CONCHO COUNTY HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT

JANUARY 28, 2019

Prepared by:

Dave Clark

TORCH Management Services, Inc. (“TORCH”) appreciates Brian Lady, Administrator of Concho County Hospital (“CCH or the “Hospital”) for giving TORCH the opportunity to conduct the assessment, and for providing assistance throughout, the compilation of the Community Health Needs Assessment, and Priscilla Aguirre of CCH for assistance in scheduling the participants for the focus groups. TORCH also appreciates the time and effort the focus group participants made to provide their thoughts and insights concerning the health needs of Concho County.

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Conducted: January 28, 2019

Dave Clark, TORCH Management Services, Inc.

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GENERAL OVERVIEW

A Community Health Needs Assessment ("CHNA") was conducted for Concho County Hospital on January 28, 2019. The value of the Assessment is that it allows healthcare organizations to better understand the needs of the communities they serve, with the ultimate goal of improving the overall health of the local citizens. Whether or not an organization is required to conduct a Community Health Needs Assessment, it is an extremely valuable tool for fulfilling its role in the community. An old adage goes, "You can't provide the right kind of services when you haven't asked the customers you serve what they like or not." By listening to members of the community and reviewing demographic data, the Hospital can gain information on health status and where gaps in healthcare delivery currently exist. Further, it solidifies the Hospital's role in the community as a partner in improving overall health status, as well as in areas beyond health, such as education and economic development.

The Association for Community Health Improvement (ACHI) points out that this process provides help in understanding where the needs are, and where and how to spend the available health care dollars in a community. ACHI also describes the importance of the Hospital working together as a partner with other local organizations (health department, schools, churches, businesses, etc.) to improve the health of all citizens, from the child to the senior adult.

GENERAL OVERVIEW OF CONCHO COUNTY[1]

CONCHO COUNTY, in Central Texas, straddles the northern edge of the Edwards Plateau. The county derives its name from the Concho (or "Shell") River, which in turn was named for the large number of mussels found there. Paint Rock, the county seat, is situated in the north central part of the county on U.S. Highway 83, approximately thirty miles east of San Angelo and 150 miles northwest of Austin. Concho County comprises 992 square miles with an elevation of 1,600 to 2,100 feet above mean sea level. The terrain in the north is rolling, with steep slopes and trenches while that to the south, on the Edwards Plateau, is flat but broken by numerous deep creek beds.

Historically, agriculture and livestock have been the main source of income for the county. In 1988, when Concho County was the leading sheep-producing county in Texas, 60 percent of its $15 million in farm income came from sheep, cattle, and goats, and the leading crops were grains and cotton. In 1982 farms and ranches occupied 95 percent of the county. Sheep were first introduced into the county in the 1870s and by 1890, the year of the first enumeration, numbered 41,724. Around 11 to 22 percent of the county area is considered to be prime farmland. The county was originally settled by cattle ranchers, but sheep ranching and cotton cultivation became more prominent. Oil and gas are also produced in the county. Local attractions such as boating, fishing, hunting, the Indian pictographs, and the Concho County Fair boost tourism in the county.

The U.S. census counted 4,050 people living in Concho County in 2014. About 42.6 percent were Anglo, 54.5 percent were Hispanic, and 2.5 percent African-American. Of residents age twenty-five and older, 66 percent had completed high school, and 15 percent had college degrees. In the early twenty-first century agriculture remained the central element of the local economy. In 2002 the county had 411 farms and ranches covering 544,312 acres, 72 percent of which were devoted to pasture and 26 percent to crops. That year farmers and ranchers in the area earned $14,309,000; livestock sales accounted for $7,444,000 of the total. Sheep, cattle, goats and feed grain were the chief agricultural products. More than 506,500 barrels of oil were produced in the county in 2004; by the end of that year 25,948,824 barrels of petroleum had been taken from county lands since 1940, when oil was first discovered in the area.

Paint Rock (population, 262) remains the county’s seat of government; other communities include Eden (1297), Eola (215), Millersview (80), and Lowake. Eden’s population dropped in 2017 with closure of prison from 2010 census of 2766.

GENERAL HOSPITAL BACKGROUND

Concho County Hospital (“CCH”), located in the city of Eden in the south central part of Concho County Texas, primarily serves the needs of Concho County and Menard, Texas.

The Hospital’s mission is “Committed to Improving the Health and Wellness of the People in the Communities We Serve”. The hospital provides general medical services for inpatient and outpatient services which includes the following:

Provided Services

Alcohol and/or Drug Services

Blood Bank Services

Certified Trauma Center Services

Clinical Laboratory Services

Dedicated Emergency Department Services

Diagnostic Radiology Services

Emergency Services

Long Term Care (Swing-Beds) Services

Occupational Therapy Services (Limited)

Tissue Bank Services

Outpatient Services

Pharmacy Services

Physical Therapy Services

Respiratory Care Services

Social Services

CCH accepts private insurance and participates in Medicaid and Medicare programs. For those residents of Concho County who qualify, CHH offers financial assistance through its indigent and charity care programs. Licensed for 16 beds, CCH staffs and operates sixteen beds as a Critical Access Hospital. Several of the patient rooms had been converted into offices. CCH currently is exploring expansion plans to be completed over a three to four year period. These plans include expanding to a new hospital and clinic facility located on Highway 87. The existing hospital has deteriorating plant issues that will cost more than a replacement boutique facility off the main highway.

Hospital District facilities include Concho County Hospital located in Eden, Texas. The hospital provides critical access short-term acute care and Level IV emergency room services, swing bed services, a pharmacy, and a helipad. The Concho County Hospital Health and Wellness Center opened September 14, 2015. The center includes cardio equipment, strength training equipment, and group classes.

Other hospitals within a 35 mile radius include:

- BRADY HEALTH CARE SERVICES INC (BRADY, 31.24 miles)
- BRADY WEST NURSING AND CONVALESCENT CENTER (BRADY, 31.28 miles)
- HEART OF TEXAS MEMORIAL HOSPITAL (BRADY, 30.67 miles) (Critical Access Hospital)
- MEDWAY HOME HEALTHCARE (BRADY, 31.22 miles)
- MENARD Clinic (MENARD, 21.38 miles)
- MENARD MANOR (MENARD, 21.38 miles)
- SHUFFIELD REST HOME #1 (BRADY, 31.33 MILES)

Frontera Health Clinics

Frontera Healthcare Network is the result of a multiple county effort to preserve access to quality health care in each of the communities of Eden, Menard, and Mason, Texas.

Their mission has changed since their founding. Their mission now is to enhance primary care services in underserved urban and rural communities.[2] In particular; they serve underserved, underinsured, and uninsured Americans, including migrant workers and non-U.S. citizens.[3]

Federally Qualified Health Centers (FQHCs) provide their services to all persons regardless of ability to pay, and charge for services on a community board approved sliding-fee scale that is based on patients' family income and size. FQHCs must comply with Section 330 program requirements.[3]

In return for serving all patients regardless of ability to pay, the centers receive from the Federal government cash grant, cost-based reimbursement for their Medicaid patients, and malpractice coverage under the Federal Tort Claims Act (FTCA).[4]

The local organization was formed in 2005 with contributions from the Eden Economic Development Corporation, Spirit of Eden Fund, and the Texas Office of Rural Community Affairs. Frontera Healthcare Network is a private non-profit organization governed by a board of directors representing the communities served. The organization operates FQHC medical clinics and behavioral health services in Eden, Menard, Mason, Junction, Brady, and Fredericksburg, Texas. Eden was the site of one of the first Frontera clinics*. As a footnote, CCH can provide sliding scale fee schedules, receive cost reimbursed for Medicare and Medicaid patients, and serve all patients regardless for their ability to pay plus qualify patients for the Hospital District Charity Program*

San Angelo is located approximately 45 miles from Eden, Texas. San Angelo is considered the regional healthcare provider and referral center.

These major healthcare facilities include:

- Shannon Hospital, (Tom Green County) is the major health facility with a wide contingency of clinics, surgical center, wound and hyperbaric, women and children's services, urgent care and Shannon Clinics. Shannon is considered the premier regional trauma and inpatient and out-patient services provider.
- San Angelo Community Medical Center is a general and acute care facility providing similar services but on a lower scale.

DEMOGRAPHICS[5]

General Overview

In general terms, the state of health for Concho County is that 21% of adults report being in fair or poor health and 6% of days per month that adults feel mentally unhealthy. Of the total percentage of Concho County residents, 30% of adults are obese and 28% of adults are physically inactive. The County Uninsured and Poverty rates demonstrate 21% of those under 65 are uninsured, compared to 19% in Texas, with 27% of the County population living in poverty.

In addition, the State Demographer's projections indicate that Hispanic residents are likely to account for all of the county's population increase in the near future. The expectation is for the Hispanic segment of the community to steadily grow from 54% to 58% between 2012 and 2025. All other race and ethnic groups are projected to decrease proportionately.

Official State projections suggest brisk growth of the senior population to 20% by 2025. Hispanics will account for much of the increase. The number of Hispanic seniors is expected to nearly double between 2012 and 2025, increasing their representation within the elder population from 20% to 26%. There are 2.21 males in Concho County for every female. Women and girls accounted for 31% of the population according to the State Demographer's 2012 population estimates. Projections indicate the female population will slightly increase by 2025.

Eden compared to Texas state average

- Median *house value below* state average.
- *Unemployed percentage* significantly *below* state average.
- *Black race population* percentage significantly *below* state average.
- *Hispanic race* population percentage *above* state average.
- *Median age* significantly *above* state average.
- *Foreign-born* population percentage significantly *above* state average.
- *Length of stay* since moving in significantly *above* state average.
- *House age* significantly *above* state average.
- *Institutionalized population* percentage significantly *above* state average.
- Number of *college students* significantly *below* state average.
- Percentage of *population with a bachelor's degree or higher* significantly *below* state average.

Eden on top lists

- #4 on the list of "Top 101 cities with the largest percentage of people in federal prisons and detention centers (population 1,000+)"
- #53 on the list of "Top 100 cities with the largest percentage of males"
- #40 on the list of "Top 101 counties with the lowest surface withdrawal of fresh water for public supply"

Supporting Data: See next page

CONCHO COUNTY PROFILE

Compiled by
The County Information Program, Texas Association of Counties[2]

POPULATION (Census Bureau)	
County Population «History»[5] «Group Quarters»[5]	
Estimate 2017:	2,717
Estimate 2016:	4,273
Estimate 2015:	4,140
Estimate 2014:	4,065
Estimate 2013:	4,094
Estimate 2012:	4,055
Estimate 2011:	4,117
Census 2010:	4,087
Census 2000:	3,966
Population of the County Seat **(Paint Rock)**	
Census 2010:	273
Census 2000:	320
POPULATION OF PLACES IN CONCHO COUNTY - 2017 (Census Bureau)	
Note: City and town populations include only those parts of each place found within this county.	
Eden city:	1,297
Paint Rock town:	293
GENERAL INFORMATION	
County Size in Square Miles (Census Bureau and EPA)	
Land Area:	983.8
Water Area:	9.9
Total Area:	993.7
Population Density Per Square Mile	
2010:	4.15
Urban and Rural Population of the County, 2010 (Census Bureau)	

DEMOGRAPHICS	
Ethnicity - 2017 (Census Bureau)	
Percent Hispanic:	36.6%
Race - 2017 (Census Bureau)	
Percent White Alone:	95.0%
Percent African American Alone:	1.8%
Percent American Indian and Alaska Native Alone:	0.9%
Percent Asian Alone:	1.3%
Percent Native Hawaiian and Other Pacific Islander Alone:	0.0%
Percent Multi-Racial:	1.0%
Race and Ethnicity - 2017 (Census Bureau)	
Percent Not Hispanic White Alone:	59.8%
Percent Not Hispanic Black Alone:	1.1%
Age - 2017 (Census Bureau) «Age Groups»[7]	
17 and Under:	20.2%
65 and Older:	25.4%
85 and Older:	2.8%
Median Age:	47.5
Income	
Per Capita Income - 2017 (BEA):	$32,328
Total Personal Income - 2017 (BEA):	$87,836,000
Median Household Income - 2017 (Census Bureau):	$42,723
Poverty - 2017 (Census Bureau)	
Percent of Population in Poverty:	15.4%
Percent of Population under 18 in Poverty:	28.2%
Educational Attainment (Census Bureau, 2012-2016 American Community Survey 5-Year Estimate)	
Percent high school graduate and higher:	61.4%
Percent bachelor's degree or higher:	11.5%
Pay (BLS)	
Average Annual Pay - 2017:	$40,797

Average Annual Pay - 2016:	$38,282
Average Annual Pay - 2015:	$36,775
Average Annual Pay - 2014:	$34,972
Average Annual Pay - 2013:	$34,051
Annual Unemployment Rate, Not Adjusted (Texas Workforce Commission)	
Unemployment Rate - 2017:	4.2
Unemployment Rate - 2016:	3.4
Unemployment Rate - 2015:	3.3
Unemployment Rate - 2014:	3.0
Unemployment Rate - 2013:	4.0
COUNTY FINANCES (Texas Comptroller of Public Accounts)	
Property Taxes - 2017	
Total County Tax Rate: «Detailed Tax Rates»[7]	$0.934800
Total Market Value: «Values and Levies»[7]	$981,148,713
Total Appraised Value Available for County Taxation:	$261,994,571
Total Actual Levy:	$2,445,927
For property tax information about a specific property, contact the Appraisal District[8].	
Sales Tax Allocation History	
CY 2017:	$96,703
CY 2016:	$79,345
CY 2015:	$80,122
CY 2014:	$80,937
CY 2013:	$80,136

City ID	City	2012	2013	2014	2015	2016	2017
048-101	Eden	$0.640280	$0.652121	$0.687000	$0.664580	$0.690000	$0.653300
048-102	Paint Rock	$0.753789	$0.753900	$0.732328	$0.732328	$0.732328	$0.732328

Other Critical Data[1]

- ✓ Language spoke in Eden

- 43.2% of residents of Eden speak English at home
- 54.3% of residents speak Spanish at home

- 25.5% speak English very well
- 74.5% speak English less than very well

✓ Education of population 25 years and over in Eden:
  ✓ High school or higher: 46.8%
  ✓ Bachelor's degree or higher: 7.5%
  ✓ Graduate or professional degree: 4.1%

  ✓ Unemployed: 4.4%

✓ For population 15 years and over in Eden:
- Never married: 40.9%
- Now married: 41.3%
- Separated: 1.9%
- Widowed: 2.5%
- Divorced: 13.4%

✓ Most common Industries in 2016 (%)
- Construction (29%)
- Public administration (19%)
- Agriculture, forestry, fishing and hunting (13%)
- Administrative and support and waste management services (9%)
- Educational services (9%)
- Retail trade (7%)
- Other services, except public administration (4%)

✓ Most common occupations in 2016 (%)
- Construction and extraction occupations (28%)
- Management occupations (14%)
- Arts, design, entertainment, sports, and media occupations (9%)
- Installation, maintenance, and repair occupations (7%)
- Office and administrative support occupations (7%)
- Farming, fishing, and forestry occupations (7%)
- Law enforcement workers including supervisors (5%)

Health and Nutrition

Adult diabetes rate:

Eden: 8.3%
Texas: 8.9%

Adult obesity rate:

Eden: 28.1%
Texas: 26.6%

Overweight people:

Eden: 27.2%
Texas: 33.0%

Average BMI:

Eden 28.2
Texas: 28.5

People feeling badly about themselves:

Eden: 19.2%
Texas: 21.2%

Health and Nutrition: Healthy diet rate:

Eden: 47.0%
Texas: 48.0%

Average overall health of teeth and gums:
Eden: 45.2%
Texas: 46.4%

People not drinking alcohol at all:

Eden: 7.3%
Texas: 10.4%

Average hours sleeping at night:

Eden: 6.8
Texas: 6.8

General health condition:

Eden: 56.9%
Texas: 55.5%

Average condition of hearing:

Eden: 80.6%
Texas: 80.4%

Health Status of the Rural Community

A National Overview of Our Problems[9]

An Economy Based on Self-Employment and Small Businesses

Rural people and rural communities are faced with many of the same health care issues and challenges confronting the rest of the nation: exploding health care costs, large numbers of uninsured and underinsured, and an overextended health care infrastructure. However, there are numerous unique health care issues facing rural people and rural places.

The rural economy is unique in its composition, making issues of uninsurance and underinsurance more prominent. Since the late 1990s, rural areas have witnessed a significant decline in manufacturing jobs and a rise in service sector employment, losing jobs with higher rates of employer-sponsored health insurance while gaining jobs with much lower rates of employer-sponsored coverage. The lack of employer-sponsored health insurance is particularly acute for low-skilled jobs, which are more common in rural areas.

The rural economy is largely based on self-employment and small businesses. Since 1969, the number of self-employed workers in rural areas has grown by over 240%. With an economy dominated by small businesses and self-employment, rural people are generally less insured, more underinsured, and more dependent on the individual insurance market. There are twice as many underinsured in rural as in urban areas, and the challenges faced by the underinsured are ultimately similar to those of the uninsured.

Any health care reform provision that relies exclusively on maintaining the current employer-sponsored health insurance system will not be as relevant for rural areas because of lower rates of employer-sponsored insurance and the composition of the rural economy.

A Stressed Health Care Delivery System

The health care infrastructure in much of rural America is a web of small hospitals, clinics, and nursing homes (frequently attached to the hospital) often experiencing significant financial stress. Many rural hospitals have financial margins too narrow or too low to support investments in critical plant and technological upgrades. Medicaid and Medicare reimbursement rates remain generally below actual costs of services provided, thus stressing providers that depend on reimbursements from public programs.

The financial stress on the rural health care system is in large measure an expression of public policy. It is estimated that Medicaid and Medicare account for 60% of rural hospital revenues; both programs are subject to legislative and administrative decisions and state and federal budgets that may result in declining hospital revenues. It is also estimated that nearly half of those classified as underinsured are facing collection or other legal action for their medical debts, causing a domino effect of financial stress for rural families and health care providers and facilities.

Health Care Provider and Workforce Shortage

More than a third of rural Americans live in Health Professional Shortage Areas (Concho County) and nearly 82% of rural counties are classified as Medically Underserved Areas (Concho County). Most rural areas in the nation have a shortage of practicing physicians, dentists, pharmacists, registered nurses, and ancillary medical personnel. Any trends in this regard are not improving. All of these workforce shortages exist despite the fact that, in general, rural people have greater medical care needs than do non-rural people. A lack of family physicians that care for families from birth to death in every medical aspect, the so-called “medical home,” leads to a lack of preventive care that results in more serious (and more expensive) medical problems down the road. Health care reform legislation will need to address the promotion of rural medical practices, incentives to practice in rural areas, and recruitment and education of all forms of rural health care professionals. New methods of financing health care must not contribute to a worsening of the rural health care shortage by providing even more economic disincentives to rural, primary-care professionals.

An Aging Rural Population

Many rural areas of the United States are experiencing significant demographic shifts, chief among them an aging population. In 2007, approximately 15 % of rural residents were 65 years of age or older, 25% greater than the nation as a whole. The nation’s population of those 65 or older is predicted to double by 2030, reaching 20% of the nation’s total population, and the fastest age cohort in rural America are residents 85 and older. An increasing aging population leads to greater incidences of chronic diseases and disability, taxing an already stressed rural health care system. An aging population also brings with it numerous social and community issues. Large portions of rural seniors live at home alone, without a spouse or family caretaker to provide or obtain necessary health care services. While seniors have nearly universal care coverage due to Medicare, there are certainly issues related to rural seniors that should be addressed in health care reform legislation. Examples include: providing health care services in community settings that allow rural seniors to remain in their communities (through rural health clinics and critical access hospitals); addressing rural health care worker shortages; enhancing Medicare funding of telemedicine and other health care information technology in more health care facilities frequented by rural seniors; strengthening long-term services and support.

A Sicker, More At-risk Population

The Center on an Aging Society at Georgetown University summarizes the health status as this: “The rural population is consistently less well-off that the urban population with respect to health.” Most rural people have arthritis, asthma, heart disease, diabetes, hypertension and mental disorders than urban residents. The differences are not always large, but they are consistent-the proportion of rural residents with nearly every chronic disease or condition is larger.

The Kaiser Commission on Medicaid and the Uninsured found that despite an older population and higher rates of disability in rural areas–which *should require* higher health care needs–rural residents actually receive comparable or less care in many measures, suggesting rural residents many not be receiving adequate care.

Despite an array of health care differentials between urban and rural people, there is evidence that the ultimate health status of rural people has much to do with health insurance and the type of health insurance coverage. There is evidence that rural people with employer-provided health insurance obtained more and less costly health care services than those with privately purchased health insurance. Insurance that provided better coverage at a lower cost, therefore, resulted in more-and presumably regular and better-health care services. Unfortunately, most rural health care people lack such coverage.

Need for Preventive Care, Health and Wellness Resources

A growing body of research documenting problems in nutrition and activity in rural areas have found that rural residents generally fare worse that their urban counterparts in regards to obesity, which is opposite to the situation that existed prior to 1980. No one explanation appears satisfactory for why problems with nutrition, activity and weight are so prominent in rural America. In spite of this uncertainty, it is critical to consider some of the most widely discussed factors, most of which concern the environment of modern rural living. The relative lack of nutritious food in many rural food system; challenges to and decreases in physical activity, especially among rural children; fewer people employed in agriculture and other physically rigorous occupations; strong social networks may actually reinforce unhealthy eating and sedentary behaviors; and a deficit in health education in rural areas are all factors leading to a worsening health situations in rural areas. Perhaps the most important reasons working against rural areas in regards to obesity and general health concern demographics. Rural residents are older, less educated and poorer than urban residents. All of these demographics increase the risk for obesity.

Increasing Dependence on Technology

Medical providers are increasingly employing health information technology to improve patient safety, quality of care, and efficiencies. However, adoption of health information technology has remained slow in rural areas. For example, a consortium of rural health research centers has shown that while 95% of critical access hospitals have computerized their administrative and billing functions, only 21% employ forms of electronic health records. 80% of critical access hospitals use teleradiology, yet only 24% employ telepharmancy services.

Several barriers exist in rural areas to the expansion of health care information technology. Broadband and high-level telecommunications technology coverage in rural areas is a significant barrier. Without a national commitment to provide accessible and affordable broadband and high-level telecommunications technology in all rural areas, rural use of health information technology will likely remain limited. Capital resources are also constrained for rural health care providers. Often rural providers have to choose between medical equipment, building improvements, and technology resources. Rural areas have difficulty in recruiting and retaining information technology professionals, particularly in small hospitals, clinics, and physician practices. The Agency for Healthcare Research and Quality has indentified physician resistance to health information technology as a barrier to rural use. Many rural physicians believe more technology will negatively affect productivity and workflow, and additional reliance on technology is often financially impractical for small offices and providers.

Effective Emergency Medical Services

Emergency medical services (EMS) are often the first-line medical and health care providers in rural areas. For many of the demographic and health care system issues outlined here, EMS have had placed on them growing demands and health care responsibilities. At the same time, many rural EMS providers are underfunded and face workforce and volunteer shortages.

The National Conference of State Legislatures has outlined other issues facing EMS. Many EMS providers have inadequate communications infrastructure and are thus often isolated from the rest of the health care delivery. A major example is the lack of access EMS providers has to medical records and medical history, something health information could potentially resolve if EMS providers were able to obtain the resource to connect with other rural providers.

Another identified EMS issue is the lack of integration of EMS into the rural health care system. An integrated system will provide more efficient patient referrals, a reduction in costs, improvement of medical services, and a broader primary care and public health model in rural areas. Of course, integration has its challenges in rural areas, chiefly communication over wide geographic areas and EMS reliance on volunteers.

Concho County Health Status

This section of the assessment reviews the health status of Concho County residents. As in the previous section, comparisons are provided with the state of Texas. This assessment of health outcomes, health factors, and mental health indicators of the residents that make up the community will enable the hospital to identify priority health issues related to the health status of its residents. Good health can be defined as a state of physical, mental and social well-being, rather than the absence of disease or infirmity. According to Healthy People 2020, the national health objectives released by the U.S. Department of Health and Human Services, individual health is closely linked to community health. Community health, which includes both the physical and social environment in which individuals live, work, and play, is profoundly affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community.

Healthy people are among a community's most essential resources. Numerous factors have a significant impact on an individual's health status: lifestyle and behavior, human biology, environmental and socioeconomic conditions, as well as access to adequate and appropriate health care and medical services. Studies by the American Society of Internal Medicine conclude that up to 70 percent of an individual's health status is directly attributable to personal lifestyle decisions and attitudes. Persons who do not smoke, who drink in moderation (if at all), use automobile seat belts (car seats for infants and small children), maintain a nutritious low-fat, high-fiber diet, reduce excess stress in daily living and exercise regularly have a significantly greater potential of avoiding debilitating diseases, infirmities, and premature death. The interrelationship among lifestyle/behavior, personal health attitude, and poor health status is gaining recognition and acceptance by both the general public and health care providers. Some examples of lifestyle/behavior and related health care problems include the following:

- Smoking: lung cancer, cardiovascular disease, emphysema, chronic bronchitis
- Alcohol/drug abuse: cirrhosis of liver, motor vehicle crashes, unintentional injuries, malnutrition, suicide, homicide, mental illness
- Poor nutrition: obesity: digestive disease, depression
- Driving at excessive speeds: trauma, motor vehicle crashes,
- Lack of exercise: cardiovascular disease, depression,
- Overstressed: mental illness, alcohol/drug abuse, cardiovascular disease

Health problems should be examined in terms of morbidity as well as mortality. Morbidity is defined as the incidence of illness or injury and mortality is defined as the incidence of death. However, law does not require reporting the incidence of a particular disease, except when the public health is potentially endangered. Due to limited morbidity data, this health status report relies heavily on death and death rate statistics for leading causes of death in Concho Counties and the state of Texas. Such information provides useful indicators of health status trends and permits an assessment of the impact of changes in health services on a resident population during an established period of time. Community attention and health care resources may then

be directed to those areas of greatest impact and concern. Leading Causes of Death reflects the leading causes of death for residents of Concho County and compares the rates, per thousand, to the state of Texas average rates, per thousand.

As a result of the data, the following general conclusions can be made:

Identification and Prioritization of Health Needs

The following data provide a foundation for identifying pertinent community health needs in Concho County:

- Demographic Trend Data: Demographic projections of population growth in Concho County were reviewed. Growth trends for vulnerable population groups were included in the review. With the prison closing in 2017, one-half of the population diminished.

- Other Health Care Resources: Data and information on the supply of health care professionals, community clinics, nursing homes, home health agencies, and mental health services were reviewed. The hospital's clinic closure left the primary care role with an independent third party entity. The gateway of patients into the hospital was severely compromised and will continue to be without complete hospital ownership/leadership and their own full-time medical staff.

- Family and Maternal Health: Indicators of family composition, domestic abuse data, and maternal health were reviewed. There is no family and maternal care of any significant presence in Concho County.

- Leading Causes of Death: Data on leading causes of death were used to identify specific diseases associated with higher death rates in Concho County compared to the state. The leading causes of death are heart disease, cancer and cerebral accidents with none or little healthcare response in this county.

- Survey of the Poor and Extremely Poor in West Texas: Survey data to identify elevated health and behavioral health risks among the poor and extremely poor population of Concho County. It is important to assert the community-wide health needs of vulnerable populations in Concho County. With this perspective at the forefront, the needs assessment has made every effort to use data to identify needs of community-level importance which, in many instances, can only be addressed through cooperative, collective community action including senior citizens, churches, and school.

Analysis of the data from the community level focus leads to the following summary list of identified needs for Concho County. These listed are not only hospital needs but

community health needs. This will be discussed further in the report. These represent the analysis of the health data and not the focus groups.

1. **Needs of children and seniors**. Increase capacity and a need to address health needs of growing numbers of children and seniors through physical activity programs and nutritional support.

2. **Recruit and Retain Core Health Professionals**. Work cooperatively with the hospital district and all community sectors to create an engaged process for recruiting and retaining core health professionals including one or more:

    - Physician
    - Physician Assistant or Nurse Practitioner
    - Psychiatrist or Psychologist (Telemedicine)
    - Social Worker (Share with Education system)
    - Community Health Worker (Share with Education system)

3. **Community Health Programs and emphasis of Hospital Clinical Services**

    - Heart disease and cerebral-vascular diseases through clinic screens
    - Cancer detection screening programs through dermatology, mammography, PAP and PSA screening clinics
    - COPD programs and screening
    - Complications arising from diabetes with a diabetic clinic
    - Influenza and pneumonia immunization/vaccination programs

4. **Develop capacity and access to quality behavioral health services (Telehealth)**

5. **Increase access and capacity for the poor and other vulnerable groups by**:

    - Reducing cost and other barriers to quality behavioral health services thru the prevention and treatment for depression screens in the clinic (s)/Office.
    - Providing smoking and tobacco cessation classes
    - Providing prevention and treatment of alcohol and drug abuse classes

6. **Preventative outreach to the poor and extremely poor**. Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to:

    - Reduce obesity through community classes and use of the free wellness center

    - Reduce cost and other barriers to medical care and treatment thru cash or discounted programs, sliding scales and hospital district charity.

    - Improve case management and routine preventative screenings in a clinic or Emergency Room Setting (Current volume indicates time to accomplish screens)

    - Provide educational classes to promote healthy living and wellness

7. **Food, housing, and neighborhood security**. Increase the security of poor and extremely poor individuals and households by:

    - Increasing access to nutritious foods through WIC, Summer Meal Programs for Children and the Supplemental Nutrition Assistance Program, etc.

    - Increasing affordable housing in safe neighborhood environments

8. **Investment in community health needs**. Develop collaborative community efforts to increase investment in community health needs. Consider solutions for expanding quality coverage of the uninsured, coordinated funding and development of proposals or campaigns, coordinated organizational and agency strategic planning, and other collaborative community capacity building approaches Prioritization of Community Health Needs

Community Healthcare Needs Focus Group

The purpose of the Community Healthcare Needs Assessment is to identify the healthcare needs of the community, regardless of the ability of the hospital (CCH, in this case) to meet these needs. Information about the community healthcare needs for Concho County was obtained through interviews in organized focus groups. These participants represented an excellent cross culture of this small rural community in south central Texas. Individuals in Focus Groups consisted of members of various, races, income levels, education levels, government, schools, banking, churches, law services, healthcare and general businesses with varying household statuses.

Participants of the focus groups included the following participants:

- Retired citizens (seniors)
- School Principal of Eden CISD
- Frontera Operation Officer
- Athletic Director of Eden CISD
- County Clerk, City of Eden
- Librarian, Friends of the Library
- TxDOT Maintenance Supervisor
- Florist, Eden Flower Shop
- City Administrator, City of Eden
- Economic Development Corporation Coordinator
- Deputy Sheriff/Chairman of Hospital Board
- Retired Contractor
- Retired Teacher
- County Treasurer
- Concho County Extension Office
- Chief Appraiser
- Landscaper (Former Healthcare worker)
- Deputy Treasurer
- Radiology Imaging Services Manager/School Board member
- Retired Principal
- Head Start Teacher
- General Contractor
- Mayor, City of Eden
- Retired citizen
- Retired School Teacher
- Retired Registered Nurse
- Attorney
- Pastor
- Bank Teller
- Bank Teller and Church Secretary

Priorities Identified in Interviews

Much of the information presented from the Focus Groups is based on perceptions of the members of the community, most of whom have had some experience with Concho County Hospital and its services and staff. Even if a comment made was only perception and not based on actual experience, perception is reality to those individuals, and needs to be considered. Additionally, information shared in Focus Groups or direct conversations is often what gets repeated within the community, and therefore becomes the basis for what people believe about the Hospital. When all participants were asked to grade the hospital on a scale of 1-10 (5 being average and 10 being the best), the average personal rating was 5-7. When asked how you sense the community grades the hospital, the rating remained 5-7 or about average. There were not outstanding reviews or personal stories of “how the hospital saved my husband’s life.”

The following topics were most often repeated by a significant number of participants, and are listed as priorities for the Board and Administration to consider as future planning is being developed.

The Elephant in the Room

The consensus of all Focus Group participants is that “you do not have a health system without physicians.” These overwhelming needs for one to two physicians with a physician assistant/nurse practitioner, and the necessity for Concho County Hospital to take full control of its destiny with a replacement hospital and clinic, are the largest concerns of the community. Without these two top issues being resolved (first being physicians), the health needs stated by the health data statistics and of Focus Group participants will simply fade away into dark space. The lack of inpatient days, outpatient service utilization, and the current out-migration of patients to San Angelo hospitals is and will continue to be the single biggest threat to the hospital compounded by poor reimbursement rates and a declining county and city population. Without swift and focused goals, Concho County will be one of several Texas hospital closures. When questioned, all participants agreed the hospital could not be closed because of its role in the community and the overall devastating financial consequences to the community.

The top discussion of all Focus Group meetings revolved around the need for a replacement hospital in a new location (Highway 87) with same-day clinic appointments, DOT physicals, and pediatrics. The consensus of the participants is that the hospital made a significant negative decision in the closure of its clinic. In saying this, the current mid-level provider was viewed extremely positive and Frontera clinic was viewed generally OK but with complaints of not being able to get an appointment same day or next day. Frontera was viewed as the ‘low income clinic or no income’ clinic and not viewed as my family doctor clinic. The same opinion was made of the dental services. The majority of participants went to San Angelo for all care. When asked if one or two Family Practice Physicians or a combination of a Physician/Mid-Level Provider was acceptable, there was a 100% acceptance and most said they would use the new physician and hospital clinic. It may be noted that a Critical Access Hospital is financially impacted in a positive way by maintaining a hospital provider Rural Health Clinic. The new theme of rural hospitals for future viability is that the ***“clinic is the new front door of the hospital”*** and this controls the destiny of healthcare services. The hospital must control this function to exist and be able to offer a physician(s) any offer of employment. It cannot provide this function with an independent third party provider who has no interest in Concho County Hospital. It is not their stated mission.

This was the number one and dominant conversation of all focus groups. This issue must be addressed before addressing other health issues because of the need of a physician medical staff plus mid-level providers (PA’s and NP’s).

Lack of Usable Insurance for Low Income Households

The Patient Protection and Affordable Care Act of 2013 (PPACA) was intended to increase the quality and affordability of health insurance, lower the rate of uninsured individuals by expanding public and private insurance coverage and reduce the healthcare costs for individuals and the government. If an individual can afford to purchase a health insurance policy and chooses not to, he or she must pay a fee called the individual shared responsibility payment. The Internal Revenue Service collects this fee when taxpayers file their annual tax return. This fee increases with each year the individual or family does not have health insurance and the significant portion of this fee for most families is the fee imposed per adult and child in the household, as noted below.

For 2014, the fee was the higher of

- 1% of household income (up to maximum amount is the total yearly premium for the national average price of a Bronze plan sold through the Marketplace
- $95 per adult and $47.50 per child under 18 (up to a maximum of $975).

For 2015, the fee was the higher of

- 2% of household income (up to maximum amount is the total yearly premium for the national average price of a Bronze plan sold through the Marketplace
- $325 per adult and $162.50 per child under 18 (up to a maximum of $975).

For 2016, the fee is the higher

- of 2.5% of household income up to maximum amount is the total yearly premium for the national average price of a Bronze plan sold through the Marketplace
- $695 per adult and $347.50 per child under 18 up to a maximum of $2,085

However, with the more recent changes of the US Government, the recent administration is in the process of either discontinuing or reorganizations the entire plan or major parts of this plan and penalties imposed by the IRS. However, it still does not negate the overall issues with premiums, available plans, deductibles, physician availability, etc. In addition, the retired school teachers of Texas are now with a low reimbursement insurance product and a supplemental Medicare Advantage Plan which is a direct threat of reimbursement for Critical Access Hospitals and Provider Based Rural Health Clinics. The current biggest financial threat to rural hospitals in Texas is the Blue Cross/Blue Shield products with poor hospital reimbursement fees.

Almost every member of low income households who did not qualify for Medicaid, charity care or indigent programs prior to 2016 who purchased health insurance in 2014 to comply with the Patient Protection and Affordable Care Act (PPACA) found they could not afford the monthly insurance premiums even when purchasing insurance through the Marketplace. In addition, they stated while they had the health insurance coverage, either the deductibles or co-pays were so high they could not take advantage of the insurance.

Furthermore, they could not find healthcare providers who accepted their insurance plan or found it extremely difficult to get pre-authorizations for services. In essence, they were forced either to buy insurance they essentially could not use or pay the individual shared responsibility payment fee for not having insurance.

Many residents stated they would have rather used the money they spent on the insurance or the fee for actual healthcare needs. All residents stated they could have used the money for basic living expenses. Of the individuals interviewed who could not afford insurance prior to the passage of PPACA, these individuals also did not purchase insurance in 2015 and they also had not enrolled in the available exchange programs during 2016. They said the individual shared responsibility payment fee was at least sixty percent less than the annual insurance premiums. They stated the same was true of their friends and family members as well. Based upon provider statistics, the percentage of uninsured patients in Concho County amounted to approximately 21% with the state average at 27%. *This, along with declining patient admissions and out-migration to San Angelo hospitals, poses a critical threat to the future of healthcare for Concho County.*

The insurance market remains a significant threat to the future of local rural hospitals and Concho County is not an exception. The impact has been lessened due to the poor utilization of CCH services.

Other Health Insurance Issues

Some members of the community mentioned the differences between insurance policies offered through their employer or the Marketplace was so complicated or confusing that they chose not to obtain coverage. Others stated they “fell through the cracks” when starting a new job because of the probation period before they could get insurance through their employer and they could not afford to purchase short term insurance during this period or afford the COBRA payments from their previous employer.

Due to the lack of insurance or not having adequate insurance, some residents said that they delayed seeking medical care for chronic diseases and other health issues because they felt they could not afford the care, their insurance policy did not provide adequate coverage or they did not qualify for charity or indigent care programs. Many of these residents were unaware that CCH offered a cash discount to all patients.

Chronic Diseases

The most common chronic diseases also coincided with the State most common diseases and those stated in the Focus Groups. Those mentioned included:

- Diabetes (child and adult)
- Obesity (child and adult)
- Hypertension
- Cardiovascular disease and stroke
- Cancer
- Kidney disease
- Arthritis
- Allergies
- Dementia

Many individuals suffer from more than one of these diseases. CCH will need to offer several health fairs and health screenings throughout the year as well as education presentations. Most people interviewed said they were not aware of any fairs and screenings. When discussing this item, many acknowledged that time would be an issue, would see that many seniors did not have transportation, did not feel they would benefit, or would be done in San Angelo. Many expressed a desire to see more education presentations, and in contrast, there were also those residents who might not attend health screenings or education or were not interested in hearing more about health education.

As with every community, some participants do not seek care for illnesses or chronic diseases and need to be hospitalized. The reasons for not seeking care included the inability to afford routine healthcare visits or medications, the inability to take time off from work and the lack of transportation. As a note, all this contributes to re-hospitalizations and costs to the health system.

Healthy Living

As noted earlier, childhood and adult obesity is a chronic problem for the community. Members of the community again expressed that they would like to have more education offerings of living healthy lifestyles which included nutrition and exercise for both children and adults. By living a healthier lifestyle, many residents feel they can avoid or control many chronic illnesses such as obesity and diabetes, which often lead to hypertension and cardiovascular, kidney and other diseases. When noted of the excellent and free exercise facility by the hospital, most stated how positive and wonderful the facility was to the community (free) but with poor utilization including the majority of participants.

Lack of Specialists or Services

Many residents want to see more specialists in the community. Specialists mentioned include cardiologists, podiatry, orthopedics, rheumatologists (arthritis), counseling, ophthalmologists (for cataracts), and geriatric physicians.

Participants also felt that, with the aging population of Concho County, there was a need for physicians who could focus more on the unique needs of the elderly and pediatrics, more so than the physician who provides general adult medical care.

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The hardship in availability of specialty practitioners and services is an area in healthcare where most all rural and small community hospitals struggle, largely because of the cost of such specialty services in comparison to the amount of need. As mentioned, while the hospital does recognize the need for specialty services in the community, and provides measures to address where they are able, many times the cost of providing these specialty practitioners and services exceeds the level of need due to the smaller populations. To most specialists, it is a negative revenue to come to

a rural community with fewer patients whereby they could double their volume by remaining at their practice. The economic impact to a specialist can be a negative.

The "One Stop Shopping" Bias

If a patient needs a particular medical service not available in Concho County, they travel to San Angelo for that service. Once they leave the Concho County area, they tend not to come back for other healthcare services in CCH. This includes routine medical, skilled nursing/rehabilitation, diagnostic and imaging services. Many reasons exist for this bias. Some feel it is easier to have all of the healthcare needs met in one general location. Others felt if the Concho County could not meet one particular need, they would receive overall better healthcare for all needs in the cities offering more services. Many were not aware CCH could provide skilled nursing/rehabilitation, laboratory, diagnostic and imaging services. Several stated they would feel more comfortable going to San Angelo because they perceived those doctors had more experience overall in treating certain conditions than providers in Concho County. The majority of the residents were favorable to the Physician Assistant in Eden but that he was not a physician and transfers would continue to escalate to San Angelo. All participants expressed a desire to stay home for healthcare needs because of convenience they receive by support of family, friends and church.

It should be noted that while the community perspective is illustrated in the responses to the outreach and interviews performed, we should also recognize that the primary role of the rural hospital is to focus on the primary care needs for the community in which the hospital serves. It is not within the design or reimbursement mechanism for the rural and community hospital to administer the more complex diagnosis and treatment that the larger systems provide. The hospital focuses on the treatment of primary care and some tertiary levels of care and maintains a strong intent to educate their community on the services they are able to provide.

The hospital administrative and professional staff has noted that they do lose a certain amount of the local patient population to the larger tertiary healthcare systems in San Angelo. This transition of patients to some of the larger healthcare systems may be due to the 'One stop shopping bias", referred to above, or may even potentially result from the marketing and professional staff communication between the respective healthcare system practitioners and patients, while the patient is receiving care at those system facilities. It is also likely that some transition of patients to the larger healthcare systems is that certain patients from the local communities may not be aware that CCH offers many of the services patients are seeking. Once a solid medical team is arranged,

patient education of this nature may need to be a combined effort between the hospital and the community leaders to educate the local population that they do have options in local high quality healthcare services, such as swing-bed services, occupational and physical therapy, and other services. This would translate to much more convenient healthcare close to home. The hospital and the community as a whole may wish to focus efforts on providing insight to the patient population locally that the hospital can serve the needs of patients in primary care, but can also serve as high-quality post-tertiary care during the transition stages of recovery, in areas of swing-bed and therapy services.

Mental Health Needs

As noted in the data analysis, this area's percent of Poor Mental health Days remain an issue (3.1) compared to the state of (3.4) and national average of 3.8. Several residents felt the community needed mental healthcare providers for both children and adults. The most common mental health issues mentioned were anxiety, general depression and bipolar depression. The residents felt they did not have adequate access to services or knew where to go for services. The hospital should consider shared counseling services with the school system or private providers in San Angelo along with Tele-Mental health services. This area of health needs is now the Number 1 focus area with the State of Texas with major Mental Health initiatives. When asked if the counseling services provided to Frontera were beneficial, the general comments were we would go to San Angelo.

Male and Female Health Needs

When questioned about the above average comparisons with State, National and County statistics regarding overall health and opportunities to improve family health, several discussion points were prevalent among all focus groups. The points of discussion revolved around the lack of health services for men and women. It was determined in all groups that the availability of PAP screens, Mammography, and HPV testing would be beneficial to improve female health risks. Likewise in men were PSA, HPV testing and dermatology skin cancer screening would be helpful plus comprehensive yearly physicals. Weight loss programs were discussed but not viewed in the means of a service by the hospital but viewed the Free Fitness Center as excellent, free but under-utilized. It was discussed as information that, indeed, supervised physician weight programs are considered cash only boutique hospital programs.

Alcohol and Substance Abuse

Participants of Concho County felt that there exists an alcohol and substance abuse problem similar to other communities. The abuse of prescription medicines has become more common. Patients, particularly on pain medications, pressure their doctors to authorize refills on their medications even though their current medical condition does not warrant the use of prescription drugs. In addition, children often find it easier to take their relatives prescription drugs than to purchase illegal drugs. This presents a problem to both the children and the people for whom the drugs were prescribed.

Focus groups mentioned the need for education about alcohol and drug abuse. The Drug Abuse School Programs are excellent in addressing the issue of how students are educated to alcohol and drug abuse curriculum but rarely did programs educate parents or seniors in the community. There was a consensus that the school and hospital should work closely on drug abuse especially with the opioid epidemic.

Candid Summary of Community Health Care Needs

The Following Summary is based on the Health Data of Concho Count and Eden, Texas.

1. **Needs of children and seniors**. Increase capacity to address health needs of growing numbers of children and seniors.
    - Suggestions include: activities at a location easily accessible to seniors are make available with travel resources for attendance.
    - Utilize the Regional Advisory Councils (RACs) to provide bike safety awareness and utilize their “free helmet” give-away and have drawings for free bikes sponsored by local businesses.

2. **Recruit and Retain Core Health Professionals**. Work cooperatively with the community leaders to create an engaged process for recruiting and retaining core health professionals including one or more:
    - The Hospital has hired one Physician coupled with a Mid-level provider should locate a second physician. A new facility and clinic will be an excellent “recruitment” incentive.
    - Physician Assistant or Nurse Practitioner: Dependent on Physician recruitment
    - Psychiatrist or Psychologist (Telemedicine): Work with school system for mental health telemedicine.
    - Social Worker (share with education system)
    - Community Health Worker (share with education system)

3. **Community Health Programs and emphasis of Hospital Clinical Services**
    - Heart disease and cerebral-vascular diseases
    - Cancer
    - COPD
    - Complications arising from diabetes
    - Influenza and pneumonia immunizations/vaccinations

4. **Develop capacity and access to quality behavioral health services (Telehealth).**

5. **Increase access and capacity for the poor and other vulnerable groups by**:

    - Reducing cost and other barriers to quality behavioral health services
    - Providing prevention and treatment for depression with counseling services shared with school with private providers in San Angelo.
    - Providing smoking and tobacco cessation classes
    - Providing prevention and treatment of alcohol and drug abuse for adults in conjunction with the school.

6. **Preventative outreach to the poor and extremely poor**. Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to:
    - Reduce obesity thru weight loss programs and exercise programs sponsored by the hospital
    - Reduce cost and other barriers to medical care and treatment by offering cash discounts or deductible pay-outs
    - Improve preventative screenings to the public
    - Provide education to promote healthy living and wellness

7. **Food, housing, and neighborhood security**. Increase the security of poor and extremely poor individuals and households by:
    - Increasing access to nutritious foods with healthy eating classes by the local Ag agents or school personnel
    - Increasing affordable housing in safe neighborhood environments

8. **Investment in community health needs.** Develop collaborative community efforts to increase investment in community health needs. Consider solutions for expanding quality coverage of the uninsured, coordinated funding and development of proposals or campaigns, coordinated organizational and agency strategic planning, and other collaborative community capacity building approaches Prioritization of Community Health Needs. Consider more frequent clinic visits on a sliding scale fee structure to keep the "sick from becoming sicker."

Additionally, the following is based on the Focus Group Meetings:

9. **Pursue the development of a Hospital replacement facility on Highway 87.**

10. **Consider the long-term placement of the recently purchased clinic building**

11. **Consider sliding scale fee service for the clinic for the medically uninsured**

12. **Upon arrival of a physician, "aggressively re-market the new physician and mid-level provider"** with direct mailing, small group introductory meetings and renew the healthcare relationships with the school district emphasizing female services, DOT exams, family care and eldercare. Accentuate the positive opinions of the Hospital pharmacist.

13. **Conduct community health classes (drug, alcohol, diabetes, obesity, heart)** with the high risk groups with a Mid-level provider, RN and Pharmacist. It was suggested that health fairs and other educational or screening services should be off-site, in order to draw more people into the activities. It was suggested that businesses or community meeting places would be appropriate locations to reach many of the residents. It was suggested the new physician could be at these

meetings. As to be noted, the hospital of today needs to be “out there” and instead of demanding all services to be held at the hospital.

Summary and Recommendations

In summary, the feedback from the various participants can be very beneficial to the hospital, as the future needs of the Hospital are considered. The level of services currently being provided by the hospital and a deteriorating plant, lack of a physician pose a significant threat for closure. However, it is to be highly noted that the fact the hospital has cash and is opened despite these huge obstacles is “Nothing Short of a MIRACLE.” In any other situation, a similar hospital would be closed. Over five hospitals have closed in Texas the last year with far better situations. It is remarkable that there is cash in the bank, a clinic building has been purchased, salaries being paid and a new physician recruited.

There needs to be some discussion of the relationship of San Angelo Hospitals particularly Shannon Hospital. Questions should include if the relationship is “predatory” or if Shannon is a community partner helping Concho County provide every vital service possible and being a partner is its survivability. Concho County (as well as the other surrounding counties) are included in the Shannon CHNA Plan and is a vital part of their overall success of referral business into the Shannon Health System. This relationship needs to be evaluated and closely monitored as to their leadership intent. They should be viewed as “partners” helping Concho County maintain the utmost viability. This should be investigated and clarified through a written Letter of Agreement. A word of mouth or meeting does not suffice with leadership changes from year to year.

Based on the federal requirements for this organization, both the Community Health Needs Assessment and the Implementation Plan, after Board approval, are to be shared with the Community, either by posting on the website and/or distributing by other means. A Plan of Action will need to accommodate this report. This cannot occur until a new physician arrives in practice.

Recommendations are as follows:

1. Improve the physician staff services and mid-level services to insure the availability of a Primary Care Doctor.
2. Review the Hospital’s ability to address the major health issues in the community, particularly Diabetes, Obesity, Cancer and Heart Disease, through adequate staffing, programs, equipment and space. Consider partnerships as appropriate.
3. Review and implement plans to address any perceptions that the hospital can survive without its own clinic or replacement hospital. The fact the hospital is not advocating raising taxes for a new facility is remarkable and smart. Even if raising taxes is being considered, the community needs to weigh the financial economic impact of the loss of a community hospital on community viability. Along with the loss of the prison and hospital, the future for Eden would be very dark.
4. Implement a smart and effective marketing plan once the new physician is in place.
5. Address in some framework of response the prior 13 recommendations

TORCH Management Services, Inc. is appreciative of the leadership team lead by Brian Lady and the willing residents to attend the Focus Group Meetings. Concho County Hospital is a vital part of the success of Concho County.

Appendix

Focus Group Questions

I. **Introductions of facilitator and group members**
II. **Purpose of Focus meetings**
III. **Questions about hospital and services to spur discussions:**
    - ✓ Do the present hospital services seem adequate
    - ✓ What services or programs worked well and are no longer present
    - ✓ What would you like to see that is different
    - ✓ How would you rate the hospital on a scale of 1-10 with 10 best
    - ✓ What have you heard as good and bad things of hospital
    - ✓ Do you trust going to the hospital
    - ✓ Why do you go elsewhere for services
    - ✓ Do you hear good or bad things about the hospital management and board
    - ✓ Do you think they are involved in community projects
    - ✓ Do you think the present facility is adequate
    - ✓ Do you see the town “not having a hospital”

IV. What is healthy & unhealthy about Concho County?

V. What are the major health issues in your community?

VI. What can the hospital do to address the health issues in the community?

Major Data Sources

[1] www.city-data.com
[2] www.hrsa.gov

[3] www.dshs.state.us/diabetes

[4] www.dshs.state.tx.us/CHS

[5] http://www.txcip.org/tac/census/hist.php?FIPS=48095

[6] www.countyhealthranking.org

[7] http://www.txcip.org/tac/census/profile
[8] http://www.window.state.tx.us/propertytax/references/directory/cad/
[9] *The Top 10 Rural Issues for Health Care Reform*, John Bailey, March 2009

Additionally:

www.quickfacts.census.gov

www.ahd.com