger@compassbh.org
High Plains Mental Health	David Anderson	david.anderson@hpmhc.com, 785-628-2871
Community Infusion Solutions		

Organization	Contact Name	Contact Information
Southwest Kansas Missions-based Recruiting Group	Benjamin Anderson	banderson@kearnycountyhospital.com
ACO (KU)	Robert Moser, M.D.	rmoser@kumc.edu
Kansas Recruitment Center	Joyce Grayson	jgrayson@kumc.edu

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

Organization	Contact Name	Contact Information
Greeley County Community Development	Christy Hopkins	clhopkins@fairpoint.net
Wallace County Foundation	Christy Hammer	christyhammer@me.com

3. **Aging Population/Elder Wellness – Also a 2016 Significant Health Need; The >65 Population in GCHS's service area is higher compared to the state and national average**

Public comments received on previously adopted implementation strategy:

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

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

- GCHS-sponsored "Aging Expo" to educate seniors
- Host community seminars to educate on Medicare benefits and other aging issues
- GCHS Patient financial assistance counselor
- GCHS long-term care (LTC) unit
    - Social services and benefit navigation
    - Community-wide events in the LTC, including birthdays and weekly gatherings
- Volunteer programs for senior care
- Support Wallace County Community Care Center with marketing and outreach efforts
- Specialty services available for senior population include:
    - Wellness visits
    - Access to specialists
    - Physician / Clinician referrals

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

- Offer "Welcome to Medicare" visits
- Explore options for ongoing management of the Wallace County Community Care Center
    - Analyze benefits of both skilled and non-skilled services
    - Investigate opportunity for physical and occupational therapy services
- Train financial assistance counselors to be a resource for the community
- Expand community health education offerings
    - Investigate opportunity for legal, mental health, other related services
- Expand therapy services with occupational therapy, speech therapy, or additional physical therapy resources
- Expand Telemedicine offerings to possibly include mental Health, urology, and diabetes management
- Explore group visits or support groups for caregivers or other elder issues

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

- Hosted several community education events

- Offered annual Medicare wellness visits
- Began providing marketing information for services available at community gatherings
- Implemented a successful Health Coach program
- Recruited new physician to grow practice volumes

Anticipated results from GCHS Implementation Strategy

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

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

- Volume of Medicare wellness visits
- Participation in insurance benefit navigation and other, related education activities

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

- Increased census in LTC beds
- Outcomes in Health Coach program
- Payer-specific outcomes, including quality and financial
- Counts of vaccinations administered for pneumonia, shingles, and Influenza

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

Organization	Contact Name	Contact Information
Wallace County Community Care Center	John Kennedy	jkennedy@mygchs.com
Clinkscales Elder Law Office		(785) 625-8040, www.clinkscaleslaw.com
Greeley County Health Department	Lisa Moritz	Nurse04@sunflowertelco.com
Wallace County Health Department	Aften Gardner	wcountyhealth@fairpoint.net
Dixon Drug	Jeremi Whitham Jentri Hahn	Jayhawk.rx22@gmail.com Jentri.dixon@hotmail.com 620-376-4224

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

Organization	Contact Name	Contact Information
Greeley County Senior Center	Chelsee Cavenee	
Wallace County Senior Center	Multiple community members	
TZP Retirement Services	Travis Peter	

4. **Mental Health/Behavioral Health – 2016 Significant Health Need; Population to Mental Health Provider Ratio in Wallace County is worse compared to the state and national average; Suicide is the #7 leading cause of death in Greeley County and the #11 leading cause of death in Wallace County; Mental and substance use related deaths in Greeley and Wallace Counties have increased from 1980 to 2014**

Public comments received on previously adopted implementation strategy:

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

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

- Collaboration with Compass Behavioral Health including on-site services and telemedicine
- Telemedicine for behavioral health through FreeState Healthcare

- GCHS Employee Assistance Program (EAP)
    - Local clinicians provide depression screenings
- Dr. Lindquist hosts a mental health journal club for regional providers on a quarterly basis to educate on mental health issues

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

- Evaluate to provide depression and anxiety screenings in scheduled school physicals
- Dr. Lindquist is evaluating training in cognitive behavioral therapy
- Evaluate opportunity for an adolescent psychiatric care unit in LTC
- Partner with schools to offer school-based educational opportunities
- Evaluate opportunity to provide depression screenings in ER at triage

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

- Recruited a primary care physician with focus in behavioral health
- Implemented mental health screenings
- Collaborated with High Plains Mental Health in Sharon Springs

Anticipated results from GCHS Implementation Strategy

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

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

- Number of mental health screenings provided by GCHS clinicians

- Number of depression-related diagnoses
- Number of community resources available

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

- Suicide rate
- Utilization of behavioral health services in hospital and clinics
- Telemedicine volumes for behavioral health visits
- Number of community resources available

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

Organization	Contact Name	Contact Information
Greeley County Schools	Stuart Holmes	620-376-4265
Wallace County Schools	Joni Pearce Mr. Orton	785-852-4252
Compass Behavioral Health	Max Meschberger	mmeschberger@compassbh.org
FreeState Healthcare	Elisha Yaghami	eyaghami@freestatehealthcare.com
Local FFA Chapter	Melissa Zerr	mzerr@tribuneschools.org
Regional Provider Journal Club	Sam Lindquist, M.D.	slindquist@mygchs.com

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

Organization	Contact Name	Contact Information
Greeley County Extension Office	Todd Schmidt	620-376-4284
Wallace County Extension Office	Melinda Daily	mdaily@ksu.edu
Greeley County Health Department	Lisa Moritz	Nurse04@sunflowertelco.com
Wallace County Health Department	Aften Gardner	wcountyhealth@fairpoint.net
Ministerial Alliance	Rick Dewees	rickleedewees@gmail.com

Organization	Contact Name	Contact Information
County Courts / resources – Multi-disc group (Meets regularly)	Brandy Cleavenger	620-376-4274
Greeley County Senior Center	Chelsee Cavenee	620-376-2176
Wallace County Senior Center		785-852-4807

5. Health Education/Prevention – 2016 Significant Health Need

Public comments received on previously adopted implementation strategy:

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

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

- County Health fair(s)
- GCHS booth at the county Fair(s)
- Rotating medical students and local providers provide community outreach
- Annual Medicare wellness visits

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

- Partner with schools to educate students on relevant health issues
- Work with medical and work study students to expand community outreach efforts
- Work with employees to improve employee wellness, including:
    - Make GCHS a Smoke-Free campus
    - Offer free mental health visits to employees through Compass Behavioral Health
    - Raise awareness for Flu shots and vaccinations
    - Provide educate on annual wellness opportunities and GCHS-sponsored health benefits
    - Improve benefits and incentives for wellness
- Expand mental health program offerings (See Priority #4 above)
- Community immunization education
- Enhance social media presence for health education
    - Have clinician contribute content (Articles, blog posts, etc.)
    - Facebook content (Videos, tutorials, articles, etc.)
    - Ads in the newspaper and post office

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

- Greater Physical Therapy outreach in the community
- County health data shows people are taking greater responsibility for their health
- Improved access to employee wellness programs
- Expanded mental health offerings (See Priority #4 Above)

Anticipated results from GCHS Implementation Strategy

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

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

- Participation in employee wellness programs
- Participation in community wellness programs

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

- Number of Immunizations administered
- Number of employee health screenings

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

Organization	Contact Name	Contact Information
Greeley County Health Department	Lisa Moritz	Nurse04@sunflowerteleco.com
Wallace County Health Department	Aften Gardner	wcountyhealth@fairpoint.net
Greeley County Schools	Stuart Holmes	620-376-4274
Wallace County Schools	Joni Pearce / Mr. Orton	785-852-4252
Local FFA Chapter	Melissa Zerr	620-376-4274
Clinkscales & Clinkscales		www.clinkscaleselderlaw.com
Greeley County Senior Center	Chelsee Cavenee	620-376-2176
Wallace County Senior Center		785-852-4807

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

Organization	Contact Name	Contact Information
Greeley County Extension Office	Todd Schmidt	tschmidt@ksu.edu
Wallace County Extension Office	Melinda Daily	mdaily@ksu.edu
CYAT Center		620-376-8122

6. **Alcoholism and Drug Abuse – 2016 Significant Health Need; Alcohol-impaired driving deaths rate in Greeley and Wallace Counties are higher compared to the state and national average; Residents of Greeley and Wallace Counties are 14% more likely to Consume 3+ Drinks per Session; Mental and substance use related deaths in Greeley and Wallace Counties have increased from 1980 to 2014**

Public comments received on previously adopted implementation strategy:

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

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

- Education on pain control options through Physical Therapy services with dry needling procedures and other therapy options
- Offers access to behavioral health providers with a substance abuse certification

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

- Improve communication / education around alcoholism/substance abuse
    - Educate youth (with mental health)
- Grow outreach with community partners
    - FFA, county health departments, schools, churches, and others
- Explore opportunity to sponsor grief counseling
- Engage schools in conjunction with law enforcement and other multi-disciplinary groups

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

- Added an alcohol consumption question on ER and clinic triage questionnaire

Anticipated results from GCHS Implementation Strategy

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

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

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

- Participation in community education events
- Number of education events provided
    - Number Solely provided and number done joint with community partner

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

- Community Health Service Behavior statistics related to alcohol consumption and substance abuse
- Mortality and injury statistics related to alcohol and substance abuse
- Responses on the alcoholism questionnaire

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

Organization	Contact Name	Contact Information
Greeley County Schools		See previous listed contact info
Wallace County Schools		See previous listed contact info
Greeley County Health Department		See previous listed contact info
Wallace County Health Department		See previous listed contact info
Greeley County Sherriff's Office	Mark Rine	620-376-4233
Wallace County Sherriff's Office	Larry Towsend	785-852-4288
Ministerial Alliance		
County Health Fair		Local health departments and extension offices – see previous contact

Organization	Contact Name	Contact Information
County Fair		Local health departments and extension offices – see previous contact

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

Organization	Contact Name	Contact Information
Local churches		
Compass Behavioral Health	Max Meschberger	mmeschberger@compassbh.org

Other Needs Identified During CHNA Process

7. **Access to Ancillary Care Services (Examples include Dental Care, Home Health and Optometry) – 2016 Significant Need**
8. **Women's Health**
9. **Affordability**
10. **Diabetes**
11. **Heart Disease**
12. **Physical Inactivity**
13. **Accidents**
14. **Alzheimer's**
15. **Chronic Pain Management**
16. **Trauma Informed Care/Adverse Childhood Events (ACEs)**
17. **Flu/Pneumonia**
18. **Smoking/Tobacco Use**
19. **Hypertension**
20. **Child birth services**
21. **Stroke**
22. **Complete Ob/GYN services**
23. **Kidney Disease**
24. **Liver Disease**
25. **Lung Disease**
26. **Education on the effectiveness/safety of childhood vaccines**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[31]

1. Obesity – 2016 Significant Need
2. Access to Primary Care and Specialty Care Physicians – 2016 Significant Need
3. Aging Population/Elder Wellness – 2016 Significant Need
4. Mental Health/Behavior Health – 2016 Significant Need
5. Health Education/Prevention – 2016 Significant Need
6. Alcoholism and Drug Abuse – 2016 Significant Need

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

1. None

Other needs where hospital developed implementation strategy

1. None

Other needs where hospital did not develop implementation strategy

1. None

[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 2016 CHNA.[33] 35 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	8	23	31
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	8	21	29
3) **Priority Populations**	8	20	28
4) Representative/Member of **Chronic Disease Group** or Organization	3	26	29
5) Represents the **Broad Interest of the Community**	31	2	33
Other	1	0	1
Answered Question	**35**		
Skipped Question	**0**		

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)

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

- 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?**

   - *We have a lot of older adults in Greeley Co & surrounding areas so many are requiring more and more care. Some need someone to make them get the help they need. Some people -all ages- doctor out of town since we don't offer full medical care.*
   - *Access to quality general medical care as well as emergency medicine and critical care.*
   - *Child care, elder care, home health*
   - *Affordable health care, easy access to specialists/therapies*
   - *Housing-availability and affordability, emergency health care, end of life care, in home care.*
   - *Access to specialty services*
   - *We need to be sure we are providing culturally competent care to our clients who do not speak English, providing an interpreter or using a language line when communicating with them and not relying on their family members or children. Addressing lack of available resources for low income families and linking them with services in our community or surrounding communities. There is a lot of recent information and movement in work surrounding Trauma Informed Care and the assessment and use of ACEs scores and how a high ACEs score can lead to chronic illnesses, risk for drug/alcohol abuse, higher risk of being in poverty or victim of abuse, and many other things. It would be interesting if we could figure out a way to help incorporate ACEs into how we care for and treat those who have high ACEs scores. As residents of a frontier county, not everyone has access or ability (financial or physical) to go to a doctor or specialist in Denver/Wichita/Hays/Kansas City. Figuring out ways to bring in more specialists or services to our local hospital or clinic would be great. There is a huge gap in services available to those with disabilities, ESPECIALLY disable pediatric patients. Trying to find a physical therapist who is comfortable working with very young children is difficult. Home health services are hard to find, no matter the patient's age. Patients shouldn't have to go without PT/home health or have to move from their home to a town/city, just so they can receive these services. LGBT can be stigmatized and marginalized in small communities, and it shouldn't be that way.*

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

   1. **Alcoholism and drug dependence**
   2. **Obesity education, nutrition and preventative medicine**
   3. **Access to behavioral health and awareness of mental health conditions**
   4. **Issues of aging, end of life decision making and elder wellness**
   5. **Patient care (additional physicians)**
   6. **Additional healthcare resources such as dental care, home health options and optometrists**

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

	Yes	No	Response Count
Alcoholism and drug dependence	28	5	33
Obesity education, nutrition and preventative medicine	30	3	33
Access to behavioral health and awareness of mental health conditions	32	1	33
Issues of aging, end of life decision making and elder wellness	32	1	33
Patient care (additional physicians)	25	8	33
Additional healthcare resources such as dental care, home health options and optometrists	27	6	33

Comments:

- *We were also promised that we would have -work hard to get labor & delivery back in the hospital the last 2 votes for taxes to be raised for the hospital improvements & it's not a possibility at all apparently. So I doubt I'm the only one losing trust in the hospital.*
- *I feel they are adequately staffed with providers*
- *Hospice care is needed*

4. **Please share comments or observations about the actions the Hospital has taken to Reducing the <u>ALCOHOLISM AND DRUG DEPENDENCE</u>.**
   - *I do not know how this is working*
   - *Only difference I see is a push to no longer prescribe pain medications even when people are in need. Patients that have chronic pain are made to feel like drug addicts. Not sure that's the solution to the problem.*
   - *Seem to have lost a little ground since the death of GCHS physician.*
   - *More needs to be done in the schools to keep kids away from it!*
   - *I am not aware of any help for those with alcohol or drug addictions*
   - *Have not seen any actions.*
   - *Need to improve in this area.*
   - *To my knowledge we have not taken action.*
   - *GCHS has a seat at the table and is represented well during discussions around dependence*
5. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>OBESITY EDUCATION, NUTRITION AND PREVENTATIVE MEDICINE</u>.**
   - *I have heard /seen efforts on nutrition and some preventative medicine. I think more effort could be spent in encouraging tests/endoscopies and vaccinations in over 50 group. I have not heard of anyone having obesity education*
   - *Have no knowledge of actions*
   - *Addition of Health Coach has been a positive addition.*

- *More needs to be done in the schools to help students become aware of the issues with obesity and nutrition.*
- *I have seen literature about obesity, nutrition and preventive medicine available at the clinic and in the hospital waiting rooms.*
- *Hired a health coach.*
- *They do a good job in this area.*
- *Involved in the health fair and outreach support with health grant*
- *I think that my physician should work with me and the hospital food service staff to help me learn how much to eat and what to eat to help with my diabetes. I would like to eat some noon meals in the hospital cafe to get improved nutrition for my diabetes.*
- *I think Wallace County has some new tools.*
- *I believe they have really worked to educate patients and to surround them with a team when they come into the clinic.*
- *The clinic has instituted the Health Coach Model and acquired a smart scale.*
- *Partnered with Public Health at annual Health Fair, partnered with Rec Board for activity challenge and other activities*

6. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>ACCESS TO BEHAVIORAL HEALTH AND AWARENESS OF MENTAL HEALTH CONDITIONS</u>.**
   - *I am not sure if the behavioral health services are well utilized but I do see the ads for it in the local paper*
   - *Not enough information made available about options*
   - *Continue to work with Compass Health and expand if needed.*
   - *Kids are pulled out of class a lot to get help from Compass Mental Health.*
   - *I know that people from Area Mental Health out of Scott City are available to help persons with mental health conditions.*
   - *Compass comes once a week. Need more options other than compass.*
   - *Need to improve in this area.*
   - *Continues to partner with areal mental health agency and offer tele counseling*
   - *Providers have information that they provide patients with.*
   - *GCHS has partnered with Compass Behavioral Health and has a counselor come to our clinic for visits.*
   - *GCHS has a seat at the table and is represented well during discussions around mental health. Has telecommunications for behavioral health*
7. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>ISSUES OF AGING, END OF LIFE DECISION MAKING AND ELDER WELLNESS</u>.**
   - *I think we could be more proactive in getting these conversations going. My father and I and my siblings had these conversations amongst each other but little medical input until the end of his life*
   - *Much of the focus and actions seem to be in this area. If you are young and should be healthy, if you're not, you seem to get brushed under the rug.*
   - *I personally don't know what is available for the elderly in our community. I know that the senior center offers many things to help elderly persons. I just do not have any knowledge of what it is.*

- *Very good with long term care*
- *There seems to be a good relationship between the elderly population (and their families) and providers/ltc facility to make the transition into LTC quick and smooth. Good communication between residents/their families and LTC facility/providers.*
- *There have been no further actions taken to my knowledge.*
- *I have seen education opportunities in the community regarding elder wellness*

8. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>PATIENT CARE (ADDITIONAL PHYSICIANS)</u>.**
   - *While we must always be looking for additional providers for the future, I feel we are staffed at this time.*
   - *Have got 1 new doctor*
   - *Addition of GCHS physician has been a positive step in the right direction.*
   - *Since our newest doctor has arrived it seems as if it is a little easier to get in to see a doctor. I am very glad to see the extended hours for the clinic to make health care a little more accessible to everyone.*
   - *Hired new physicians*
   - *Very good*
   - *They have hired a new physician and added an additional mid-level provider*
   - *Need less PA's*
   - *Added an m.d. to staff.*
   - *Great job recruiting and signing a new physician to GCHS. Seems to want to continue the vision of excellent healthcare and is motivated to make healthcare system even better.*
   - *Recent addition of MD*
   - *One physician was added.*
   - *GCHS hired physician in 2018 and participates in residency programs.*
   - *I know of at least 1 new physician in Wallace County*
9. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>ADDITIONAL HEALTHCARE RESOURCES SUCH AS DENTAL CARE, HOME HEALTH OPTIONS AND OPTOMETRISTS</u>.**
   - *This I don't know. I have had people in the community ask about this*
   - *I haven't noticed any actions*
   - *No knowledge if actions take In for dental or optometrist*
   - *Dental and vision screenings happen each year during the school day.*
   - *I am not aware of any actions that have been taken to address Dental care, home health care or optometrist in Greeley County. I would like to see some of these things available here so I would not have to go out of town for any of these.*
   - *Haven't seen any*
   - *Wallace County Clinic was built with bringing a dentist to the area in mind. Unfortunately, that room isn't used as it was intended.*
   - *Still see a need in these areas*

- *GCHS LTC partnered with 360 care to aid in Dental and optometry coming to the LTC.*

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
2. Obesity – 2016 Significant Need	298	19	11.92%	11.92%	Significant Needs
6. Access to Primary Care and Specialty Care Physicians – 2016 Significant Need	286	16	11.44%	23.36%	
5. Aging Population/Elder Wellness – 2016 Significant Need	256	21	10.24%	33.60%	
4. Mental Health/Behavioral Health – 2016 Significant Need	254	20	10.16%	43.76%	
3. Health Education/Prevention – 2016 Significant Need	234	17	9.36%	53.12%	
1. Alcoholism and Drug Abuse – 2016 Significant Need	211	17	8.44%	61.56%	
7. Access to Ancillary Care Services (Examples include Dental Care, Home Health and Optometry) – 2016 Significant Need	152	15	6.08%	67.64%	Other Identified Needs
11. Cancer	94	13	3.76%	71.40%	
23. Women's Health	82	12	3.28%	74.68%	
9. Affordability	81	10	3.24%	77.92%	
13. Diabetes	77	11	3.08%	81.00%	
15. Heart Disease	66	10	2.64%	83.64%	
20. Physical Inactivity	66	11	2.64%	86.28%	
8. Accidents	62	10	2.48%	88.76%	
10. Alzheimer's	51	11	2.04%	90.80%	
12. Chronic Pain Management	48	10	1.92%	92.72%	
27. Trauma Informed Care/Adverse Childhood Events (ACEs)	30	1	1.20%	93.92%	
14. Flu/Pneumonia	28	9	1.12%	95.04%	
21. Smoking/Tobacco Use	24	8	0.96%	96.00%	
16. Hypertension	22	7	0.88%	96.88%	
26. Child birth services	20	1	0.80%	97.68%	
22. Stroke	19	7	0.76%	98.44%	
25. Complete OB/GYN services	10	1	0.40%	98.84%	
17. Kidney Disease	8	6	0.32%	99.16%	
18. Liver Disease	8	6	0.32%	99.48%	
19. Lung Disease	8	6	0.32%	99.80%	
24. Education on the effectiveness/safety of childhood vaccines	5	1	0.20%	100.00%	
Total	2500		100.00%		

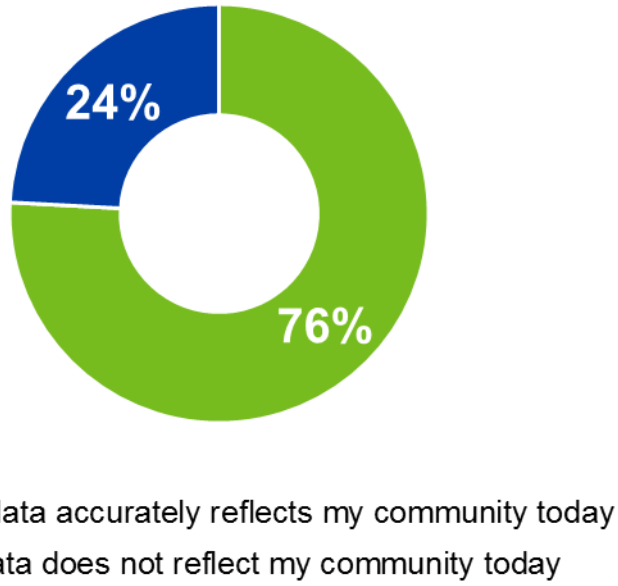
Individuals Participating as Local Expert Advisors[34]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	8	23	31
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	8	21	29
3) **Priority Populations**	8	20	28
4) Representative/Member of **Chronic Disease Group** or Organization	3	26	29
5) Represents the **Broad Interest of the Community**	31	2	33
Other	1	0	1
Answered Question	**35**		
Skipped Question	**0**		

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

Advice Received from Local Expert Advisors

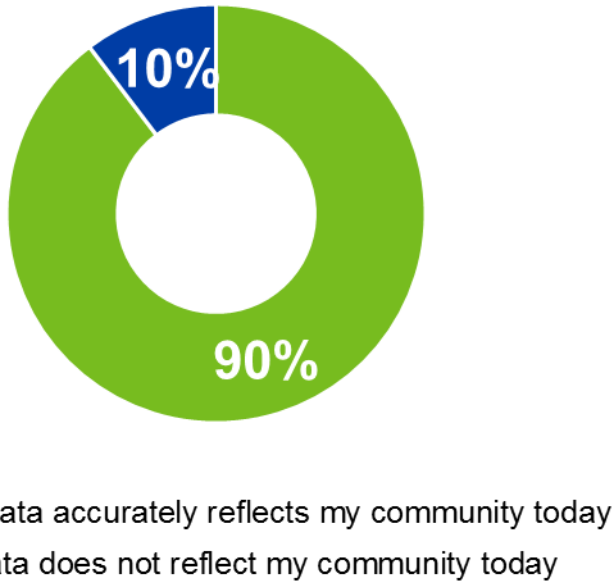
Question: Do you agree with the comparison of Greeley and Wallace Counties compared to KS and the US?



Comments:

- *Our 2019 Greeley County Health Ranking has us at 34, not 43rd in the state. I argue with the point about no access to locations for physical activity, as the walking trail and disc golf course are accessible to all, free of charge. We also have a wellness center at the CYAT Center that enables members to have 24/7 access to a variety of equipment. I'm not as aware as to how some of the other factors are determined, but this doesn't seem to be an overly accurate picture of Greeley County.*
- *We have access to exercise at the senior center, the CYAT center and a very nice walking trail. I would think having the Compass Behavioral health at the clinic would provide some mental health coverage. I was surprised at the violent crimes/injury deaths numbers*
- *The alcohol related driving deaths is 100%. Just wondering if that's correct- everyone that is driving impaired dies or I'm just reading it wrong.*
- *I feel that clinical care is too low.*
- *With the accept ion of access to physical activity in Greeley County.*
- *Except for access to exercise opportunities in Greeley County. We have access to a workout center and many other sports/recreational activities.*
- *I'm confused by the "100%" on "Alcohol-impaired driving deaths". It has been a few years since we have had an alcohol-impaired driving death, as far as I know. The "0%" for "Access to Exercise Opportunities" is not accurate--we have a robust recreation department in Greeley County, have updated a county park, have a walking trail, tennis courts, swimming pool, physical activities at the Senior Center.*
- *I see that we have many in our population that are in poverty and are uninsured.*
- *Wallace County is not calculated*

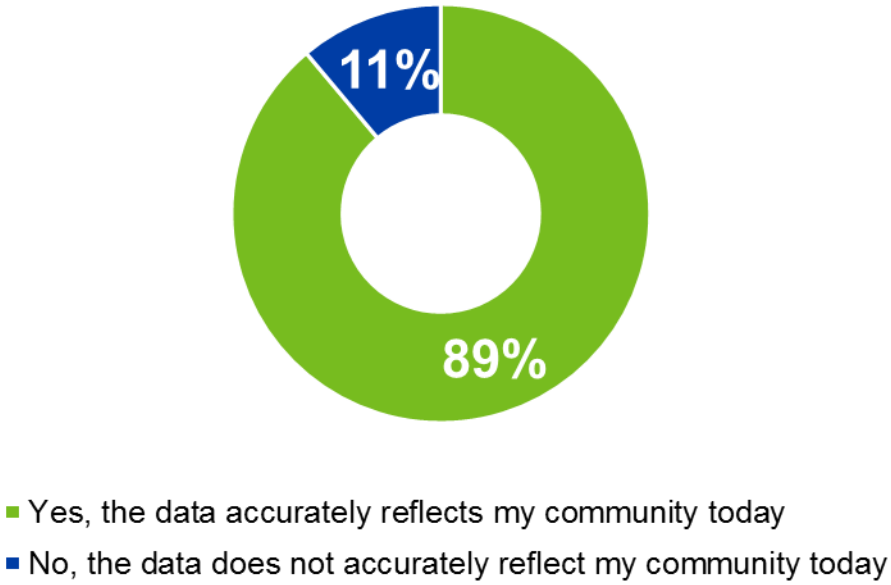
Question: Do you agree with the demographics and common health behaviors of GCHS's Service Area?



Comments:

- *I would think the population % for those over 65 is well over 22%. As well as childbearing age women over 16.3%.*
- *Back pain yes-so much labor intensive work in a small town I can see that number being very high. I do not go for check ups. I know several that don't.*
- *Our school system has around 30% Hispanic students so the 13% Hispanic percentage may have gone up some, though I know that many of the new Hispanics to move in are younger with children which would be reflected in the school population maybe more than the overall population.*
- *Many are the boomers and the younger generations are relocating to more populated areas of the country. Due to lack of services and quality care for their children. IF they have health needs they will move as well.*

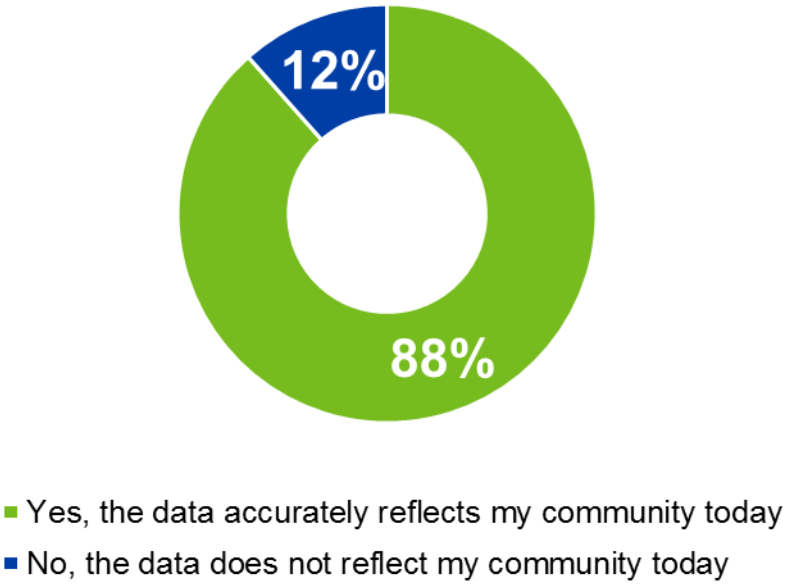
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *I don't have enough information to definitively answer this. I'm curious as to how the rankings were determined. perhaps I missed a homicide (not sure how!) but I have no idea how we're ranked 13 of 91 in the state in that particular metric. Unfortunately, when I start questioning one metric, I start questioning the methodology for all of them.*
- *Not sure about the suicide rate*
- *I'm sure it's all true but homicide cases here-how many are there to get it ranked?*
- *Data skewed due to small sample size*
- *I am not surprised that cancer is "higher than expected" in Greeley County; a lot of people have had to go through cancer treatment.*
- *This is due to the older generation of smoking and the poverty level does not take the care that is needed.*

Question: Do you agree with the health trends in Greeley and Wallace Counties?



Comments:

- *I don't feel close enough to the health care field to accurately answer this question.*
- *Data skewed due to small sample size*
- *the data reflects poverty and drug abuse as being a major concern of health in each county*

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.

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.

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

- 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.

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

[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.

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 footnotes 16 and 18 on page 11

   b. **Demographics of the community**

      See footnote 19 on page 12

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

      See footnote 28 on page 25; and footnote 29 on page 27

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 27 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 34 on page 52

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

      See footnotes 8 and 9 on page 7

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

      See footnote 10 on page 8, footnotes 13 and 14 on page 9, and footnote 23 on page 17

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

      N/A

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

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

   2016

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

   Yes, see footnote 14 on page 9 and footnote 33 on page 46

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)**

      http://mygchs.com/

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

      No other website

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

      Yes

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

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

   Yes

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

   2016

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

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

       http://mygchs.com/wp-content/uploads/2016-GCHS-CHNA-Executive-Summary-Final-Nov.pdf

    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 28 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