COMMUNITY HEALTH NEEDS ASSESSMENT TOOLKIT

Prepared by:

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Prepared with Input and Advice from:

Community Health Needs Assessment National Advisory Team

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OUTLINE OF STEPS AND ACTIVITIES

APPENDICES

COMMUNITY HEALTH NEEDS ASSESSMENT TOOLKIT

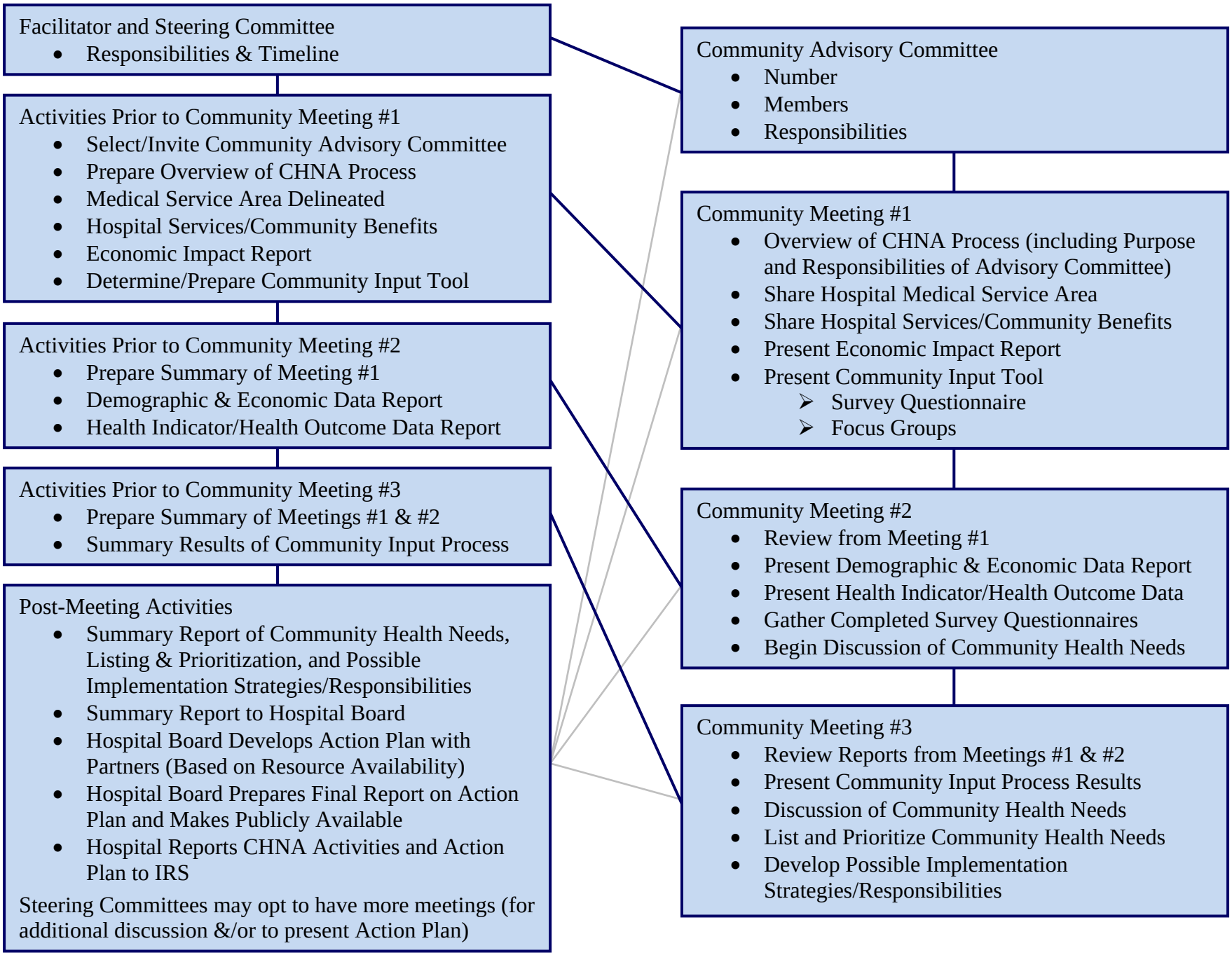
I. Executive Overview

"The Patient Protection and Affordable Care Act" of 2010 requires that all 501(c)(3) hospitals conduct a community health needs assessment. The purpose of this toolkit is to provide a relatively quick, non-intensive process to complete the requirement for rural hospitals. The toolkit is designed for state level professionals such as state offices of rural health, state hospital associations, state cooperative extension agencies, health departments, or consultants to facilitate the process in rural hospitals at no or low cost to the hospitals. The toolkit is also relatively easy to adopt if hospitals desire to conduct the assessment themselves. All data sources and materials for implementation are included, with additional assistance available from the National Center for Rural Health Works and additional online resources available from the website of the National Center (www.ruralhealthworks.org).

The process is designed to be conducted through three community meetings. An overview of the process is presented in **Figure 1**. The facilitator and steering committee will oversee the entire process. The facilitator could be a hospital employee or an outside professional from a state agency or a consultant. The steering committee is a small group (three to five members) that will oversee the process. The steering committee members would typically be the hospital administrator, hospital marketing personnel, health department representative, hospital board member, or others identified by the hospital administrator. The responsibilities of the steering committee include:

- **Activities Prior to Community Meeting #1**
  - Select/Invite Community Advisory Committee
  - Determine Facilitator to Oversee Meetings
  - Prepare Overview of CHNA Process
  - Medical Service Area Delineated
  - Prepare Overview of Hospital Services/Community Benefits
    - Prepare Economic Impact Report

Figure 1. Overview of Community Health Needs Assessment (CHNA) Toolkit



- Determine/Prepare Community Input Tool (i.e., Focus Groups, Survey Questionnaire)

XIII. **Community Meeting #1**

- Introduction of Community Advisory Committee
- Present Overview of CHNA Process
- Share Medical Service Area
- Share Overview of Hospital Services/Community Benefits
- Present Economic Impact Report
- Present Community Input Tool
    i. Survey Questionnaire Methodology
        1. Have Community Advisory Committee complete survey questionnaire
        2. Have Community Advisory Committee take five or six questionnaires and have their constituents complete questionnaires
        3. Community Advisory Committee returns the completed questionnaires at Meeting #2
- Review dates of Community Meetings #2 and #3

- **Activities Prior to Community Meeting #2**
    - Prepare Summary of Meeting #1
    - Prepare Demographic & Economic Data Report
    - Prepare Health Indicator/Health Outcome Data Report

XIV. **Community Meeting #2**

- Review of Meeting #1
- Present Demographic & Economic Data Report
- Present Health Indicator/Health Outcome Data Report
- Gather Completed Survey Questionnaires from Community Advisory Committee Members
- Begin Discussion of Community Health Needs
- Review date of Community Meeting #3

XV. **Activities Prior to Community Meeting #3**

- Prepare Summary of Meetings #1 & #2
- Summary Results of Community Input Process

XVI. **Community Meeting #3**

- Review Reports from Meetings #1 & #2
- Present Community Input Process Results
- Discussion of Community Health Needs
- List and Prioritize Community Health Needs
- Develop Possible Implementation Strategies/Responsibilities

XVII. **Post-Meeting Activities**

- Summary Report of Community Health Needs, Listing & Prioritization, and Possible Implementation Strategies/Responsibilities
- Summary Community Health Needs Report Presented to Hospital Board
- Hospital Board Develops Action Plan with Partners (Based on Resource Availability)
- Hospital Board Prepares Final Report on Action Plan and **Makes Publicly Available**
- Hospital Reports CHNA Activities and Action Plan to IRS

The toolkit proposes that three meetings be conducted. Three meetings should allow enough time for presentation, and discussion and input from the community advisory committee. Community meetings work best when held over lunch with a light lunch provided. The community meetings should be held one month to six weeks apart to allow for preparation and evaluation of the materials. The process should take about four to six months. The steering committee may add additional meetings to allow more time for discussion from the community advisory committee and/or to present the final action plan from the hospital board.

The complete toolkit will enable a facilitator and steering committee the ability to provide a community health needs assessment with relative ease. All data sets are identified and example products are provided. Documents and templates are available on the website of the National Center for Rural Health Works (www.ruralhealthworks.org).

For state agencies and consultants working with not-for-profit hospitals, the products and facilitation would be provided by these agencies and consultants. The final action plan would typically be completed by the hospital.

II. **Introduction**

Why?

"The Patient Care and Affordable Care Act" of 2010 requires that all 501(c)(3) hospitals conduct a community health needs assessment (CHNA). The overarching view of the community assessment must be health needs from the perspective of the community, not the perspective of the health providers within the community. This is an important distinction because much of the discussion will be focused on health provider activities. Thus, the community orientation is critically important.

Duplication and/or Partnering

There are other community health needs assessment processes available. Potential users are encouraged to evaluate this toolkit and other available CHNA processes to select the one which best fits their delivery style and their community needs. Two other community assessment processes that are readily available include the Catholic Healthcare Community Assessment Process and Association of Community Health Improvement. The toolkit provided here is intended to be very effective and efficient in achieving the legislative requirements, as well as being applied at a minimal cost to the hospital.

Duplication of community health needs assessments in your community should be avoided if possible. Other organizations involved in community assessment may be open to collaborating in a combined community assessment. For instance, many, if not all, public health departments have long been hosting community assessment processes with various partners. If a public health department has recently completed a community assessment and the medical service areas of the public health department and the local hospital are basically the same, the results of the recently completed community assessment of the public health department may possibly be utilized by the hospital governing board to determine which community issues the

hospital can address. The hospital governing board will review the community issues to determine resources available, develop appropriate work plans, determine who will provide the necessary components of the plans, plan any coordination and collaboration with other organizations and agencies, and propose timetables for implementation. The results of the community assessment from the public health department and the hospital governing board's plans on how to deal with the community issues will be reported to the Internal Revenue Service (IRS) to fulfill the requirements of community assessment.

Again, local organizations are encouraged to partner or collaborate to work together to avoid duplication. This is especially important for future community assessments. Many public health departments conduct a community assessment every five years and the new legislation requires that hospitals conduct one every three years. This is the perfect opportunity for these two organizations to partner and conduct a comprehensive community assessment every five years with an updated shorter version in the middle, every 2 ½ years. This could avoid duplication and develop more cooperation and coordination between the hospital and public health department, while both organizations meet their reporting requirements.

Background

In order to develop this toolkit to meet the hospital CHNA requirement, the National Center for Rural Health Works formed a national advisory team to assist with development of a toolkit which rural hospital administrators and personnel from state hospital associations, state offices of rural health, and others can use to meet the new requirements. Members of the national advisory team are included in **Appendix A**. The national advisory team met in Kansas City on November 23, 2010 to share ideas and to begin development of the toolkit. The U. S. Department of Health and Human Resources, Federal Office of Rural Health Policy, provided financial support for the meeting.

The national advisory team recommended that the proposed toolkit be tested in several communities. The toolkit was tested and revised based on pilot applications with Labette Health in Parsons, KS, Oswego Community Hospital in Oswego, KS, and Battle Mountain General Hospital in Battle Mountain, NV. The toolkit was further tested in communities in Mississippi, Florida, Texas, and New Mexico. Products from the most recent community CHNA process, Guadalupe County, New Mexico, will be utilized to illustrate the toolkit.

Legislative Requirements

Before discussing each of these points, the new requirements for Section 501(c)(3) Status hospitals for the community health needs assessment will be shown.

Community Health Needs Assessment Requirements

i. The organization must conduct a "community health needs assessment" not less frequently than every three years and adopt an implementation strategy to meet the community health needs identified through the assessment.

ii. A "community health needs assessment" must include input from persons "represent[ing] the broad interests of the community served by the hospital facility," including those "with special knowledge of or expertise in public health."

iii. The assessment must be made widely available to the public.

Even though the requirements state that the organization must conduct a needs assessment and adopt an implementation strategy, the organization does not have to include an implementation strategy for each need. It may not be economically feasible to implement every suggested strategy. The strategy must only address what can be completed and what actions are to be implemented. The requirements state that the first needs assessment must be completed during the first tax year following March 2011. After that, the assessment must be completed every three years.

The Act also requires hospitals to have financial and billing and collection policies in place and available to the public. Example policies and procedures may be available from the American Hospital Association (AHA); please check with AHA directly. Hospital boards should review their policies and procedures and modify them to reflect the requirements. Below are the new requirements for Section 501(c)(3) Status hospitals for the financial assistance and billing and collections:

Financial Assistance Policy Requirements

i. The organization must establish a financial assistance policy that –

1. Is in writing.
2. Includes the eligibility criteria for financial assistance and specifies whether such assistance includes free or discounted care.
3. States the method for applying for financial assistance.
4. Includes a description of the actions the hospital may take in the event of non-payment where the organization does not have a separate billing and collections policy.
5. Includes measures to widely publicize the policy within the community served by the organization.

ii. The organization must establish an emergency medical care policy that –

1. Is in writing.
2. Requires the organization to provide non-discriminatory emergency medical care to an individual, regardless of that individual's eligibility under the financial assistance policy required above.

Requirements Regarding Charges

i. Charges for emergency or other medically necessary care provided to persons who are eligible for assistance under the financial assistance policy described above cannot exceed "the amounts generally billed to individuals who have insurance covering such care."

ii. The use of gross charges is prohibited.

Billing and Collection Requirements

i. The organization cannot engage in "extraordinary collection efforts" before it has made a reasonable effort to determine whether the individual is eligible for assistance under the organization's financial assistance policy.

This toolkit does not include any other information on the financial assistance requirements, requirements regarding charges, or billing and collection requirements. This toolkit is designed to assist with the community health needs assessment requirements only.

III. **Facilitator and Steering Committee**

Prior to the first community meeting, the local hospital administrator will select a steering committee to guide the process and a facilitator to lead the community meetings and present materials and reports. The local hospital administrator will select a small group of local leaders as the steering committee to guide the process. Possible members for the steering committee include director of local health department, hospital management team or marketing director, local government representative, social service agency representative, and/or other knowledgeable community members. The suggested size of the steering committee is three to five members.

The facilitator will be designated by the hospital administrator (or the steering committee). This designated professional will be the lead facilitator for the meetings and will present materials and reports, as decided by the steering committee. This facilitator could be the local hospital administrator, a representative from the state office of rural health (SORH), a representative from the state hospital association, a consultant, or other community, region, or state leader. A list of the state offices of rural health (**Appendix B**) and the state hospital associations (**Appendix C**) are included.

The duties and responsibilities of the steering committee include:

- Selecting members for the community advisory committee,
- Identifying the medical service area of the hospital,
- Summarizing the hospital services and community benefits,
- Preparing materials and reports (or have these prepared) for the community meetings, and
- Assisting in facilitating the meetings.

Detailed information on each of the activities of the steering committee are given in the next chapters.

IV. **Activities Prior to Community Meeting #1**

The facilitator and steering committee will need to complete the following tasks prior to Community Meeting #1. These include:

- Select/Invite Community Advisory Committee
- Determine Facilitator to Oversee Meetings
- Prepare Overview of CHNA Process
- Medical Service Area Delineated
- Prepare Overview of Hospital Services/Community Benefits
- Prepare Economic Impact Report
- Determine/Prepare Community Input Tool (i.e., Focus Groups, Survey Questionnaire)

Select/Invite Community Advisory Committee

The steering committee will identify and invite community leaders willing to serve on the community advisory committee. The size of the committee will be determined by the population of the medical service area. It is suggested that a smaller rural hospital service area might need 15 to 25 members and a larger rural hospital service area from 30 to 35 members. The requirements clearly state:

> 'A "community health needs assessment" must include input from persons "represent[ing] the broad interests of the community served by the hospital facility," including those "with special knowledge of or expertise in public health."'

A listing of potential membership on the community advisory committee is included in **Table 1**. The community advisory committee should have a diversified membership representing the medical service area and the membership should be broad-based including not only health care providers but also representation from the other groups listed in **Table 1**. This listing is also available in **Appendix D**. It is strongly suggested that members of the steering committee initially call the potential members to personally invite them to be part of the community advisory committee. During the invitational call, the member of the steering committee can

Table 1
Potential Community Advisory Committee Members

City government(s); city manager, mayor, city council members
County government(s); county commissioners, county officers
State government; human services, health department, state legislators
Tribal government(s); tribal leaders, health care coordinator, local IHS representative
Health care providers
- Hospital administrator and other key hospital personnel
- Hospital board members
- Physicians
- Dentists
- Optometrists
- Chiropractors
- Clinics or community health centers
- Mental health professionals—i.e., psychiatrist, psychologist, counselors
- Nurse practitioners
- Physician assistants
- Therapists—physical, massage, speech, rehabilitation, occupational
- Pharmacists
- Medical equipment suppliers
- Home health providers
- Hospice
- Nursing homes, assisted living facilities, and adult day services
- School health
- Others

Emergency medical services (ambulance services)
Local public health officials
Chamber(s) of commerce
Economic development groups; coalitions, councils of government, sub-state planning districts
Industry/business; manufacturing, banks, phone companies, retail sales (Main St. businesses), groceries, realtors, insurance, fishing, farming, forestry, mining, petroleum, etc.
Public education; superintendent, principals, school nurse
Technology education (formerly vo-tech)
Higher education
Private education
Volunteer organizations; local food banks, soup kitchens
Religious leaders; ministerial alliance, ministers
Minority or disparate population groups or group leaders
Service organizations; Kiwanis, Lions, Rotary, Toastmasters, etc.
Social service organizations
Other community leaders

provide a short overview of the CHNA process, the responsibilities of the community advisory committee members, the number and duration of the meetings, and the date, time, and location of the first meeting. If the potential member agrees to participate as a community advisory committee member, a letter outlining the process should then be sent to the committee member. An example of an invitational letter is included in **Appendix D**.

The CHNA process includes three community meetings. Through these meetings, the hospital will obtain a prioritized listing of identified community needs with suggested implementation strategies/responsibilities. The hospital board will be able to develop an action plan from the listing, based on available hospital resources. The hospital will ultimately be able to meet the IRS reporting requirements. This will be accomplished through a minimum amount of time and resources from the hospital and community. However, some hospital administrators, in conjunction with their steering committee and facilitator, may desire to have more than three meetings.

Determine Facilitator to Oversee Meetings

The facilitator will be designated by the hospital administrator (or the steering committee). This designated professional will be the lead facilitator for the meetings and will present materials and reports, as decided by the steering committee. This facilitator could be the local hospital administrator, a representative from the state office of rural health (SORH), a representative from the state hospital association, a consultant, or other community, region, or state leader. A list of the state offices of rural health (**Appendix B**) and the state hospital associations (**Appendix C**) are included.

Prepare Overview of CHNA Process

The steering committee will need to prepare an overview of the CHNA process for Community Meeting #1. An example of a PowerPoint presentation is included in **Appendix E**. This is designed for the steering committee to personalize with the local community and hospital names. There should be minimal time involved in utilizing the PowerPoint presentation provided and personalizing it to the local community and hospital.

Medical Service Area Delineated

The steering committee will work closely with the hospital administrator and hospital data to delineate the medical service area of the hospital. Every effort should be made to avoid duplication of medical service areas with other hospitals. Many other groups already have designated medical service areas, such as the health department. The medical service area of the hospital has to be realistic in terms of neighboring hospitals. One method to determine the medical service area would be to base the area on the home address locations of a percent (i.e., 75 to 85 percent) of the hospital admissions. The hospital administrator may want to analyze the data closely to determine the appropriate percentage. The key is to designate an area which clearly defines where the majority of the patients using the hospital services live. It may be necessary to designate both a primary and secondary medical service area. The majority of the population utilizing the hospital would be located in the primary medical service area and a much lower percent of the population utilizing the hospital would be located in the secondary medical service area.

The medical service area should be identified along county or zip code area boundaries. The boundaries are necessary to provide medical service area demographics. The advantage of a

county boundary is that much more data are available at the county level. Some county level data sources include:

- U. S. Census Bureau <www.census.gov>;
- U. S. Census Bureau County Business Patterns <http://www.census.gov/epcd/cbp/index.html>;
- U. S. Department of Commerce, Bureau of Economic Analysis <www.bea.gov>; and
- U. S. Department of Labor, Bureau of Labor Statistics <www.bls.gov>.

At the zip code level, only Census year data is available.

A discussion of the medical service area could be provided by the hospital administrator or facilitator. Also, a map of the medical service area could be provided to delineate the area(s). An example of a map delineating the medical service area is included in **Appendix F**.

Prepare Overview of Hospital Services/Community Benefits

Many residents may not be aware of all of the services and community benefits provided by the hospital. It is suggested that the hospital administrator prepare a one- or two-page summary of the hospital services and community benefits. **Appendix G** provides an example of a summary of hospital services and community benefits.

Prepare Economic Impact Study (Optional)

The economic impact of the hospital is proposed as an OPTIONAL study. While this is listed as an OPTION, the economic contribution of the hospital on the local economy is tremendous. The national advisory team feels that this is an extremely important report to provide to the local community. However, the economic impact study is **not** part of the CHNA requirements from the IRS. The economic impact report illustrates that the hospital is often the cornerstone of the healthcare delivery system. Without a hospital, other health services such as

physicians and pharmacies soon disappear. The national advisory team recognizes the importance and usefulness of the economic impact study.

This community benefit should not be overlooked. For example, the hospital is often the second largest employer in a rural community; typically second only to schools. The national advisory group views this as extremely important to provide information showing the economic importance of the hospital and the health sector to the local economy.

Three alternatives are presented to assist the steering committee in providing this:

I. Contact state offices of rural health (**Appendix B**) or state hospital associations (**Appendix C**) to see if economic impact studies for hospitals in your state are available. Some states have professionals that can quickly compile an economic impact study and others have tools to develop them. For example, see Wisconsin's website <http://www.wha.org/financeanddata/healthyhospitals.aspx>.

OR

II. A *generic* PowerPoint presentation showing the "Economic Impact of a Rural Hospital on a Local Economy" could be presented to the community advisory committee. The National Center for Rural Health Works has prepared this 18-slide PowerPoint presentation from its rural hospital research in several states (**Appendix H**).

OR

III. An *actual* short, three-page economic impact study could be prepared using local multipliers. The National Center for Rural Health Works could derive the multipliers. This service is available to those hospitals that do not have the IMPLAN multipliers available from any organizations in their states (as in the first alternative above). The National Center for Rural Health Works has limited staffing and funding and would have to charge a fee of $250 plus the cost of the IMPLAN data to derive the multipliers for a hospital. To determine the cost of the IMPLAN data, the medical service area of the hospital must be designated. A couple of examples of a short economic impact study is presented in **Appendix I**. These are the example Economic Impact of Guadalupe County Hospital and a generic example Economic Impact of XYZ Hospital.

Detailed materials on how to conduct an economic impact study are also included in **Appendix I**. Materials available on the website include:

- Steps for Preparing an Economic Impact Study
- Example Data Collection Form for Economic Impact Study
- Example Completed Data Collection for Economic Impact Study
- A PowerPoint on "HOW TO DERIVE THE MULTIPLIERS" for an Economic Impact Study
- An IMPLAN Price Sheet (showing costs for IMPLAN data)
- Example Excel Spreadsheet – Building the Economic Impact Tables
- Example Community Economic Impact Study
- Example Generic XYZ Economic Impact Study Format

Determine/Prepare Community Input Tool

The steering committee will have to determine how they will obtain community input prior to the Community Meeting #1. Community input is mandatory in the requirements. Several options are available:

1. **Conduct a community survey questionnaire through the members of the community advisory committee**. A questionnaire will be prepared, personalized to the hospital community and medical service area (example available in **Appendix J**). At Community Meeting #1, each member of the community advisory committee will be asked to complete a survey and then to obtain five or six completed questionnaires from the community group(s) they are representing. The completed questionnaires would be returned at Community Meeting #2 or to a designated person from the steering committee (typically, mailed to the hospital administrator) by a designated deadline. An instruction sheet will be provided with the health survey questionnaires to provide this information to the community advisory committee members. An example instruction sheet is also included in **Appendix J**. A generic health survey questionnaire is also provided in **Appendix J**. This is the copy that the local hospital administrator and steering committee should utilize when designing their survey form. Instructions on how to develop the survey questionnaire and how to analyze the survey data are also available in **Appendix J**. More detail on the community survey is included in **Appendix O**. A spreadsheet has been designed such that the steering committee (or designated hospital personnel) will be able to enter the data from the completed questionnaires and the results will be generated. The summary of the survey results will then be printed for presentation at Community Meeting #2. Additional information on the community health survey questionnaire is available in **Appendix J** and **Appendix O** on the website (www.ruralhealthworks.org). Spreadsheet examples are available on the website that cannot be included in a printed toolkit.

   This is not a completely random survey example; however, if the members of the community advisory committee truly represent a cross-section of the community, the survey will provide adequate community input from a somewhat random example. This method would be an easy way to get input from over 100 local residents. For example, if

the community advisory committee has 20 active members and each member completes a questionnaire and obtains five additional completed questionnaires, then the survey would have 120 completed responses.

2. **Conduct a focus group discussion with subgroups of the community advisory committee**. Focus group questions would be prepared and available for the community advisory committee to utilize (**Appendix K**). The community advisory committee would be divided into small groups (no more than ten per group and optimum group size is five to six per group). Members of the steering committee would facilitate the small focus groups. Each focus group facilitator will conduct a small focus group session, take extensive notes, and prepare the results for consolidation with the other focus group sessions. A final consolidated focus group report would be prepared by the steering committee or hospital personnel. The summary focus group report would be presented at Community Meeting #2.

3. Other Community Input Options

i. ***Phone Survey***. If a community has access to funds, a professional survey company could be contracted to conduct a random phone survey. These surveys are quite expensive. See the National Rural Health Works website <www.ruralhealthworks.org> for an example.

ii. ***Computer Survey***. A computer survey instrument could be designed and community residents could respond to the online survey. The advantage is that the process is cost efficient but not random. Many elderly residents who are heavy users of medical services would not have an opportunity to participate because of lack of computer knowledge or availability.

iii. ***Patient Survey***. Many hospitals conduct surveys from patients who use their services. This information can be utilized as input, but again, it is not inclusive of the community as whole because this information is only gained from residents that have actually used hospital services.

V. **Community Meeting #1**

Past community planning experience indicates that a lunch meeting works well in getting optimum participation from community advisory committee members. If a local organization can provide a simple, light lunch in a timely and efficient manner, the community advisory committee members will be able to participate and minimize their time away from their regular business activities. If funds are not available for lunch, find a local restaurant with a separate meeting room and have each individual pay for their lunch. The length of the meeting should be kept to a reasonable time; typically about one to two hours. In some cases, meetings in the early morning or in the evenings will be necessary. The steering committee will need to be flexible and decide on the best day and time for their community meetings.

A suggested agenda for Community Meeting #1 is presented in **Table 2** below. An example agenda from a community meeting is included in **Appendix L**. An example PowerPoint for Community Meeting #1 is also included in **Appendix L**.

Table 2
Suggested Agenda for Community Meeting #1

I.	Introductions (hospital administrator)	10 minutes
II.	Overview of community health needs assessment process (facilitator)	20 minutes
III.	Medical service area (hospital administrator)	5 minutes
IV.	Hospital services/community benefits (hospital administrator)	8 minutes
V.	Economic impact of hospital (facilitator)	15 minutes
VI.	Community input tool (facilitator) If survey questionnaire methodology: • Each Community Advisory Committee Member completes survey • Each Member takes five or six surveys to be completed by the constituents they represent • Members will bring completed surveys to Community Meeting #2	22 minutes
VII.	Questions (facilitator)	8 minutes
VIII.	Time and date of next community meeting(s) (facilitator)	2 minutes

Introductions

The community meeting should start on time with the hospital administrator welcoming the community advisory committee. At this meeting it is generally helpful to have members introduce themselves and indicate who they are in a short manner (i.e. Joe Brown, County Commissioner).

Overview of Community Health Needs Assessment Process

It is important to have the facilitator give a brief overview of the community health needs assessment process. This includes the purpose and responsibilities of the community advisory committee. A sample PowerPoint providing an overview of the CHNA process is provided in **Appendix E**.

Medical Service Area

Following the CHNA overview presentation, the medical service area should be delineated. An example illustrating the delineation of a medical service area is included in **Appendix F**. The medical service area can be discussed or shown through an illustration. This presentation should be provided by the hospital administrator.

Hospital Services/Community Benefits

The hospital administrator will provide a summary of all the services and community benefits provided by the hospital. An example of a hospital services and community benefits is provided in **Appendix G**.

Economic Impact of Hospital

The facilitator will typically present the economic impact study. An example economic impact study is provided in **Appendix I**. Methodology for preparing an economic impact study is

discussed earlier in this overview and materials and spreadsheets are provided on the website under **Appendix I** (www.ruralhealthworks.org).

Community Input Tool (Community Health Survey Example Provided)

Alternative community alternative tools are discussed earlier in this overview. The community health survey questionnaire methodology will be presented in the illustrations. Each member of the community advisory committee will complete a survey questionnaire at Community Meeting #1. In addition, each member will be asked to take five or six community health survey questionnaires to their constituents for completion. The members are asked to return the completed questionnaires at Community Meeting #2 or to return to a particular individual by a certain date. An instruction sheet stating how to return the completed survey forms should be given to each community advisory committee member when leaving the meeting. An example of this survey return instruction sheet is included in **Appendix J**.

Questions

The facilitator will allow a few minutes at the end of the meeting for questions. The facilitator, hospital administrator and/or other steering committee members will be available to answer questions from the community advisory committee members.

Times and Dates for Meetings #2 and #3

The facilitator will close with a reminder of the date and time for the next two community meetings. Community Meeting #2 should be scheduled a month to 6 weeks after Community Meeting #1 to allow time for preparation of data and reports.

Additional Suggestions for Meeting

After each report is presented, the community advisory committee should be encouraged to comment or ask questions. A steering committee member should be assigned as recorder and

should take detailed notes of the questions, comments, and discussion from the community advisory committee. From these notes, a summary of Community Meeting #1 will be provided at the beginning of the next community meeting.

VI. **Activities Prior to Community Meeting #2**

The facilitator and steering committee will have three reports to prepare prior to Community Meeting #2:

- Summary of Community Meeting #1
- Demographic and Economic Data Report
- Health Indicator/Health Outcome Data Report

Summary of Community Meeting #1

The recorder from the steering committee will prepare a summary report of the activities, presentations, and discussion from Community Meeting #1. This report can be presented by the recorder or typically by the facilitator.

Demographic and Economic Data Report

Since health care usage is a function of the demographics of the medical service area, it is crucial to have demographic data. Furthermore, the elderly are extremely high users of health services and thus the number of elderly in the medical service area should be clearly identified. An example demographic and economic data prepared is presented in **Appendix M**. The report contains nine tables of demographic and economic data. The main sources of the data are:

- U. S. Census Bureau, <www.census.gov>;
- U. S. Census Bureau, County Business Patterns, <http://www.census.gov/epcd/cbp/index.html>;
- U. S. Department of Commerce, Bureau of Economic Analysis, <www.bea.gov>;
- U. S. Department of Labor, Bureau of Labor Statistics, <www.bls.gov>.

The new 2010 Census zip code data (<www.census.gov>) is now available. Zip code data is only available in Census years and not for the ten year period between Censuses.

Additional materials and information are included in **Appendix M** on the website, including:

- Excel spreadsheet showing how the tables were developed in Excel
- Cover Sheet for Demographic and Economic Data Report in Word
- Demographic and Economic Data Report in Adobe Acrobat

Additional assistance is also available from the National Center in preparing the demographic and economic data report.

Health Indicator/Health Outcome Data Report

The community health indicator data/health outcome data are available from the following sources:

1) County health rankings <www.countyhealthranking.org>;
2) U. S. Department of Health and Human Services, Community Health Status Indicators <www.communityhealth.hhs.gov/>; and
3) State health departments (vital statistics) from individual state websites.

The steering committee will determine which data to report to the community advisory committee. An Example County Health Indicator/Health Outcome Data Report contains eight tables and is presented in **Appendix N.** The data are typically only available at the county level and may reflect behavior habits, health indicators, or health outcomes and may include comparisons between county and state data.

Instructions for preparing this report are included in **Appendix N**. Additional interactive spreadsheets and tools are available on the website (www.ruralhealthwork.org) for your convenience.

VII. **Community Meeting #2**

A suggested agenda for Community Meeting #2 is presented in **Table 3** below. An example community agenda and example PowerPoint of Community Meeting #2 is included in **Appendix L**.

Table 3
Suggested Agenda for Meeting #2

I.	Introductions (hospital administrator)	8 minutes
II.	Review of Community Meeting #1(facilitator)	10 minutes
III.	Collect completed health survey questionnaires (steering committee)	5 minutes
IV.	Economic and Demographic data report (facilitator)	25 minutes
V.	Health Indicator/Health Outcome data report (facilitator)	25 minutes
VI.	Questions (facilitator)	15 minutes
VII.	Time and date of next community meeting(s) (facilitator)	2 minutes

Introductions

The meeting will begin with introductions by the hospital administrator.

Review of Community Meeting #1

The facilitator will provide a brief review of activities from Community Meeting #1, including a review of the economic impact study and the community input methodology.

Collect Completed Health Survey Questionnaires

The completed health survey questionnaires will be collected by the steering committee members.

Presentation of Economic and Demographic Data Report

The Economic and Demographic Data Report will be presented by the facilitator. An example report is shown in **Appendix M**.

Presentation of Health Indicator/Health Outcome Data Report

The community health indicator/health outcome data report will be presented by the facilitator. An example report is illustrated in **Appendix N**.

Questions

The facilitator will allow a few minutes at the end of the meeting for questions. The facilitator, hospital administrator and/or other steering committee members will be available to answer questions from the community advisory committee members.

Time and Date for Meeting #3

The facilitator will close with a reminder of the date and time for the next community meeting. Community Meeting #3 should be scheduled a month to 6 weeks after Community Meeting #2 to allow time for preparation of the community input summary report.

Additional Meeting Suggestions

After each report is presented, the community advisory committee should be encouraged to comment or ask questions. A steering committee member should be assigned as recorder and should take detailed notes of the questions, comments, and discussion from the community advisory committee. From these notes, a summary of Community Meeting #2 will be provided at the beginning of the next community meeting.

VIII. **Activities Prior to Community Meeting #3**

The activities to be completed prior to Community Meeting #3 are the following:

- Summary of Community Meetings #1 and #2
- Tabulate and Summarize Community Input Report (Health Survey Results)
- Have flip charts, blackboard, or other method of recording community health needs and showing prioritization of community health needs
- Have a suggested format for illustrating the outcomes of the CHNA process

Summary of Community Meetings #1 and #2

The designated recorder will prepare a summary of the activities from both Community Meeting #1 and Community Meeting #2.

Community Input Summary Report (Health Survey Results)

The steering committee will prepare summary results from the community input methodology, based on which methodology was utilized. Whatever tool is used to collect local community input, the results need to be tallied, summarized, and presented back to the community advisory committee. This is the most difficult report to complete in the community assessment toolkit. An example community health survey is included in **Appendix O**. The steering committee should allow sufficient time between the two community meetings to prepare the results. The community input summary report will assist the community advisory committee in identifying community health needs.

Community Health Survey Questionnaire Methodology

If the community health survey questionnaire methodology is utilized, the community advisory committee will complete the health survey questionnaire at Community Meeting #1. After the meeting, each community advisory committee member will take five to six community

health survey questionnaires to be completed by members of their constituency. The completed survey questionnaires will be returned at Community Meeting #2 or through other arrangements with a designated steering committee member. A survey instruction sheet will be included with the survey questionnaires with the date of Community Meeting #2 and/or the deadline and name and address of the steering committee member the completed survey questionnaires should be returned.

A spreadsheet has been designed to enable a local person to enter the data from the completed survey questionnaires and the results are generated in report form for presentation at Community Meeting #3. An example health survey questionnaire (**Appendix J**) and health survey results (**Appendix O**) are presented. Also included in **Appendix O** are "Instructions for Community Health Survey Questionnaire," giving details on how to analyze the survey results and prepare a report of the health survey reports. To access the interactive documents, please go to the website (www.ruralhealthworks.org).

Focus Group Methodology

If the focus group methodology is utilized, the facilitators of each focus group will take extensive notes and prepare preliminary results to be aggregated with the other focus group summary results. A final aggregated group report would be prepared by the steering committee or hospital personnel to be presented at Community Meeting #3.

Other Community Input Methodologies

Phone Survey. If a community has access to funds, a professional survey company could be contracted to conduct a random phone survey. This methodology may be expensive.

Computer Survey. A computer survey instrument could be designed and community residents could respond to the online survey. This methodology may be more cost

effective but will not be random. Many elderly residents who are heavy users of medical services may not have an opportunity to participate because of lack of computer knowledge or availability.

Patient Survey. Many hospitals conduct surveys from patients who use their services. This information can be utilized as input, but again, it is not inclusive of the community as whole because this information is only gained from residents that have actually used hospital services.

Available Tools for Listing and Prioritizing Community Health Needs

The steering committee will provide flip charts, blackboards, or other method of recording community health needs and illustrating prioritization of community health needs.

Suggested Format for Illustrating Community Health Needs

The steering committee should have a suggested format for illustrating the outcomes of the community health needs assessment process. One method is included in the tables below. This table is also included in **Appendix P**. The community advisory committee will list all community health needs and then prioritize the list. For each of the community health needs, a suggested implementation strategy will be developed with suggested responsibilities for organizations or persons. A table is provided below as a possible format to summarize and illustrate the community advisory committee's community health needs and suggested implementation strategies and responsible organizations or persons. An example summary of community health needs is also presented in **Appendix P**.

Community Needs and Suggested Implementation Strategies and Responsibilities

	Community Need	Implementation Strategy	Responsible Org. or Person
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(Continued – Page 2)

Community Needs and Suggested Implementation Strategies and Responsibilities

	Community Need	Implementation Strategy	Responsible Org. or Person
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

IX. **Community Meeting #3**

A suggested agenda for **Community Meeting #3** is presented in **Table 5**. An example community agenda and example PowerPoint for Community Meeting #3 are included in **Appendix L**.

Table 5
Suggested Agenda for Meeting #3

VIII.	Introductions (hospital administrator)	8 minutes
IX.	Review of Community Meetings #1& #2 (facilitator)	18 minutes
X.	Presentation of community input summary report (health survey results) (facilitator)	23 minutes
XI.	Discuss community health needs/issues (facilitator)	65 minutes
	a. Identify and prioritize community health needs	
	b. Suggest possible implementation strategies/responsibilities	
	c. Summarize community recommendations	
XII.	Response and final comments (hospital administrator)	6 minutes

Introductions

The meeting will begin with introductions by the hospital administrator.

Review of Community Meetings #1 and #2

The facilitator will provide a brief review of activities from Community Meetings #1 and #2, including a review of the economic impact study, the community input methodology, the demographic and economic report and the health indicator/health outcome report.

Presentation of Community Health Survey Results

The facilitator will present the results of the health surveys. An example of a report illustrating the community health survey results is provided in **Appendix O**.

Community Advisory Committee Discussion

The community advisory committee will

a. Identify and prioritize community health needs

b. Suggest possible implementation strategies and responsibilities

c. Summarize their recommendations

The form supplied can be utilized to summarize the recommendations of the community advisory committee. This form is supplied in **Appendix P**. An example of a community's health needs and proposed recommendations is also provided in **Appendix P**.

From all the discussion from the community advisory committee, the steering committee will prepare a report, summarizing the health needs identified and prioritized with the suggested implementation strategies and responsibilities. This summary report of community health needs will be provided to the hospital board and will be made available to the general public.

Response and final comments

The CEO of the hospital or the hospital administrator will respond to the community advisory committee at the end of the meeting and give comments on the recommendations that the members made. The community advisory committee is ***only*** advisory and decisions concerning hospital commitments can only be made by the hospital board.

X. **Additional Community Meetings**

The toolkit proposes that three community meetings be conducted. A three-meeting process allows time for discussion and input from the community advisory committee. Community meetings work best when held over lunch with a light lunch provided. The first two meetings are designed to last approximately 90 meetings and the third meeting is designed to last 120 minutes. The community meetings should be held one month to six weeks apart to allow for preparation and evaluation of the materials. The three-meeting process would take about five months. Additional meetings may be held if the hospital administrator and/or steering committee feel additional time is needed.

The three-meeting process is illustrated in **Figure 1** and would generate four products and a community health needs assessment report to the hospital board. The four products are:

1. The Economic Impact of the Hospital
2. Demographic and Economic Data Report
3. Health Indicator/Health Outcome Data Report
4. Summary Results of Community Input Process (Health Survey Results)

The complete toolkit will enable a facilitator and steering committee the ability to provide a community health needs assessment with relative ease. All data sets are identified and example products are provided. Many of the interactive products are available on the website at www.ruralhealthworks.org.

IX. **Post-Meeting Activities**

After the hospital administrator presents the report from the community advisory committee to the hospital board, the hospital board will decide which community recommendations the hospital will address and/or implement. The hospital board will make the final decision; only the hospital board has the authority to obligate the hospital to provide programs or activities. Each community health need will be discussed in the hospital board's action plan, whether there will be any action on that need or not. The final community health plan will be shared with the local community and the community advisory committee.

The hospital may need to partner and/or collaborate with other organizations to meet certain community health needs. Resources available to accomplish the community needs must be considered by the hospital board as the final community health plan is developed. If resources are unavailable to meet a community health need, this should be indicated in the final report to the IRS.

XI. **Reporting**

Each hospital facility is required to make the community health needs assessment widely available to community members. To accomplish this, the hospital needs to prepare a summary report of the community health needs assessment process and share the results with the community. This could be shared through newspaper articles, articles in the hospital newsletter, at local group meetings, website, etc.

The hospital board will utilize the community health needs assessment report (Example included in **Appendix P**) to determine the action plan, including the resulting community needs to be addressed, the implementation strategy for each community need, and the responsible person(s) or agency(ies). The hospital will address every need identified by the community. If the hospital is unable to address a particular need, this should also be indicated in the action plan. The hospital's action plan must also be made available to the community. This could be shared through newspaper articles, articles in the hospital newsletter, at local group meetings, website, etc. The hospital may want to share this report with the community advisory committee through an additional meeting or a report sent to them.

The hospital will also have to submit documentation or proof to the Internal Revenue Service (IRS) that a community health needs assessment process was completed. For convenience, a suggested outline of a final summary report is presented in the table below to assist in completing the IRS reporting forms. This report outline is also included in **Appendix Q**. The final report needs to include information pertaining to:

- Community Members;
- Medical Service Area;
- Community Meetings;

Summary Report Outline

Community Health Needs Assessment

Community Members Involved

Need to include name, organization and contact information for:

Hospital Administrator

Steering Committee or Leadership Group

Facilitator

Community Advisory Committee Members

Medical Service Area

Describe by county or zip code areas

Include populations and projected populations of medical service area

Include demographics of population of medical service area

Community Meetings #1, #2, and #3 (also any additional meetings)

Date

Agenda

List reports presented with short summary of each

Community Needs and Implementation Strategies

Include community needs and implementation strategies with responsibilities from community group

Hospital Final Implementation Plan

Include which needs hospital can address and the implementation strategies

Include which needs hospital cannot address and reason(s) why

Community Awareness of Assessment

Describe methodology for making assessment widely available to the community

Have Community Advisory Committee Report available to public

Have Hospital Action Plan with each health need addressed available to public

---

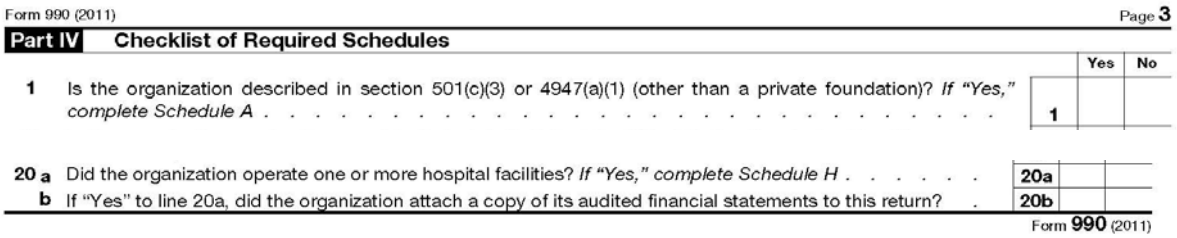
- Community Needs and Implementation Strategies;
- Hospital Final Implementation Plan; and
- Community Awareness of Assessment

The report is intended to include crucial data and not be all inclusive. If the IRS desires more data, they can request documents that were included in the community health needs assessment process, such the demographic and economic data report, community input summary report, etc.

The summary report will list all **community members** involved in the assessment, including the hospital administrator, the steering committee or leadership group, the facilitator, and the community advisory committee members. The **medical service area** of the hospital has been identified and is readily available, as well as population and demographic information of the medical service area and/or county. A summary of the date, agenda, and reports prepared and presented for all **community meetings** will be summarized. A short summary of each report presented at the community meetings would be beneficial. A summary report of the **community needs and suggested implementation strategies** from the Community Advisory Committee needs to be prepared; either utilizing the table provided in this document or a similar summary report. The **hospital final implementation plan** adopted by the hospital should also be included. This report should indicate which community needs the hospital will address and the implementation strategy planned for each. If all identified community needs or issues are not addressed, then the reason why an identified need/issue is not being addressed must be included in the report (e.g., lack of finances or human resources). Each hospital facility is required to make the **assessment widely available to the community members.** Newspaper reporters are usually available to write articles to share the community health needs assessment with the general public.

IRS Reporting Forms

The hospital is required through the new legislation to disclose any community health needs assessment activities in its annual information report to the Internal Revenue Service (IRS). **IRS Form 990** is required to be completed by all organizations exempt from income tax. When completing **IRS Form 990**, additional schedules may be required. Hospitals are required to complete Schedule H. See page 3 of ***IRS Form 990, Part IV, Checklist of Required Schedules, Question 20a, 'Did the organization operate one or more hospitals? If "Yes," complete Schedule H.'***



Form 990 (2011) Page 3

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1		
20 a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a		
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b		

Form **990** (2011)

Attached in **Appendix Q** are both of these IRS reporting forms (**Form 990** and **SCHEDULE H**).

IRS SCHEDULE H (Form 990) is required to be completed by any tax-exempt organization that operates one or more hospitals. **SCHEDULE H** is broken into six major parts with subsections for **Part V**:

PART I - Financial Assistance and Certain Other Community Benefits at Cost
PART II - Community Building Activities
PART III - Bad Debt, Medicare, & Collection Practices
PART IV - Management Companies and Joint Ventures
PART V - Facility Information
Section A. Hospital Facilities
Section B. Facility Policies and Procedures (Complete a separate Part V, Section B, for each of the hospital facilities listed in Part V, Section A.)

Community Health Needs Assessment (Optional for 2010)

Financial Assistance Policy

Billing and Collections

Policy Relating to Emergency Medical Cater

Charges for Medical Care

Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

PART VI - Supplemental Information

SCHEDULE H, Part V (Sections A and **B**) and **Part VI** address the community health needs assessment process. **Part V, Section A,** requires a listing of all hospital facilities in order of size from largest to smallest, measured by total revenue per facility.

Schedule H (Form 990) 2011 Page **3**

Part V Facility Information

Section A. Hospital Facilities (list in order of size, from largest to smallest) How many hospital facilities did the organization operate during the tax year? ____ Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1									
2									

Part V, Section B, is required to be completed for each facility listed in **Section A**. **Section B** is divided into four subsections. The first subsection, **Community Health Needs Assessment,** is the section that deals with community health needs assessment.

Schedule H (Form 990) 2011 Page **4**

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: ____

Line Number of Hospital Facility (from Schedule H, Part V, Section A): ____

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		

There are seven questions relating to Community Health Needs Assessment shown below. Some questions may require additional information; i.e., **Questions 1j**, **3**, **4**, **5c**, **6i**, and **7**.

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)				
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☐ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20__ __			
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5	Did the hospital facility make its Needs Assessment widely available to the public?	5		
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	☐ Hospital facility's website			
b	☐ Available upon request from the hospital facility			
c	☐ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a	☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	☐ Execution of the implementation strategy			
c	☐ Participation in the development of a community-wide community benefit plan			
d	☐ Participation in the execution of a community-wide community benefit plan			
e	☐ Inclusion of a community benefit section in operational plans			
f	☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	☐ Prioritization of health needs in its community			
h	☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☐ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		

The supplemental information for these questions (for each separate facility) will need to be included in **Part VI, Supplemental Information, Question 1, Required descriptions.**

Schedule H (Form 990) 2011 Page **8**

Part VI **Supplemental Information**

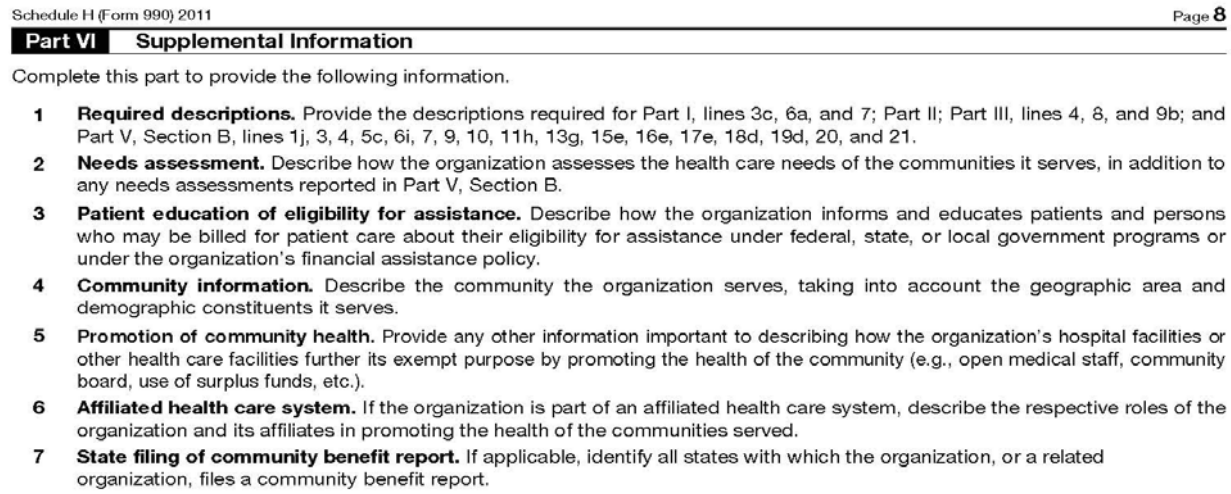
Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

Part VI, Supplemental Information, has six additional questions that must be answered. Most of these questions are related to community health needs assessment:

- **Question 2, Needs assessment.**
- **Question 4. Community information.**
- **Question 5. Promotion of community health.**
- **Question 6. Affiliated health care system.**
- **Question 7. State filing of community benefit report.**

The other questions will need answered but may not directly pertain to community health needs assessment.



Schedule H (Form 990) 2011 Page 8

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

For additional information on IRS reporting requirements, consult your tax professional.

Appendix A

National Advisory Team Members

National Advisory Team Members

Project Leaders:

Gerald A. Doeksen, Director, National Center for Rural Health Works

Cheryl F. St. Clair, Associate Director, National Center for Rural Health Works

Members of the Team:

Larry Arthur, CEO, HMC/CAH Consolidated, Inc.

Michael Bilton, Executive Director, Association for Community Health Improvement, American Hospital Association

Teryl Eisinger, Director, National Organization of State Offices of Rural Health (NOSORH)

John Gale, Research Associate, Maine Rural Health Research Center, Muskie School of Public Service

Terry Hill, Executive Director, Rural Health Resource Center

Mendal Kemp, Director, Center for Rural Health, Mississippi Hospital Association

Joseph S. McNulty, II, President and Chief Executive Officer, Pioneer Health Services

Mary Ellen Pratt, CEO, St. James Parish Hospital

Jodi Schmidt, CEO, Labette Health

Pat Schou, Flex Coordinator, Illinois Center for Rural Health

Tim Size, Executive Director, Rural Wisconsin Health Cooperative

Brock Slabach, Vice President, National Rural Health Association (NRHA)

Rick Snyder, Vice President/Finance & Information Services, Oklahoma Hospital Association

Bridget Ware, Project Officer, Office of Rural Health Policy, U.S. Department of Health and Human Services, Health Resources and Services Administration

Chris Tilden, Executive Director, Mountain States Group

Appendix B

Contact Information for State Offices of Rural Health

Provided by:

National Organization of State Offices of Rural Health (NOSORH)

State Offices of Rural Health

Alabama

Alabama Office of Rural Health
Alabama Department of Public Health
The RSA Tower, Suite 1040
Montgomery, AL 36130
Phone: (334) 206 5396
Fax: (334) 206 5434
Website: http://www.adph.org/ruralhealth/

Alaska

Alaska State Office of Rural Health
Health Planning and Systems Development
Division of Public Health
P.O. Box 110601
Juneau, AK 99811
Phone: (907) 465 8618
Fax: (907) 467 6861
Website: http://www.hss.state.ak.us/dph/

Arizona

Arizona State Office of Rural Health Program
Arizona Rural Health Office
University of Arizona Mel & Enid Zuckerman College of Public Health
1295 N Martin Ave
Tucson, AZ 85724
Phone: (520) 626 2401
Fax: (520) 626 8716
Website: http://crh.arizona.edu/programs/service/sorh

Arkansas

Arkansas Office of Rural Health and Primary Care
Arkansas Department of Health
4815 W. Markham Street, Slot 22
Little Rock, AR 72205
Phone: (501) 280 4560
Fax: (501) 280 4706
Website: http://www.healthy.arkansas.gov/Pages/default.aspx

California

California Office of Primary and Rural Health Care
California Department of Health Care Services
1501 Capitol Avenue, Suite 71.6044, MS 8500

Sacramento, CA 95899
Phone: (916) 449 5770
Fax: (916) 449 5777
Website: http://www.dhcs.ca.gov/SERVICES/RURAL/Pages/hospitalfunding.aspx

Colorado

Colorado Rural Health Center
3033 S. Parker Rd., Suite 606
Aurora, CO 80014
Phone: (303) 832 7493
Fax: (303) 832 7496
Website: http://www.coruralhealth.org/

Connecticut

Connecticut Office of Rural Health
Northwestern CT Community College
Park Place East
Winsted, CT 06098
Phone: (860) 738 6378
Fax: (860) 738 6443
Website: http://www.ruralhealthct.org/

Delaware

Delaware Office of Primary Care & Rural Health
Delaware Division of Public Health
417 Federal Street
Dover, DE 19901
Phone: (302) 744 4555
Fax: (302) 739 3313
Website: http://dhss.delaware.gov/dhss/dph/hsm/pcohome.html

Florida

Florida Office of Rural Health
Florida Department of Health
4052 Bald Cypress Way, Bin # C-15
Tallahassee, FL 32399
Phone: (850) 245 4446
Fax: (850) 414 6470
Website: http://www.doh.state.fl.us/Workforce/RuralHealth/ruralhealthhome.html

Georgia

Georgia State Office of Rural Health
Georgia Department of Community Health
502 Seventh Street South
Cordele, GA 31015
Phone: (229) 401 3090
Fax: (229) 401 3084
Website: http://dch.georgia.gov/00/channel_title/0,2094,31446711_32385451,00.html

Hawaii

Hawaii State Office of Rural Health
Hawaii Department of Health
Office of Planning, Policy & Program Development
1250 Punchbowl Street, Room 120
Honolulu, HI 96813
Phone: (808) 586 4188
Fax: (808) 586 4193
Website: http://hawaii.gov/health

Idaho

Idaho Office of Rural Health and Primary Care
Idaho Department of Health and Welfare
P.O. Box 83720
450 West State Street, 4th Floor
Boise, ID 83720
Phone: (208) 334 0669
Fax: (208) 332 7262
Website:
http://www.healthandwelfare.idaho.gov/Health/RuralHealthandPrimaryCare/tabid/104/Default.aspx

Illinois

Illinois Center for Rural Health
Illinois Department of Public Health
535 West Jefferson Street
Springfield, IL 62761
Phone: (217) 782 1624
Fax: (217) 782 2547
Website: http://www.idph.state.il.us/about/rural_health/rural_home.htm

Indiana

Indiana State Office of Rural Health
Indiana State Department of Health
2 North Meridian Street, 2J
Indianapolis, IN 46204
Phone: (317) 233 7830
Fax: (317) 233 7761
Website: http://www.in.gov/isdh/24432.htm

Iowa

Iowa Oral and Health Delivery Systems
Iowa Department of Public Health
321 East 12th Street
Des Moines, IA 50319
Phone: (515) 281 7224
Fax: (515) 242 6384
Website: http://www.idph.state.ia.us/hpcdp/rural_health.asp

Kansas

Kansas Bureau of Local and Rural Health
Kansas Department of Health and Environment
1000 SW Jackson Street, Suite 340
Topeka, KS 66612
Phone: (785) 296 1200
Fax: (785) 296 1231
Website: http://www.kdheks.gov/

Kentucky

Kentucky Commonwealth Office of Rural Health
University of Kentucky
750 Morton Blvd
Hazard, KY 41701
Phone: (606) 439 3557
Fax: (606) 439 0795
Website: http://www.mc.uky.edu/ruralhealth/korh.asp

Louisiana

Louisiana Office of Rural Health
Louisiana Department of Health and Hospitals
628 North 4th Street, 8th Floor
P.O. Box 3118
Baton Rouge, LA 70821

Phone: (225) 342 9513
Fax: (225) 342 5839
Website: http://www.dhh.state.la.us/

Maine

Maine Office of Rural Health and Primary Care
Maine Department of Health and Human Services
286 Water Street, 6th Flr.
Augusta, ME 04333
Phone: (207) 287 5524
Fax: (207) 287 5431
Website: http://www.maine.gov/dhhs/mecdc/local-public-health/orhpc/index.shtml

Maryland

Maryland Office of Primary Care & Rural Health
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
Phone: (410) 767 5746
Fax: (410) 333 7501
Website: http://fha.dhmh.maryland.gov/ohpp/SitePages/sorh-home.aspx

Massachusetts

Massachusetts Office of Rural Health
Massachusetts Department of Public Health
180 Beaman Street
West Boylston, MA 01583
Phone: (508) 792 7880
Fax: (508) 792 7706
Website:http://www.mass.gov/eohhs/gov/departments/dph/programs/rural-health.html

Michigan

Michigan Center for Rural Health
Michigan State University
B-218 West Fee Hall
East Lansing, MI 48824
Phone: (517) 432 1066
Fax: (517) 432 0007
Website: http://www.mcrh.msu.edu/

Minnesota

Minnesota Office of Rural Health and Primary Care
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164
Phone: (651) 201 3838
Fax: (651) 201 3830
Website: http://www.health.state.mn.us/divs/orhpc/index.html

Mississippi

Mississippi Office of Rural Health
Mississippi Department of Health
570 East Woodrow Wilson
P.O. Box 1700
Jackson, MS 39215
Phone: (601) 576 7216
Fax: (601) 576 7530
Website: http://msdh.ms.gov/msdhsite/_static/44,0,111.html

Missouri

Missouri Office of Rural Health
Missouri Department of Health and Senior Services
920 Wildwood Drive
P.O. Box 570
Jefferson City, MO 65102
Phone: (573) 751 6219
Fax: (573) 526 4102
Website: http://health.mo.gov/living/families/ruralhealth/index.php

Montana

Montana Office of Rural Health
Montana Area Health Education Center
Montana State University - Bozeman
304 Culbertson Hall
P.O. Box 170540
Bozeman, MT 59717
Phone: (406) 994 6003
Fax: (406) 994 5653
Website: http://healthinfo.montana.edu/

Nebraska

Nebraska Office of Rural Health
Nebraska Department of Health and Human Services
301 Centennial Mall South
P.O. Box 95026
Lincoln, NE 68509
Phone: (402) 471 2337
Fax: (402) 471 0180
Website: http://www.unmc.edu/rural/NeRHW/

Nevada

Nevada Office of Rural Health
University of Nevada School of Medicine
411 W. 2nd St.
Reno, NV 89503
Phone: (775) 784 4841
Fax: (775) 784 4544
Website: http://www.medicine.nevada.edu/cehso/orh.html

New Hampshire

New Hampshire Rural Health & Primary Care
New Hampshire Department of Health
29 Hazen Drive
Concord, NH 03301
Phone: (603) 271 4741
Fax: (603) 271 4506
Website: http://www.dhhs.nh.gov/dphs/bchs/rhpc/rural.htm

New Jersey

New Jersey Office of Rural Health
New Jersey Department of Health & Senior Services
50 East State Street, 6th Floor
P.O. Box 364
Trenton, NJ 08625
Phone: (609) 292 1495
Fax: (609) 292 9599
Website: http://www.nj.gov/health/fhs/primarycare/ruralhealth.shtml

New Mexico

New Mexico Office of Rural Health/Primary Care
New Mexico Department of Health

300 San Mateo NE
Albuquerque, NM 87108
Phone: (505) 841 5871
Fax: (505) 841 5885
Website: http://nmhealth.org/PHD/OPRH.shtml

New York

New York (Charles D. Cook) Office of Rural Health
New York Department of Health
433 River Street, 6th Floor
Troy, NY 12180
Phone: (518) 402 0102
Website: http://www.health.ny.gov/

North Carolina

North Carolina Office of Rural Health & Community Care
North Carolina Department of Health and Human Services
311 Ashe Avenue
Raleigh, NC 27606
Phone: (919) 733 2040
Fax: (919) 733 8300
Website: http://www.ncdhhs.gov/orhcc/

North Dakota

North Dakota Center for Rural Health
School of Medicine and Health Sciences
501 North Columbia, Road Stop 9037
Grand Forks, ND 58202
Phone: (701) 777 3848
Fax: (701) 777 6779
Website: http://ruralhealth.und.edu/projects/sorh/

Ohio

Ohio State Office of Rural Health
Primary Care & Rural Health Program
Ohio Department of Health
246 North High Street, 6th Floor
Columbus, OH 43215
Phone: (614) 644 8508
Fax: (614) 995 4235
Website:
http://www.odh.ohio.gov/odhPrograms/chss/PCRH_Programs/rural_health/rhealth1.aspx

Oklahoma

Oklahoma Office of Rural Health
Oklahoma State University Center for Health Sciences
One Western Plaza
5500 N. Western, Suite 278
Oklahoma City, OK 73118
Phone: (405) 842 3100
Fax: (405) 842 9302
Website: http://www.healthsciences.okstate.edu/ruralhealth/orh.cfm

Oregon

Oregon Office of Rural Health
Oregon Health & Science University
3181 SW Sam Jackson Park Road, L593
P.O.rtland, OR 97239
Phone: (503) 494 4450
Fax: (503) 494 4798
Website: http://www.ohsu.edu/xd/outreach/oregon-rural-health/index.cfm/

Pennsylvania

Pennsylvania Office of Rural Health
Pennsylvania State University
202 Beecher-Dock House
University Park, PA 16802
Phone: (814) 863 8214
Fax: (814) 865 4688
Website: http://porh.psu.edu/

Rhode Island

Rhode Island Office of Primary Care & Rural Health
Rhode Island Department of Health
3 Capitol Hill, Room 302
Providence, RI 02908
Phone: (401) 222 7626
Fax: (401) 222 1442
Website: http://www.health.state.ri.us/

South Carolina

South Carolina Office of Rural Health
107 Saluda Drive

Lexington, SC 29072
Phone: (803) 454 3850
Fax: (803) 454 3860
Website: http://www.scorh.net/

South Dakota

South Dakota Office of Rural Health
South Dakota Department of Health
600 East Capitol Avenue
Pierre, SD 57501
Phone: (605) 773 3361
Fax: (605) 773 5683
Website: http://doh.sd.gov/RuralHealth/

Tennessee

Tennessee Office of Rural Health
Tennessee Department of Health
425 Fifth Avenue North
Nashville, TN 37247
Phone: (615) 741 0417
Fax: (615) 253 2100
Website: http://health.state.tn.us/rural/index.html

Texas

Texas Department of Rural Affairs
State Office of Rural Health Division
1700 North Congress Avenue, Suite 220
P.O. Box 12877
Austin, TX 78701
Phone: (512) 936 6701
Fax: (512) 936 6776
Website: http://tdra.texas.gov/redirect.html

Utah

Utah Office of Primary Care and Rural Health
Utah Department of Health
3760 S. Highland Drive
P.O. Box 142005
Salt Lake City, UT 84114
Fax: (801) 538 6387
Website: http://health.utah.gov/primary_care/ruralhealth.html

Vermont

Vermont Office of Rural Health
Vermont Department of Health
108 Cherry Street
P.O. Box 70
Burlington, VT 05401
Phone: (802) 951 1259
Fax: (802) 951 1275
Website: http://www.healthvermont.gov/rural/rural_health.aspx

Virginia

Virginia Office of Minority Health and Health Equity
Virginia Department of Health
109 Governor Street, Suite 1016 East
P.O. Box 2448
Richmond, VA 23219
Phone: (804) 864 7425
Fax: (804) 864 7440
Website: http://www.vdh.virginia.gov/healthpolicy/

Washington

Washington Statewide Office of Rural Health
Washington State Department of Health
P.O. Box 47834
Olympia, WA 98504
Phone: (360) 236 2800
Fax: (360) 664 9273
Website: http://www.doh.wa.gov/hsqa/ocrh/

West Virginia

West Virginia Division of Rural Health & Recruitment
Office of Community Health Systems & Health Promotion
350 Capitol Street, Room 515
Charleston, WV 25301
Phone: (304) 558 4382
Fax: (304) 558 1437
Website: http://www.wvochs.org/orhp/default.aspx

Wisconsin

Wisconsin Office of Rural Health
University of Wisconsin-Madison School of Medicine & Public Health

310 N. Midvale Boulevard, Suite 301
Madison, WI 53705
Phone: (608) 261 1885
Fax: (608) 261 1893
Website: http://www.worh.org/

Wyoming

Wyoming Office of Rural Health
Rural and Frontier Health Division
Wyoming Department of Health
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002
Phone: (307) 777 6512
Fax: (307) 777 8545
Website: http://www.health.wyo.gov/rfhd/rural/index.html

Appendix C

Contact Information for State Hospital Associations

Provided by:

American Hospital Association

State Hospital Associations

Alabama

Alabama Hospital Association
500 North East Blvd.
Montgomery, AL 36117
Phone: (334) 272 8781
Fax: (334) 272 9527
www.alaha.org

Alaska

Alaska State Hospital & Nursing Home Association
426 Main Street
Juneau, AK 99801
Phone: (907) 586 1790
Fax: (907) 463 3573
www.asknha.com

Arizona

Arizona Hospital and Healthcare Association
2800 North Central Ave., Suite 1450
Phoenix, AZ 85004
Phone: (602) 445 4300
Fax: (602) 445 4299
www.azhha.org

Arkansas

Arkansas Hospital Association
419 Natural Resources Drive
Little Rock, AR 72205
Phone: (501) 224 7878
Fax: (501) 224 0519
www.arkhospitals.org

California

California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814
Phone: (916) 443 7401
Fax: (916) 552 7596
www.calhospital.org

Hospital Association of San Diego and Imperial Counties
5575 Ruffin Road, Suite 225
San Diego, CA 92123
Phone: (858) 614 0200
Fax: (858) 614 0201
www.hasdic.org

Hospital Association of Southern California
515 S. Figueroa Street, Suite 1300
Los Angelos, CA 90071
Phone: (213) 538 0706
Fax: (213) 629 4272
www.hasc.org

Hospital Council of Northern and Central California
1215 K Street, Suite 730
Sacramento, CA 95814
Phone: (916) 552 7608
Fax: (916) 552 2618
www.hospitalcouncil.net

Colorado

Colorado Hospital Association
7335 East Orchard Road, #100
Greenwood Village, CO 80111
Phone: (720) 489 1630
Fax: (720) 489 9400
www.cha.com

Connecticut

Connecticut Hospital Association
110 Barnes Road
Wallingford, CT 6492
Phone: (203) 265 7611
Fax: (203) 284 9318
www.cthosp.org

Delaware

Delaware Hospital Association
1280 South Governors Avenue
Dover, DE 19904
Phone: (302) 674 2853

Fax: (302) 734 2731
www.dha.org

Florida

Florida Hospital Association
307 Park Lake Circle
Orlando, FL 32803
Phone: (407) 841 6230
www.fha.org

South Florida Hospital & Healthcare Association
6363 Taft Street, Suite 200
Hollywood, FL 33024
Phone: (800) 624 3365
www.sfhha.com

Georgia

Georgia Hospital Association
1675 Terrell Mill Road
Marietta, GA 30067
Phone: (770) 249 4500
Fax: (770) 955 5801
www.gha.org

Hawaii

Healthcare Association of Hawaii
932 Ward Avenue, Suite 430
Honolulu, HI 96814
Phone: (808) 521 8961
Fax: (808) 599 2879
www.hah.org

Idaho

Idaho Hospital Association
615 North 7th Street
P.O. Box 1278
Boise, ID 83701
Phone: (208) 338 5100
Fax: (208) 338 7800
www.teamiha.org

Illinois

Illinois Hospital Association
1151 East Warrenville Road
P.O. Box 3015
Naperville, IL 60566
Phone: (630) 276 5400
www.ihatoday.org

Metropolitan Chicago Healthcare Council
222 S. Riverside Plaza, 19th Floor
Chicago, IL 60606
Phone: (312) 906 6100
Fax: (312) 993 1501
www.mchc.org

Indiana

Indiana Hospital Association
One American Square, Suite 1900
Indianapolis, IN 46282
Phone: (317) 622 4870
Fax: (317) 633 4875
www.ihaconnect.org

Iowa

Iowa Hospital Association
100 East Grand Ave, Suite 100
Des Moines, IA 50309
Phone: (515) 288 1955
www.ihaonline.org

Kansas

Kansas Hospital Association
215 SE 8th Street
Topeka, KS 66603
Phone: (785) 233 7436
Fax: (785) 233 6955
www.kha-net.org

Kentucky

Kentucky Hospital Association
2501 Nelson Miller Parkway

Louisville, KY 40223
Phone: (502) 426 6220
Fax: (502) 426 6226

Louisiana

Louisiana Hospital Association
9521 Brookline Avenue
Baton Rouge, LA 70809
Phone: (225) 928 0026
Fax: (225) 923 1004
www.lhaonline.org

Metropolitan Hospital Council of New Orleans
2450 Seven Avenue, Suite 210
Metairie, LA 70001
Phone: (504) 837 1171
Fax: (504) 837 1174

Maine

Maine Hospital Association
33 Fuller Road
Augusta, ME 4330
Phone: (207) 622 4794
Fax: (207) 622 3073
www.themhs.org

Maryland

Healthcare Council of the National Capital Area
8201 Capital Drive, Suite 410
Landover, MD 20785
Phone: (301) 731 4700
Fax: (301) 731 8286
www.healthcare-council.org

Maryland Hospital Association
6820 Deerpath Road
Elkridge, MD 21075
Phone: (410) 379 6200
www.mdhospitals.org

Massachusetts

Massachusetts Hospital Association
5 New England Executive Park
Burlington, MA 01803
Phone: (781) 272 8000
www.mhslink.org

Michigan

Hospital Council of East Central Michigan
315 Mullholland Street
Bay City, MI 48708
Phone: (989) 891 8810
Fax: (989) 891 8161

Michigan Health & Hospital Association
6215 W. St. Joseph Highway
Lansing, MI 48917
Phone: (517) 323 3443
Fax: (517) 323 0946
www.mha.org

North Central Council of MHA
616 Petosky Street, Suite 208
Petrosky, MI
Phone: (231) 439 9812
Fax: (231) 439 9813

Minnesota

Minnesota Hospital Association
2550 University Ave. W., Suite 350-S
St. Paul, MN 55114
Phone: (651) 641 1131
Fax: (651) 659 1477
www.mnhospitals.org

Mississippi

Mississippi Hospital Association
116 Woodgreen Place
P.O. Box 1909
Madison, MS 39110
Phone: (800) 289 8884
Fax: (601) 368 3200
www.mhanet.org

Missouri

Missouri Hospital Association
4712 Country Club Drive
P.O. Box 60
Jefferson City, MO 65102
Phone: (573) 893 3700
Fax: (573) 893 2809
www.mhanet.com

Montana

MHA: An Association of Montana Health Care Providers
1720 9th Avenue
Helena, MT 59601
Phone: (406) 442 1911
Fax: (406) 443 3894
www.mtha.org

Nebraska

Nebraska Hospital Association
3255 Salt Creek Circle, Suite 100
Lincoln, NE 68504
Phone: (402) 742 8140
Fax: (402) 742 8191
www.nhanet.org

Nevada

Nevada Hospital Association
5250 Neil Road, Suite 302
Reno, NV 89502
Phone: (775) 827 0184
www.nvha.net

New Hampshire

New Hampshire Hospital Association
125 Airport Road
Concord, NH 03301
Phone: (603) 225 0900
Fax: (603) 225 4346
www.nhha.org

New Jersey

New Jersey Hospital Association
760 Alexander Road
PO Box 1
Princeton, NJ 08543
Phone: (609) 275 4000
www.njha.com

New Mexico

New Mexico Hospital Association
7471 Pan American Freeway NE
Albuquerque, NM 87109
Phone: (505) 343 0010
Fax: (505) 343 0012
www.mnhanet.org

New York

Greater New York Hospital Association
555 West 57th Street, 15th Floor
New York, NY 10019
Phone: (212) 246 7100
Fax: (212) 262 6350
www.gynha.org

Healthcare Association of New York State
One Empire Drive
Rensselaer, NY 12144
Phone: (618) 431 7600
www.hanys.org

Iroquois Healthcare Alliance
17 Halfmoon Executive Park Drive
Clifton Park, NY 12065
Phone: (518) 383 5060

Fax: (518) 383 2616
www.iroquois.org

Nassau-Suffolk Hospital Council, Inc.
1383 Veterans Memorial Highway, Suite 26
Hauppauge, NY
Phone: (631) 963 4150
Fax: (631) 435 2343
www.nsha.org

Northern Metropolitan Hospital Association
400 Stony Brook Court
Newburgh, NY 12550
Phone: (845) 562 7520
Fax: (845) 562 0187
www.normet.org

Rochester Regional Healthcare Association
3445 Winton Place
Rochester, NY 14623
Phone: (585) 273 8180
Fax: (585) 475 0266

Western New York Healthcare Association
1876 Niagra Falls Boulevard
Tonawanda, NY 14150
Phone: (716) 695 0843
Fax: (716) 695 0073
www.wnyha.com

North Carolina

North Carolina Hospital Association
2400 Weston Parkway
Cary, NC 27513
Phone: (919) 677 2400
Fax: (919) 677 4200
www.ncha.org

North Dakota

North Dakota Healthcare Association
1622 E. Interstate Ave.
P.O. Box 7340
Bismarck, ND 58507
Phone: (701) 224 9132

Fax: (701) 224 9529
www.ndha.org

Ohio

Akron Regional Hospital Association
3200 West Market Street, Suite 200
Akron, OH 44333
Phone: (330) 873 1500
Fax: (330) 873 1501
www.arha.org

The Center for Health Affairs
1226 Huron Road East
Cleveland, OH 44115
Phone: (216) 696 6900
Fax: (216) 696 1875
www.chanet.org

Central Ohio Hospital Council
155 East Broad Street, 2nd Floor
Columbus, OH 43215
Phone: (614) 358 2710
www.centralohiohospitals.org

Greater Cincinnati Health Council
2100 Sherman Avenue, Suite 100
Cincinnati, OH 45212
Phone: (513) 531 0200
Fax: (513) 531 0278
www.gchc.org

Greater Dayton Area Hospital Association
2 Riverplace, Suite 400
Dayton, OH 45405
Phone: (937) 228 1000
Fax: (937) 228 1035
www.gdaha.org

Hospital Council of Northwest Ohio
3231 Central Park West Drive, Suite 200
Toledo, OH 43617
Phone: (419) 842 0800
Fax: (419) 843 8889
www.hcno.org

Ohio Hospital Association
155 E. Broad St., Floor 15
Columbus, OH 43215
Phone: (614) 221 7614
Fax: (614) 221 4771
www.ohanet.org

Oklahoma

Oklahoma Hospital Association
4000 Lincoln Blvd.
Oklahoma City, OK 73105
Phone: (405) 427 9537
Fax: (405) 424 4507
www.okoha.com

Oregon

Oregon Association of Hospitals and Health Systems
4000 Kruse Way Place Building 2, Suite 100
Lake Oswego, OR 97035
Phone: (503) 636 2204
Fax: (503) 636 8310
www.oahhs.org

Pennsylvania

Delaware Valley Healthcare Council of HAP
121 S. Broad Street, 20th Floor
Philadelphia, PA 19107
Phone: (215) 735 4295
Fax: (215) 790 1267
www.dvhc.org

The Hospital & Healthsystem Association of Pennsylvania
4750 Lindle Road
P.O. Box 8600
Harrisburg, PA 17105
Phone: (717) 564 9200
Fax: (717) 561 5334
www.haponline.org

Hospital Council of Western Pennsylvania
500 Commonwealth Drive
Warrendale, PA 15086
Phone: (724) 772 7206

Fax: (724) 772 8339
www.hcwp.org

Rhode Island

Hospital Association of Rhode Island
100 Midway Road, Suite 21
Cranston, RI 2920
Phone: (401) 946 7887
Fax: (401) 946 8188
www.hari.org

South Carolina

South Carolina Hospital Association
1000 Center Point Road
Columbia, SC 29210
Phone: (803) 796 3080
www.scha.org

South Dakota

South Dakota Association of Healthcare Organizations
3708 W. Brooks Place
Sioux Falls, SD 57106
Phone: (605) 361 2281
Fax: (605) 361 5175
www.sdaho.org

Tennessee

Tennessee Hospital Association
500 Interstate Blvd., South
Nashville, TN
Phone: (615) 256 8240
www.tha.com

Texas

Dallas-Fort Worth Hospital Council
250 Decker Drive
Irving, TX 75062
Phone: (972) 719 4900
Fax: (972) 719 4009
www.dfwhc.org

Greater San Antonio Hospital Council
7500 US Highway 90 West AT&T Building, Suite 200
San Antonio, TX 78217
Phone: (210) 820 3500
Fax: (210) 820 3888

Texas Hospital Association
1108 Lavaca, Suite 700
P.O. Box 679010
Austin, TX 78701
Phone: (512) 465 1000
Fax: (512) 465 1090
www.texashospitalsonline.org

Utah

Utah Hospitals and Health Systems Association
2180 South 1300 East, Suite 440
Salt Lake City, UT 84106
Phone: (801) 486 9915
Fax: (801) 486 0882
www.uha-utah.org

Vermont

Vermont Association of Hospitals and Health Systems
148 Main Street
Montpelier, VT 0
Phone: (802) 223 3461
Fax: (802) 223 0364
www.vahhs.org

Virginia

Healthcare Council of the National Capital Area
8201 Capital Drive, Suite 410
Landover, VA 20785
Phone: (301) 731 4700
Fax: (301) 731 8286
www.healthcare-council.org

Virginia Hospital & Healthcare Association
4200 Innslake Drive
Glen Allen, VA 23060
Phone: (804) 956 1216
Fax: (804) 965 0475

www.vhha.com

West Virginia

West Virginia Hospital Association
100 Association Drive
Charleston, WV 25311
Phone: (304) 344 9744
Fax: (304) 344 9745
www.wvha.com

Washington

Washington State Hospital Association
300 Elliot Avenue West, Suite 300
Seattle, WA 98119
Phone: (206) 281 7211
Fax: (206) 283 6122
www.wsha.org

Wisconsin

Wisconsin Hospital Association
5510 Research Park Drive
P.O. Box 259038
Madison, WI 53725
Phone: (608) 274 1820
Fax: (608) 274 8554
www.wha.org

Wyoming

Wyoming Hospital Association
2005 Warren
P.O. Box 249
Cheyenne, WY 82003
Phone: (307) 632 9344
Fax: (307) 632 9347
www.wyohospitals.ocom

Appendix D

Example Invitation Letter to Community Advisory Committee

Potential Community Advisory Committee Members

Consider the following categories when looking at your community for Community Committee members. We suggest a steering committee of between 20-30 people, recognizing that not all members will be able to attend all meetings. This will provide enough capacity to accomplish the tasks for each meeting.

City government(s); city manager, mayor, city council members
County government(s); county commissioners, county officers
State government; human services, health department, state legislators
Tribal government(s); tribal leaders, health care coordinator, local IHS representative
Health care providers
- Hospital administrator and other key hospital personnel
- Hospital board members
- Physicians
- Dentists
- Optometrists
- Chiropractors
- Clinics or community health centers
- Mental health professionals—i.e., psychiatrist, psychologist, counselors
- Nurse practitioners
- Physician assistants
- Therapists—physical, massage, speech, rehabilitation, occupational
- Pharmacists
- Medical equipment suppliers
- Home health providers
- Hospice
- Nursing homes, assisted living facilities, and adult day services
- School health
- Others

Emergency medical services (ambulance services)
Local public health officials
Chamber(s) of commerce
Economic development groups; coalitions, councils of government, sub-state planning districts
Industry/business; manufacturing, banks, phone companies, retail sales (Main St. businesses), groceries, realtors, insurance, fishing, farming, forestry, mining, petroleum, etc.
Public education; superintendent, principals, school nurse
Technology education (formerly vo-tech)
Higher education
Private education
Volunteer organizations; local food banks, soup kitchens
Religious leaders; ministerial alliance, ministers
Minority or disparate population groups or group leaders
Service organizations; Kiwanis, Lions, Rotary, Toastmasters, etc.
Social service organizations
Other community leaders

PROPOSED COMMUNITY ADVISORY COMMITTEE INVITATION LETTER

Dear (***County/Community***) Leader:

(Hospital Name) is requesting your assistance in conducting a community health needs assessment. "The Patient Protection and Affordable Care Act" passed in 2020 and requires all not-for-profit hospitals to conduct a community health needs assessment every three years.

We need your help! To meet this requirement, we need a community advisory committee of community leaders. You were selected because of your leadership position in the (***County/Community***). If you agree to help us, your responsibilities will be to provide counsel at a minimum of three (***County/Community***) meetings (times and dates below), to complete a community health survey questionnaire, and to assist in having five or six community members complete the community health survey.

The process will require your participation at a minimum of three meetings, scheduled on (***Meeting One Date, Time, and Place***), (***Meeting One Date, Time, and Place***), and (***Meeting One Date, Time, and Place***). The meetings will include a review of the legislative requirements. Light refreshments will be provided at all meetings.

The first two meetings will typically last one to 1 ½ hours. At the first meeting, we will provide an overview of the new legislative requirements and present a study which measures the economic contribution of the hospital. We will have you complete a community health survey questionnaire and ask you to take five or six surveys to be completed by community members. At the second meeting, the completed surveys will be collected, and an economic and demographic data report and a health indicator/health outcome data report will be presented.

The third meeting will last about two hours. The summary results of the community health survey will be shared and your counsel will be needed to determine our (***County/Community***)'s health care needs and to prioritize these needs. We will also ask for your suggestions as to implementation strategies and responsibilities.

(Hospital Name) seeks your participation in providing input about as to how ***(Hospital Name)*** can improve and expand our health services in ***(County/Community)***. Your input on the community health needs of (***County/Community***) is important. ***(Hospital Name)*** not only wants to meet the federal requirements but wants to provide for the health care needs in our ***(County/Community)***.

This committee will include about 25 - 35 (***County/Community***) leaders. Since your input is important, we would greatly appreciate your willingness to serve on this important committee. Please let us know of your availability to participate and provide this valuable service to our (***Hospital Name***) and to our (***County/Community***).

Sincerely,

Appendix E

PowerPoint Presentation – Overview of Community Health Needs Assessment Process

Community Health Needs Assessment

Facilitated by:

FACILITATOR

Community Health Needs Assessment (CHNA) Toolkit

R
H W

Community Health Needs Assessment Template

National Center for Rural Health Works

WHAT are we doing?

A community-based assessment of health care needs in the medical service area of ***Local Hospital***.

- From the community's perspective as to health care needs
- From analysis of data and information from public health department, other data sources, survey results, and economic impact study

(Cont'd) WHAT are we doing?

Outcomes of the community-based assessment will depend on:

- Community recommendations to ***Local Hospital***
- ***Local Hospital***'s resource availability

Results of the community needs assessment will be reported to the IRS on Form 990 and related schedules by ***Local Hospital***

WHY are we doing this?

The Patient Protection and Affordable Care Act (PPACA) requires not-for-profit hospitals to provide a Community Health Needs Assessment, as follows:

- The organization must conduct a "community health needs assessment" not less frequently than every three years and adopt an implementation strategy to meet the community health needs identified through the assessment.

(Cont'd) WHY are we doing this?

- A "community health needs assessment" must include input from persons "represent[ing] the broad interests of the community served by the hospital facility," including those "with special knowledge of or expertise in public health."
- The assessment must be made widely available to the public.

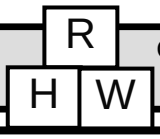
Hospitals are required to fulfill these requirements to preserve their status as not-for-profit facilities.

(Cont'd) WHY are we doing this?

The legislation also includes:

- Financial Assistance Policy Requirements
- Requirements regarding Charges
- Billing and Collection Requirements

Local Hospital will fulfill these requirements internally.



WHY we WANT to do this?

Regardless of the legislative requirements, ***Local Hospital*** wants community-based assessment to become a part of the hospital strategic plan on a long-term, continuing basis.

- Community will provide input to ***Local Hospital*** as to the community's needs.
- ***Local Hospital*** will develop communications and relationships with the community to plan and provide for the community's needs.

WHAT is required from the Community Advisory Committee?

1. To review and analyze data and information provided during process:

   ➢ From ***Local Hospital***:
   - ***Local Hospital***'s medical service area
   - Services and community benefits currently provided

   ➢ From State or Local Public Health:
   - Data on health indicators and outcomes

(Cont'd) WHAT is required from the Community Advisory Committee?

- From other sources:
  - U. S. Census Bureau and County Business Patterns
  - ESRI
  - U. S. Department of Commerce, Regional Economic Information System, Bureau of Economic Analysis
  - Other agencies and foundations that provide relevant health data

(Cont'd) WHAT is required from the Community Advisory Committee?

- Information will also be provided concerning:
  - The economic impact of ***Local Hospital***
  - Jobs and salaries, wages, and benefits generated locally by ***Local Hospital***
  - A summary of the importance of ***Local Hospital*** to the local economy

(Cont'd) WHAT is required from the Community Advisory Committee?

2. Provide input through health survey questionnaire and have other community members complete survey.
3. Review and analyze results of survey.
4. Provide input and recommendations on local community needs in the ***Local Hospital*** medical service area.

SUMMARY of Community Advisory Committee Responsibilities

- ✓ Participate in a three-meeting community-based needs assessment
- ✓ Complete community health survey and have others complete survey
- ✓ Review data and information and identify and prioritize the health needs of the community
- ✓ Community members will make recommendations to ***Local Hospital***

Local Hospital – Community Meeting #1

AGENDA FOR COMMUNITY MEETING #1

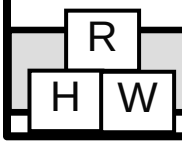
I. Introductions – ***CEO, Local Hospital***

II. Overview of CHNA Process – ***Facilitator***

III. Delineate Medical Service Area – ***CEO, Local Hospital***

IV. ***Local Hospital*** Services/Community Benefits – ***CEO, Local Hospital***

V. Economic Impact of ***Local Hospital*** – ***Facilitator***



Community Needs Assessment Template
National Center for Rural Health Works

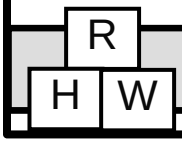
Local Hospital – Community Meeting #1

(**Cont'd**) AGENDA FOR COMMUNITY MEETING #1

VI. ***Local Hospital*** Survey Questionnaire – ***Facilitator***
- Survey Questionnaire completed at meeting
- Each member to take 5 to 6 surveys and have completed by community members of their constituency

VII. Questions – ***Facilitator***

VIII. Next Steps – ***Facilitator***
- Meetings #2 & #3 – *Day of week, Month, Day, Year, Time, Location and Place of Meetings #2 & #3*



Community Needs Assessment Template
National Center for Rural Health Works

Local Hospital – Community Meeting #2

AGENDA FOR COMMUNITY MEETING **#2**

Day of week, Month, Day, Year, Time,
Location and Place of Meeting

I. Introductions – ***CEO, Local Hospital***

II. Review of Meeting #1 – ***Facilitator***

III. Collect Completed Surveys – ***Steering Committee***

IV. Economic and Demographic Data - ***Facilitator***

IV. Health Indicator/Health Outcome Data – ***Facilitator***

V. Questions – ***Facilitator***

VI. Next Steps – ***Facilitator***

- Meeting #3 – *Day of week, Month, Day, Year, Time, Location and Place of Meetings #3*

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H W
Community Needs Assessment Template
National Center for Rural Health Works

Local Hospital – Community Meeting #3

AGENDA FOR COMMUNITY MEETING **#3**

Day of week, Month, Day, Year, Time,
Location and Place of Meeting

I. Introductions – ***CEO, Local Hospital***

II. Review of Meetings #1 & #2 – ***Facilitator***

III. Present Survey Results – ***Facilitator***

V. Discuss community health needs/issues – ***Facilitator***
- Identify and prioritize community health needs
- Suggest possible implementation strategies/responsibilities
- Summary community recommendations

VI. Response and final comments - ***CEO, Local Hospital***

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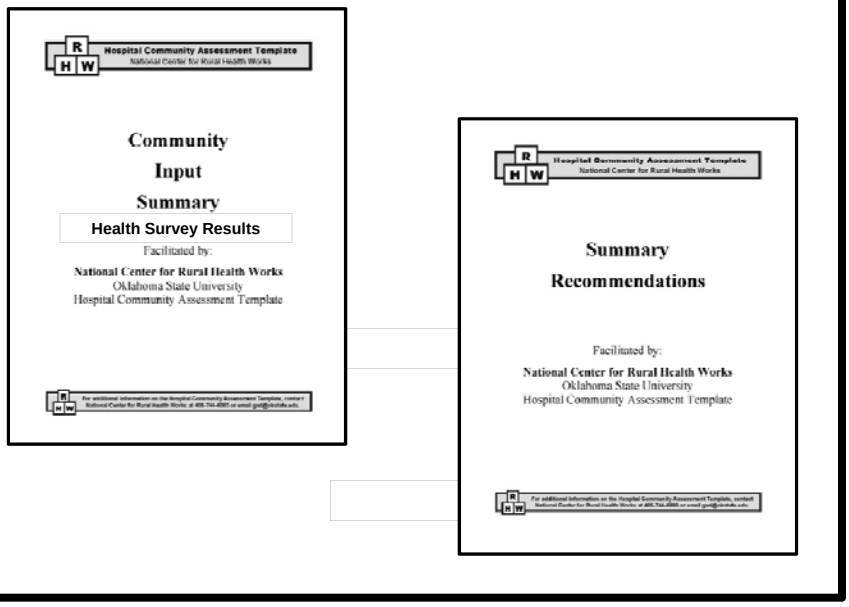
Community Needs Assessment Template
National Center for Rural Health Works

Community Health Needs Assessment - Summary Recommendations to *Local Hospital*

Community Needs and Implementation Strategies with Responsibilities

Community Need	Implementation Strategy	Responsible Organization or Person
1.		
2.		
3.		
4.		
5.		
6.		



Community Health Needs Assessment Reporting to Meet IRS Requirements

IRS Forms: Form 990 & Form 990 Schedule H

Summary Report Outline
Community Health Needs Assessment

Community Members Involved
- Need to include name, organization and contact information for:
  - Hospital Administrator
  - Steering Committee or Leadership Group
  - Facilitator
  - Community Advisory Committee Members

Medical Service Area
- Describe by county or zip code areas
- Include populations and projected populations of medical service area
- Include demographics of population of medical service area

Community Meetings #1, #2, and #3 (also any additional meetings)
- Date
- Agenda
- List reports presented with short summary of each

Community Needs and Implementation Strategies
- Include community needs and implementation strategies with responsibilities from community group

Hospital Final Implementation Plan
- Include which needs hospital can address and the implementation strategies
- Include which needs hospital cannot address and reason(s) why

Community Awareness of Assessment
- Describe methodology for making assessment widely available to the community
- Have Community Advisory Committee Report available to public
- Have Hospital Action Plan with each health need addressed available to public

For Additional Information:

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Email: gad@okstate.edu
or
Cheryl St. Clair, Associate Director
Cheryl@okstate.edu

National Center for Rural Health Works
Oklahoma State University
Phone: 405-744-6083 or 6081

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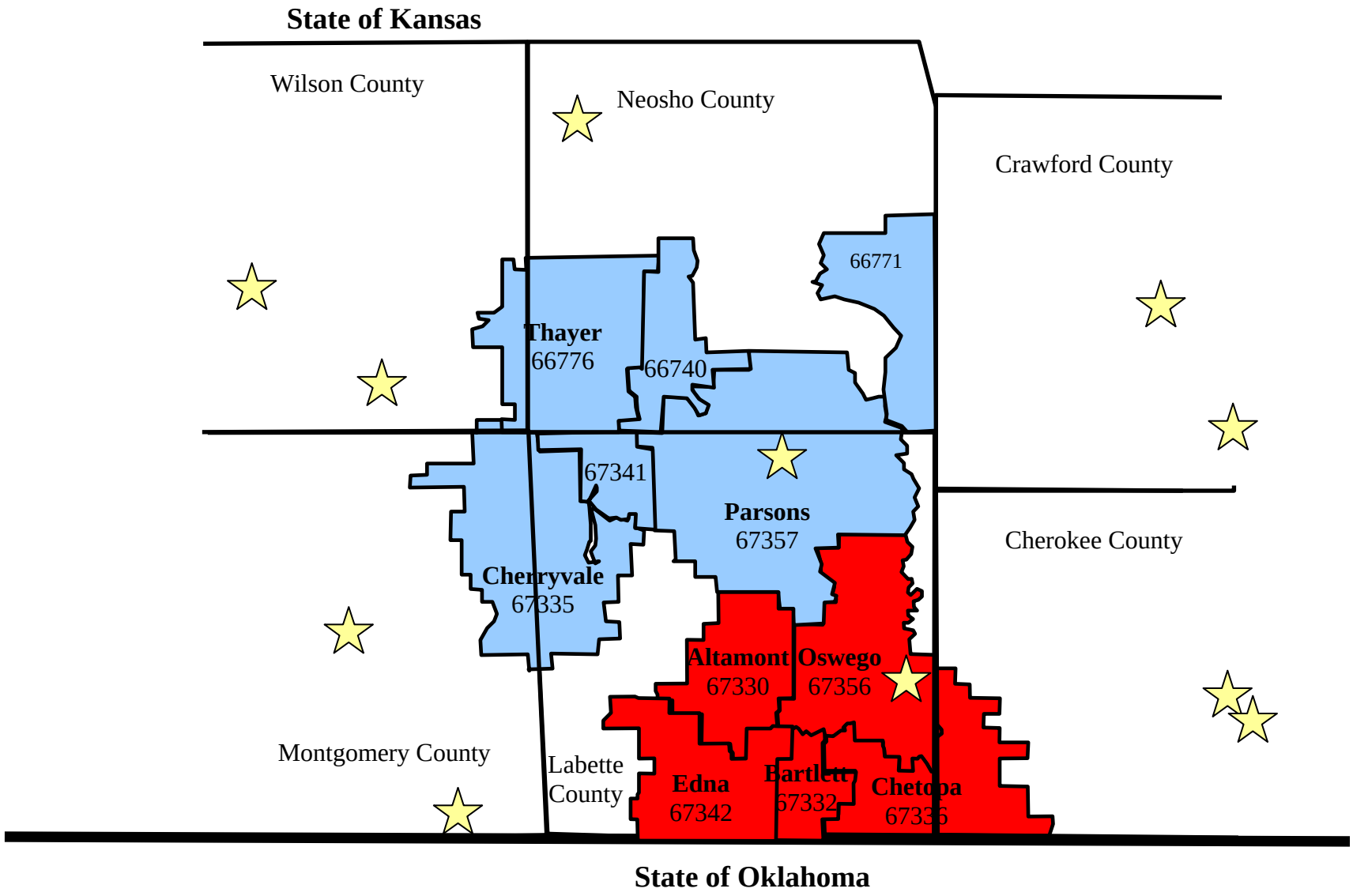
Community Health Needs Assessment Template
National Center for Rural Health Works

Appendix F

Example Medical Service Area


State of Kansas
Wilson County
Neosho County
Crawford County
66771
Thayer
66776
66740
67341
Parsons
67357
Cherryvale
67335
Cherokee County
Altamont
67330
Oswego
67356
Montgomery County
Labette
County
Edna
67342
Bartlett
67332
Chetopa
67336
State of Oklahoma

Appendix G

Example Overview of Hospital Services/Community Benefits

OSWEGO COMMUNITY HOSPITAL – SERVICES PROVIDED

INPATIENT SERVICES

Acute Inpatient - Provide acute admissions for up to 96 hours on the average. This is for any patient that can't be treated on an outpatient basis.

Observation - This is for an admit when more information is needed to determine if patient needs an acute admit or can be treated outpatient.

Swing Bed - This is for services requiring a skilled need for an undetermined length, such as IV therapy, physical therapy.

Respite - Provide patients on Hospice a place to stay to relieve family members.

Physical Therapies - Provide Physical, Occupational & Speech Therapists that work with patients who are admitted.

Laboratory - Provide a large array of laboratory tests that are done in our laboratory. Some tests are sent out.

Radiology - Provide X-Rays in house either stationary or portable.
CT Scans once a week
MRIs once a week

EKG's - Provide electrical tracings of the heart.

Pharmacy - Full line of medications to service our patients.

Wound Care - Provide wound care by a physician, certified wound care nurse & certified dietitian.

Transportation - Provide transportation as needed for medical appointments.

Social Services - Provide Social Service needs for patients.

Dietary – Provide certified dietitian.

Chaplain Service - Our dedicated Chaplains make daily rounds to patients.

OSWEGO COMMUNITY HOSPITAL – SERVICES PROVIDED

OUTPATIENT SERVICES

Laboratory - Provides lab tests to anyone with a physician's order. Most lab tests are done in house, some are sent out.

Radiology - Provides X-Rays, CT Scans & MRIs to anyone with physician's order.

Emergency Department - Our Emergency Department is open 24 hours a day seven days a week to provide care to patients with emergencies.

Sleep Lab - Provide sleep testing by a licensed tech. Most tests are split tests so you only have to come one time.

Nerve Conduction Tests - Nerve tests by a licensed tech. This can provide identifying deficits in muscles & nerves.

Pulmonary Function Tests - Testing for lung function & medication treatment.

Bone Densinometer - A 10 minute test that measures bone density to determine loss of bone mass.

Wound Care - Provide scheduled wound care visits by a physician, certified wound care nurse & certified dietitian.

Holter Monitor - A 24-hour device that monitors tracings of your heart for diagnostic purposes.

Procedure Room - A specific room to perform various types of procedures.

Physical Therapies - Provide Physical, Occupational & Speech Therapists.

Forensic Program - Provide sexual assault & abuse exams.

Reflections Program - Therapy program for seniors with emotional distress; overseen by a psychiatrist with a licensed mental health social worker.

Physicals - Provide Department of Transportation (DOT) physicals.

Workers Comp - Provide a detailed workers comp program; assists employers to save money & helps employees recover in a timely manner.

Transportation Services - Provide transportation to patients for various medical appointments within a 35-mile radius.

Social Services - Provide Social Service needs for patients.

OSWEGO COMMUNITY HOSPITAL – SERVICES PROVIDED

CLINICS

Oswego Community Clinic

Family Practice clinic providing services by a board certified family physician & a board certified physician assistant. Open Monday through Friday 9AM to 5PM.

Wound care by a physician, certified wound care nurse & certified dietitian.

Vaccine for children program - Kan Be Healthy program

Chetopa Community Clinic

Family Practice Clinic providing services by a board certified family physician & a board certified nurse practitioner.

Wound Care by a physician, certified wound care nurse & certified dietitian.

Vaccine for children program - Kan Be Healthy program

Women's Health - Provide specific services to women's needs.

Rheumatology Clinic - Provide rheumatology care to patients by a board certified Rheumatologist.

Surgeon Clinic - Provide patient care by a board certified Vascular Surgeon.

Pediatric Clinic - Provide pediatric care by a board certified Pediatrician.

Podiatry Clinic - Provide routine patient care & diabetic care by a board certified Podiatrist.

Cardiac Clinic - Provide internal medicine & cardiac care to patients by a board certified Cardiologist.

Wound Care Clinic - Providing wound care by a physician, certified wound care nurse & certified dietitian.

OSWEGO COMMUNITY HOSPITAL – SERVICES PROVIDED

COMMUNITY ACTIVITIES

Health Fair - Provide a community health fair with various vendors every two years.

Yearly Santa Claus - Santa Claus visits the hospital. Pictures are taken & given to the parents. Hospital provides cookies & punch.

Yearly Easter Egg Hunt - Hospital provides eggs filled with c&y & hides eggs in the park. Different zones for different age levels.

Adopt Families - The hospital adopts two families, one from around Oswego & one from around Chetopa every Thanksgiving & Christmas. The hospital employees donate food, gifts & money to the chosen families.

Dare Program - Participate with a booth & teach with the Sheriff's Department.

Year Books - Buy an ad in the Chetopa & Oswego yearbooks every year.

Booster Club - Support the Oswego Booster Club.

Discovery Days - Teach appropriate h& washing with a black light & kit to Oswego & Chetopa grade school children.

Halloween - Provide c&y at the hospital for trick or treaters.

Oswegofest - Provide a first-aid booth during the event.

County Fair - Provide bottled ice water to the exhibitors in the animal barn all week during the fair.

Chetopa Pecan Fest - Provide a donation every year.

Oswego Fire Department - Donate to the fire department for yearly fireworks.

Renaissance - Support the high school renaissance with a donation.

Christmas Parade - Hospital rides in the parade with a hospital float.

OSWEGO COMMUNITY HOSPITAL – SERVICES PROVIDED

INTERNAL HOSPITAL

Web Site - Maintains current website: www.oswegocommunityhospital.com

Training
- Training site for nursing students from Parsons & Coffeyville
- Training site for physician assistant student from Wichita State
- Polycom video conference for training & meetings

Memberships
- Regional Emergency Preparedness (regional warehouse for supplies)
- SEK Alliance of hospitals
- Kansas Hospital Association
- American Hospital Association
- Kansas Nurse Leaders
- Kansas Risk Management
- National Rural Health Association
- American Health Information Management Association
- Children's Advocacy Center, Pittsburg, KS
- Minnesota Children's Hospital Child Advocacy Center

Alliances
- Supporting hospital agreement with Freeman Hospital
- Supporting hospital agreement with Via Christi Pittsburg
- Supporting hospital agreement with Labette Health

Governance
- Board of Managers
- Advisory Board - consists of local community members
- Past Kansas Hospital Association Planning Board member
- Past Kansas Hospital Association Governance Board member

Staff - Monthly birthday celebrations with cake & ice cream

Advertisement
- Taylor newspaper weekly ads
- KLKC Radio
- Weekly flyers for Oswego, Chetopa & Altamont grocery stores.

Appendix H

PowerPoint Presentation Illustrating Typical Impact of a Rural Hospital on a Local Economy

Community Needs Assessment Template

National Center for Rural Health Works

Economic Impact of a Rural Hospital On a Local Economy

Prepared by

National Center for Rural Health Works

Gerald Doeksen – Director
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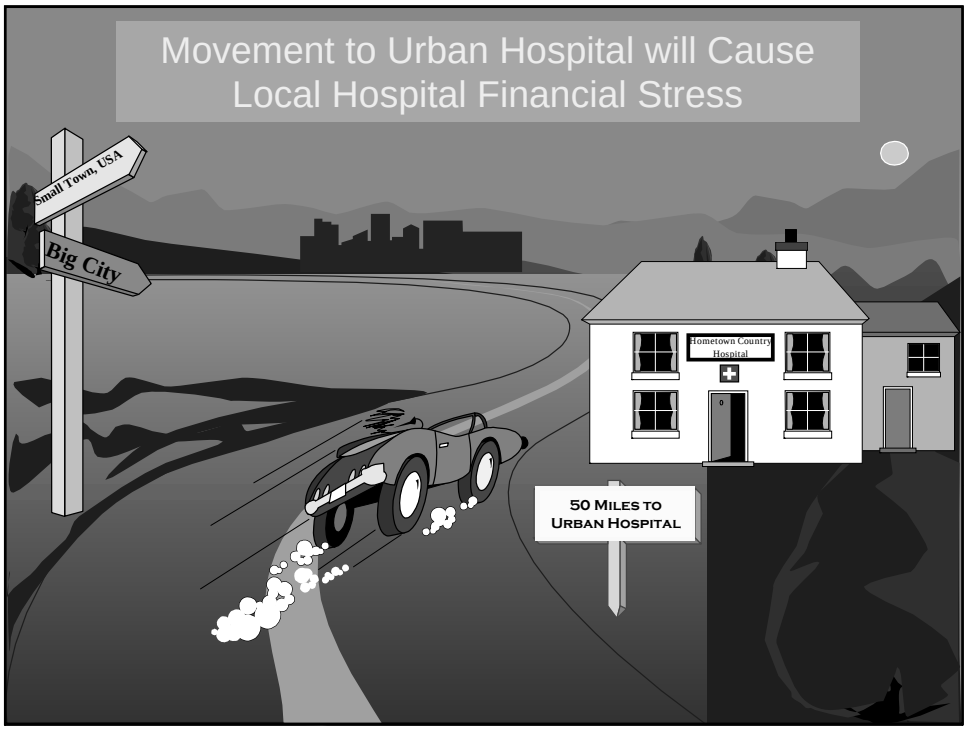
Cheryl St. Clair – Associate Director
(405) 744-6083
cheryl@okstate.edu

www.ruralhealthworks.org



If Community desires to attract business and industry, research indicates the area needs quality:

- Health services and
- Education services



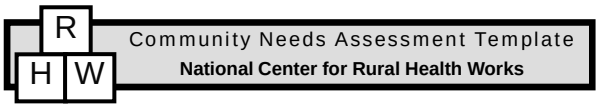
If Community desires to retain and attract retirees, research indicates the area needs quality:

- Health services and
- Safety services



Health Sector is growing in most rural areas because:

- **Absolute number of adults 65+ is growing**

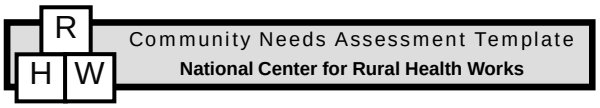


Economic Impact of a Rural Hospital:

- **Data include averages for 28 rural hospitals from 11 states**

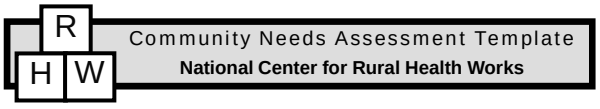
Average Hospital Employment & Payroll + Benefits:

- 150 Employees
- $7,014,527 Payroll + Benefits



Hospitals create jobs and payroll + benefits in other community businesses as the:

- Hospital spends locally
- Hospital employees spend locally



Hospital spending creates jobs locally






Impact on other businesses is measured by multipliers

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H W
Community Needs Assessment Template
National Center for Rural Health Works

Average Employment Impact of Rural Hospital

Hospital Employment	Employment Multiplier	Total Employment Impact
150	**1.38**	**210**

Employment multiplier indicates that for each job created in Hospitals, another 0.38 jobs are created in other businesses in Community

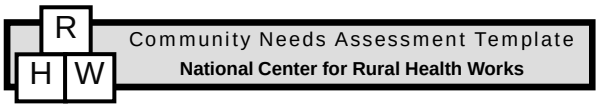
Average Income (Payroll + Benefits) Impact of Rural Hospital

Hospital Income	Income Multiplier	Total Income Impact
$7,014,527	**1.22**	**$8,582,657**

Income multiplier indicates that for each $1 created in payroll + benefits, another $0.22 is created in other businesses in Community

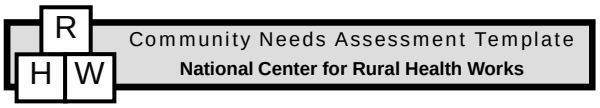
Average Impact on Community's Retail Sales

$1,604,059



Everyone Knows Hospital's Impact on Community Medical Needs

Few Know Impact Hospital Has on Community's Economy



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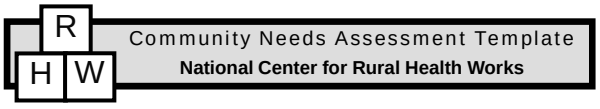


Appendix I

Example Economic Impact Study

Steps for Preparing Economic Impact Study

I. Determine medical service area of study

II. Prepare secondary data tables in Excel

III. Collect primary data from local sources

Typically, through one or two conference calls and follow-up emails; with 3 to 4 local people who know the community well(may be health providers, community residents, Chamber, health board members, etc.)

a. Need total wages, salaries & benefits and proprietor income, when applicable, (labor income) for providers willing to share data

a. Need total number of FT & PT employees for providers who share income data (***not FTEs***)

b. For providers without income data, need the type of employees with no. of FT & PT by type
EXAMPLE: For a physician office: one FT family practitioner, one FT LPN, one half-time medical assistant, one receptionist, & one three-quarter time office manager

IV. Derive economic impact

a. Prepare for Implan model
   a) Implan3 software and Implan3 appliance (Black Box; i.e. external hard drive) installed
   b) Check for Implan3 software updates
   c) Have Structural Matrices installed for year of data
   d) Implan data available and saved on Implan3 appliance
   e) Need local primary data (direct economic activities or direct impact)

b. Run Implan model
   a) Open the Implan software
   b) Build the study area in Implan
   c) Verify selected sector data in Implan
   d) Create shadow industry sector, if required
      1. If needed sector has no data, need to create shadow industry; i.e., hospital
      2. Creating shadow industry means editing the data in Implan
      3. Need to have data for three fields in edit screen; ***employment, output, & employee compensation***
      4. Edit all shadow industry data; then move to next step
      5. Construct model to derive Type II multipliers
      6. Generate reports from Implan

c. Prepare economic impact tables in Excel
   a) Utilize multipliers from reports in economic impact tables in Excel
   b) Calculate local retail sales capture ratio & determine local sales tax rate:

$$\frac{\text{Total local retail sales subject to sales tax}}{\text{Total personal income}}$$

(Data available from state tax agency & U.S. Dept. of Commerce, Bureau of Economic Analysis)

V. Prepare study in Word
   a. Pull everything together in a Word document
   b. Cover with picture of local health providers (if available) & inside cover
   c. Introduction
   d. Secondary data tables with corresponding text
      1. National and state health trends, and/or economic & demographic data
      2. Identify medical service area
      3. Economic & demographic data for medical service area
   e. Figures; i.e., national health expenditures & medical service area (Optional)
   f. Section to explain multiplier effects
   g. Economic Impact Tables with corresponding text
      1. Direct economic activities (direct impacts) table
      2. Employment impact table
      3. Income impact table
      4. Sales tax impact, if applicable
      5. Other economic impact tables; i.e., construction, etc.
   h. Summary
   i. References and appendices, if needed

Modifications

- Mold the model to fit the situation, the service area, and the industry
- Medical service area can be zip code area, county, multi-county, state, multi-state, or national
- Powerful tool to illustrate the importance of an industry or group of industries to the economy
- Tool used in the community health engagement process

Implan Changes

- With latest data for 2008, sectors have changed again
- Implan has to adjust to changes due to their source data
- Implan may change software periodically (just changed to Version 3.0)

2008 Implan Breakdown of Health Sectors

325	Retail Stores – Health and personal care (includes pharmacies)
379	Veterinary services (optional)
394	Offices of physicians, dentists, and other health practitioners
395	Home health care services
396	Medical and diagnostic labs and outpatient and other ambulatory care (Other medical and health services)
397	Private hospitals
398	Nursing and residential care facilities

DATA FOR HOSPITAL ECONOMIC IMPACT STUDY

Hospital Name _____
County location _____
City location _____

Employment
Full-time Employees _____
Part-Time Employees _____
Contract Employees _____

Income (Wages, Salaries, and Benefits)
Wages, Salaries, and Benefits _____
Contractual Wages, Salaries and Benefits _____

Construction Costs
Give capital expenditures less land costs and equipment costs _____
2011 _____
2012 _____
2013 _____

DATA FOR HOSPITAL ECONOMIC IMPACT STUDY

Hospital Name	Guadalupe County Hospital
County location	Guadalupe County , NM
City location	Santa Rosa

Employment

Categories	Annual Employment
Full-time Employees	42
Part-Time Employees	5
Contract Employees	3
TOTAL	50

Income (Wages, Salaries, and Benefits)

Categories	Annual Amounts
Wages and Salaries	$ 1,436,256.00
Fringe Benefits	$ 421,954.00
Contract Labor Costs	$ 1,051,200.00
TOTAL	$ 2,909,410.00

Construction Costs

Give capital expenditures less land costs and equipment costs

Year of Construction	Annual Construction Estimates
2011	$ 10,000,000.00

"How To" Derive the Economic Impact of Health Services on the Local Economy

Economic Impact Study Illustration:

The Economic Impact of Health Services on the Economy of Noble County, Oklahoma

National Center for Rural Health Works
Oklahoma Cooperative Extension Service, Oklahoma State University

Oklahoma Center for Rural Health
Oklahoma Office of Rural Health, OSU Health Sciences Center
College of Osteopathic Medicine, Oklahoma State University

National Association of Counties Project
Funded by the federal Office of Rural Health Policy

Study Date: March 2010

Economic Impact Study

1. Determine medical service area of study
2. Collect primary data from local sources
3. Derive economic impact
   a. Install IMPLAN software and IMPLAN data and run model
   b. Prepare economic impact tables in Excel

Determine Medical Service Area

- Medical service area
  - For this example:
    Medical service area is the county of Noble County, Oklahoma

Primary Data Collection

From the local sources in Noble County:

- Need total number of full-time and part-time employees for all health entities (NOT FTEs)
- Need total wages, salaries, and benefits and proprietor income, when and if applicable
- Need construction costs (exclude land costs and equipment costs) for each year of construction

Health Services Data Needed

All health entities in the medical service area:

- Hospitals
- Physicians & offices – primary care, specialists, dentists, other health practitioners
- Long-term care facilities; nursing homes, assisted living, mental health or developmentally disabled group homes; etc.

Health Services Data Needed

- Home health care services
- Pharmacies and DME
- Other medical & health services; outpatient rehab, independent laboratories, mental health, etc.
- May want to include Health Dept., Dept. of Human Services or Social Services or Welfare; Community Mental Health Centers, etc.

Construction Data Needed

Hospital Construction Costs

- Could be other than hospital construction; i.e, physician office building, dialysis center, etc.
- Example will illustrate hospital construction costs over two years (could be any number of years)
- Data received from local sources at the local hospital

PRIMARY Health Services Data Needed

- Should include all health services provided to the county (or medical service area)
- Determine construction or capital improvement projects to include
- Usually obtained through conference call(s) and follow-up emails from local contacts

Local Data from Noble County (Direct Economic Activities OR Direct Impact)

Component	Full-Time & Part-Time Employment	Total Personal Income
Hospital	88	$3,624,176
Physicians, Dentists, & Other Medical Practitioners	48	$3,132,571
Nursing Home	90	$2,145,417
Home Health Care	5	$181,927
Other Medical & Health Services	5	$349,524
Pharmacies	18	$967,961
Totals	254	$10,401,576

Local Construction Data for Noble County Hospital (Direct Economic Activities/Direct Impact)

Year	Construction Costs*
2008	$6,000,000
2009	$4,000,000

* Does not include land costs or equipment costs

Derive Economic Impact Multipliers Utilizing IMPLAN Software Version 3.0

- Install IMPLAN3 appliance (Black Box; i.e., external hard drive)
- Installation video is available on the MIG website and from the CD or IMPLAN3 appliance
- Be sure to keep your invoice for the IMPLAN3 software to have your registration number (must register before 9 sessions)

Derive Economic Impact of Health Services on Local Economy

Prepare IMPLAN model

1) Need IMPLAN3 software and appliance installed and check for updates
2) Need IMPLAN data available on IMPLAN3 appliance
3) Install Structural Matrices for data year
4) Run IMPLAN model and derive multipliers
5) Prepare economic impact tables in Excel

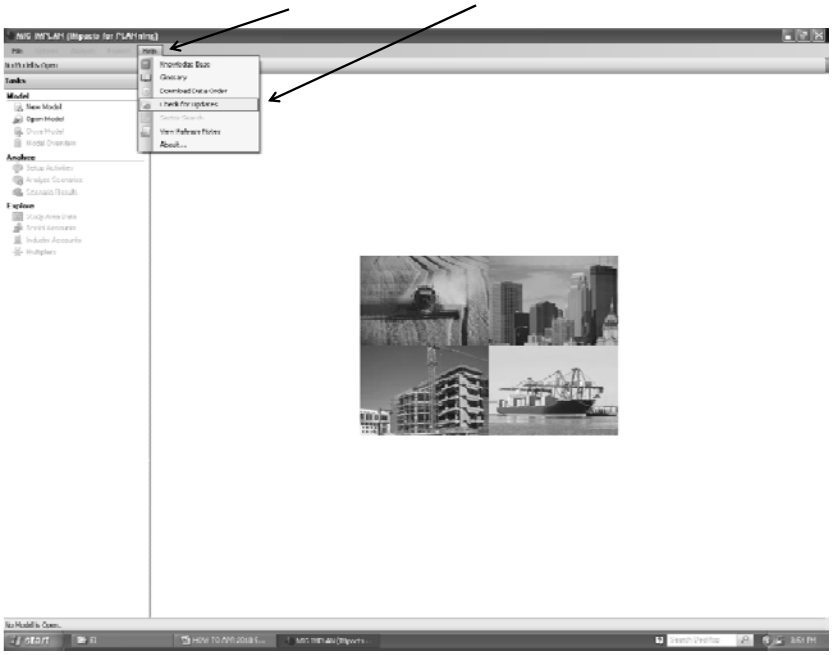
Utilize Implan Software, Version 3.0 (IMPLAN3)

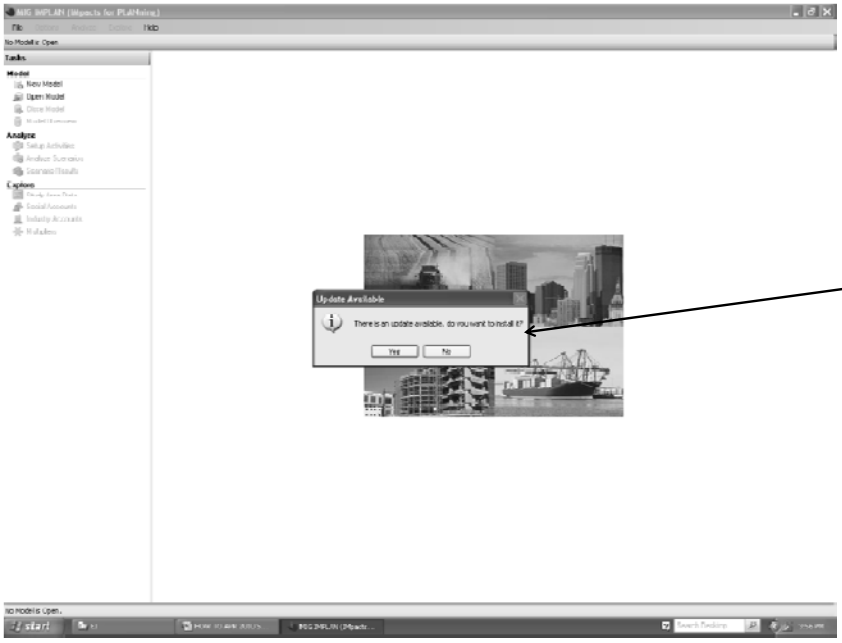
This illustration is based on the IMPLAN3 Software (Version 3.0)

Once installed, open IMPLAN3 by clicking on the IMPLAN3 icon

Check for Updates

- Once IMPLAN3 is open, go to ‘Help’
- Then select ‘Check for Updates’
- If box appears showing an update is available, then select “Yes” to install the update

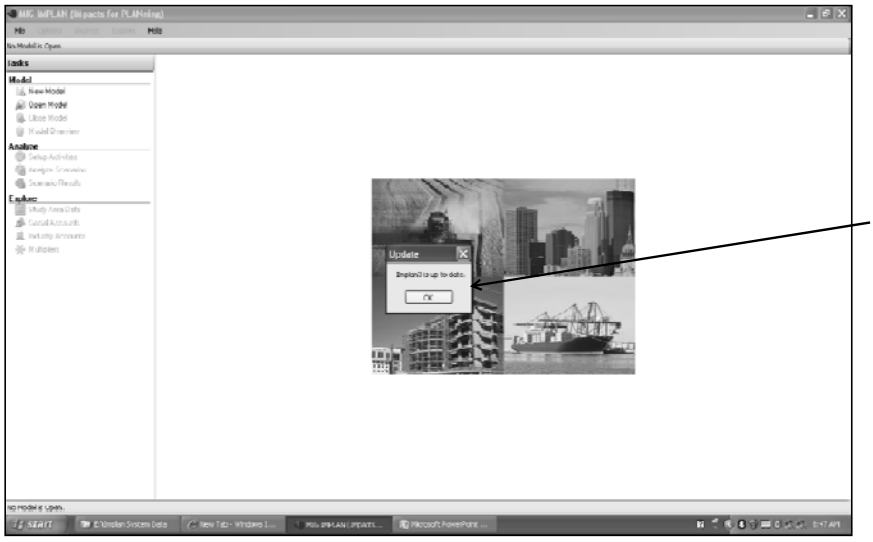



Update Available
There is an update available. do you want to install it?
Yes
No

Check for Updates

- If no updates, box will appear:
  'IMPLAN3 is up to date'

Check "OK"



Implan Data Availability

Need IMPLAN data available

Download data from CD received from Minnesota IMPLAN Group, Inc. (MIG) and save to IMPLAN3 Appliance to folder:

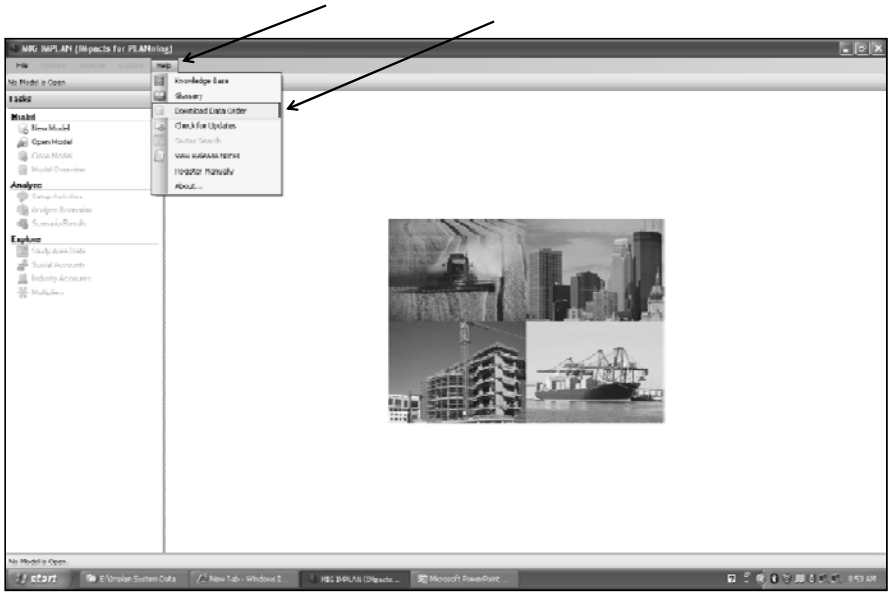
IMPLAN Data Files

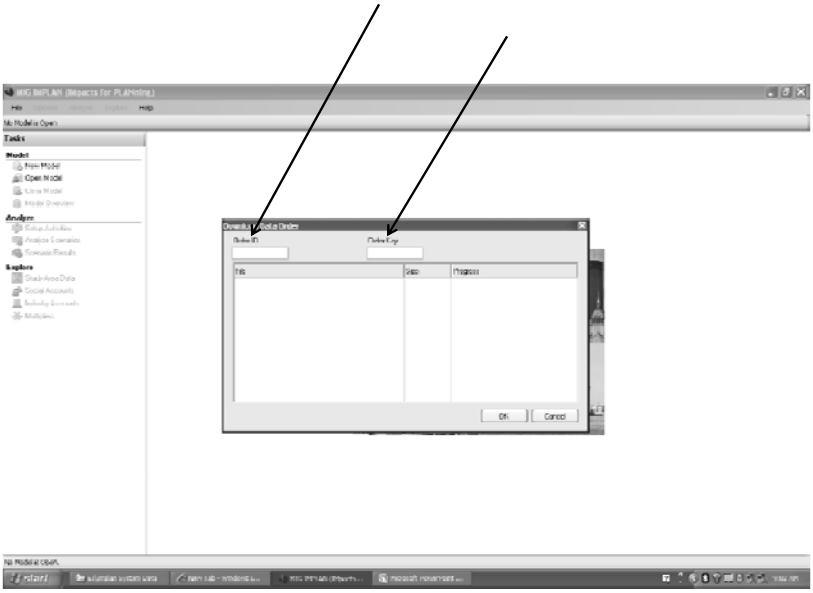
OR

Order data from MIG website; Invoice will be sent and then download data in Software

Download IMPLAN Data in IMPLAN3 Software

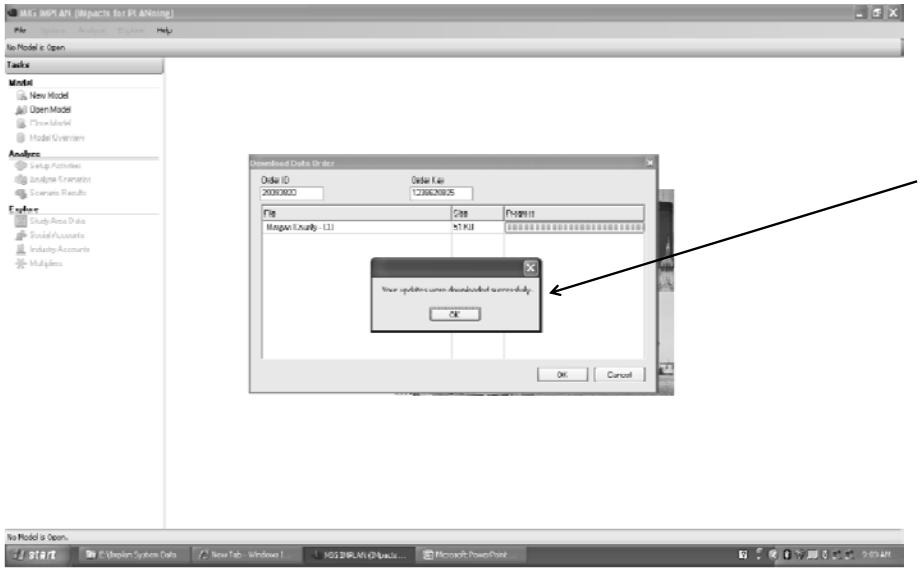
- In IMPLAN3 software, click on ‘Help’
- Then ‘Download Data Order’
- A box will appear in center
- From the invoice, use the Order Number and type in the ‘Order ID’ box
- From the invoice, use the Order Key and type in the ‘Order Key’ box





Download IMPLAN Data in IMPLAN3 Software

- If Order ID and Order Key are correct, the software will automatically download your data into the IMPLAN data files on the IMPLAN3 appliance (Black Box)
- Then click ‘OK’ (On your screen will appear ‘Your updates were downloaded successfully.’)



Structural Matrices Installed

- Each year new IMPLAN data are available and new Structural Matrices are required
- Should be updated when you download software updates.
- If you receive new data and the model does not work, check to be sure you have the latest structural matrices!

Have Local Primary Data Available Before Running IMPLAN Model

- Need full-time and part-time employment
- Need wages, salaries, and benefits
- Need proprietor income, if applicable or available
- Need this data for all health entities within the medical service area

Local Data from Noble County
(Direct Economic Activities OR Direct Impact)

Component	Full-Time & Part-Time Employment	Total Personal Income*
Hospital	88	$3,624,176
Physicians, Dentists, & Other Medical Practitioners	48	$3,132,571
Nursing Home	90	$2,145,417
Home Health Care	5	$181,927
Other Medical & Health Services	5	$349,524
Pharmacies	18	$967,961
Totals	254	$10,401,576

* Total Personal Income includes total wages, salaries, and benefits, proprietor income, and contractual employees' income

READY to Run IMPLAN model

- IMPLAN3 software and appliance are installed and updated
- IMPLAN data is purchased and downloaded onto the IMPLAN3 appliance
- Structural Matrices are installed

IMPLAN - Industry Sectors

All industry sectors are based on current government classification system:

North American Industry Classification System (NAICS)

Economic Impact Study

OBJECTIVES:

Derive the **direct, secondary,** and **total** economic impact of the health services in Noble County on employment and income.

Derive **the direct, secondary,** and **total** economic impact of construction activities on employment and income.

Run IMPLAN Model - Overview

- Have local data available (direct economic activities OR Direct Impact)
- Open the IMPLAN3 software
- Build the study area (New Model)
- Verify selected sector data in IMPLAN
- Create shadow industry sector, if necessary
- Construct model to derive Type SAM (Type II) multipliers
- Utilize multipliers from reports in economic impact tables in Excel
- Calculate local retail sales capture ratio and use to calculate retail sales and sales tax in the economic impact tables in Excel

Run the IMPLAN Model – Build the study area

- IMPLAN3 software should be open or

  Select the 'IMPLAN3 icon'

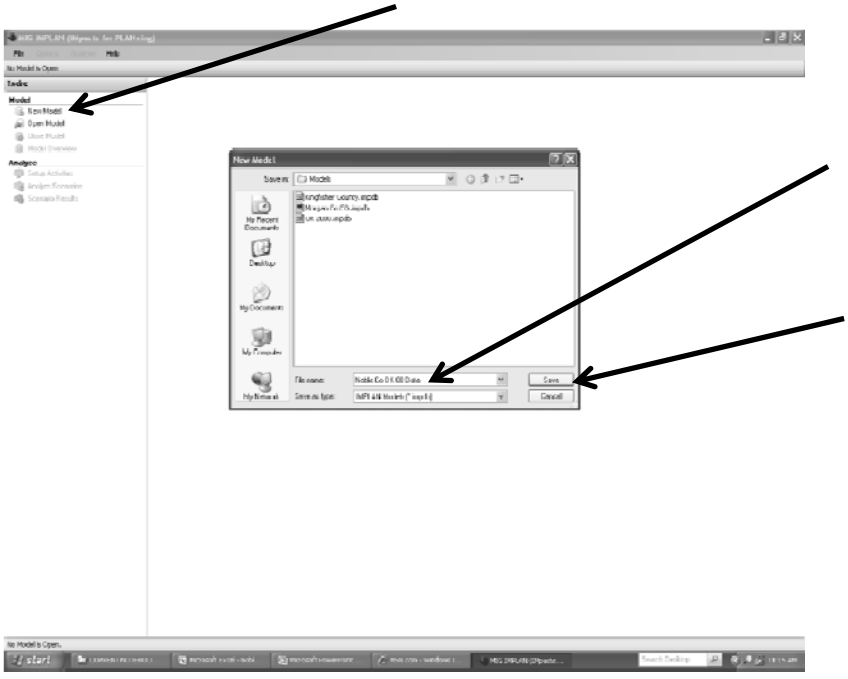
  Select 'New Model'

  Go to 'File Name' and enter a name for the study area

  <Noble Co OK 08 Data>

  Select 'Save'

  You just built the study area that you will be working on (IMPLAN saves this as a model on the IMPLAN3 appliance under 'IMPLAN User Data', 'Models'). The model will be saved there if you need to use it again later.



Run the IMPLAN Model – Select IMPLAN Data

A box ‘Available IMPLAN Data Files’ will appear

Select ‘Change Data Folder’

A ‘Browse for Folder’ box will appear

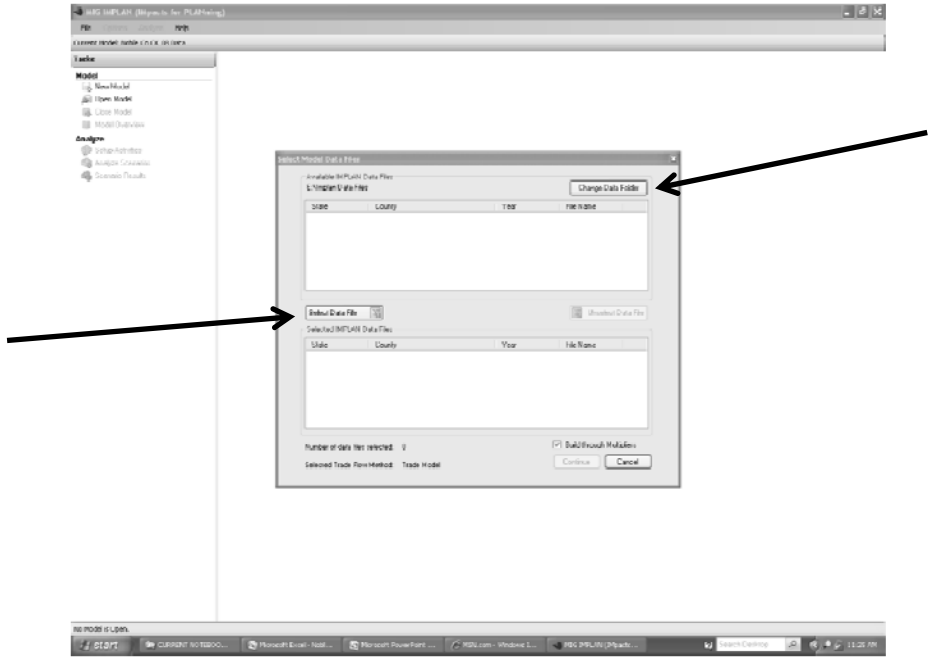
Select ‘IMPLAN3 appliance’ folder

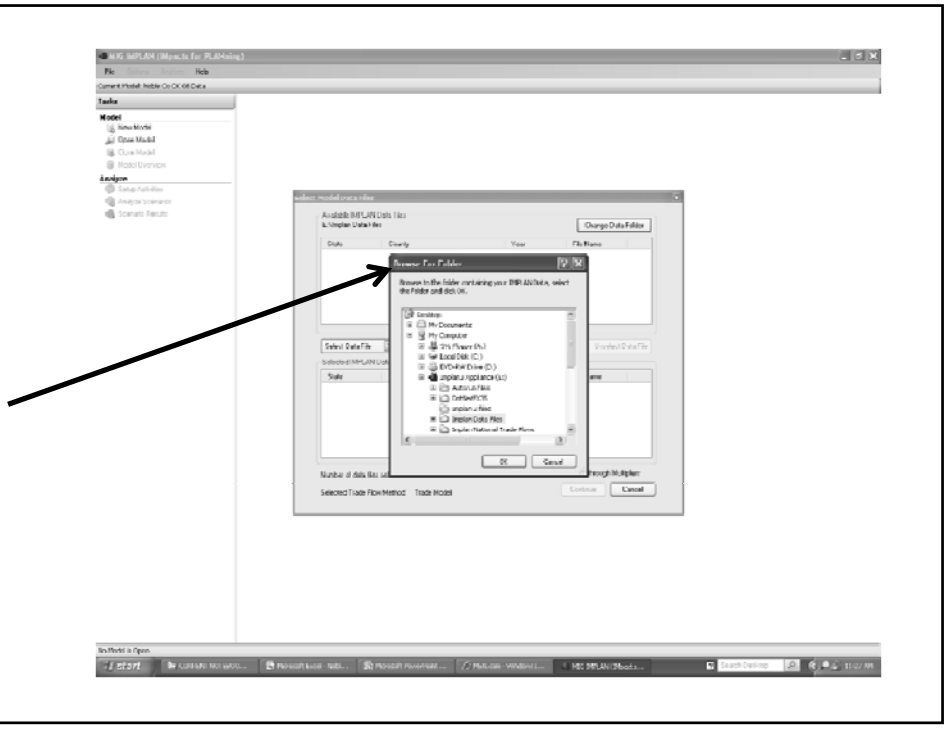
Select ‘IMPLAN Data Files’ folder

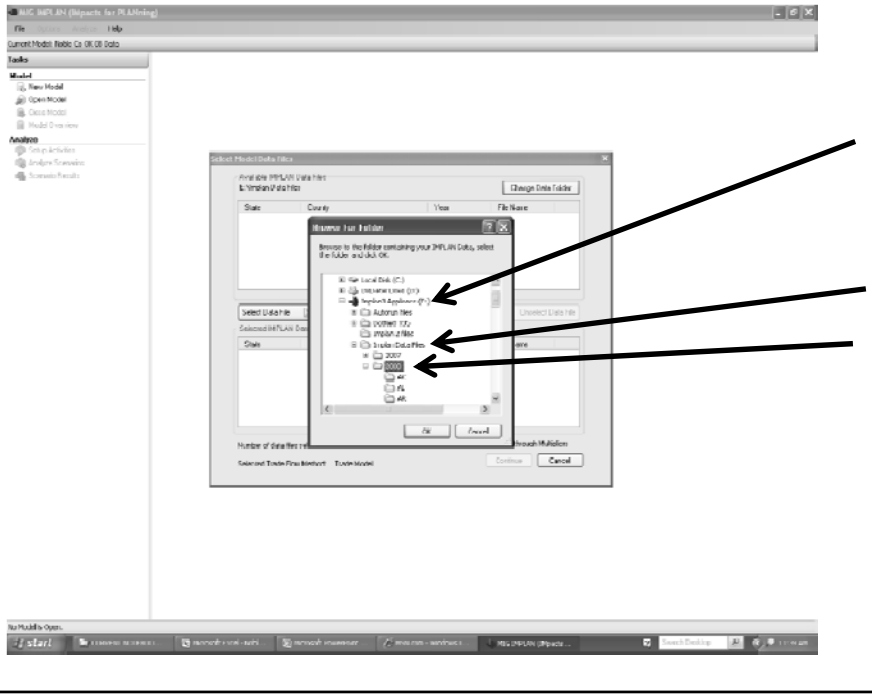
Select ‘2008’

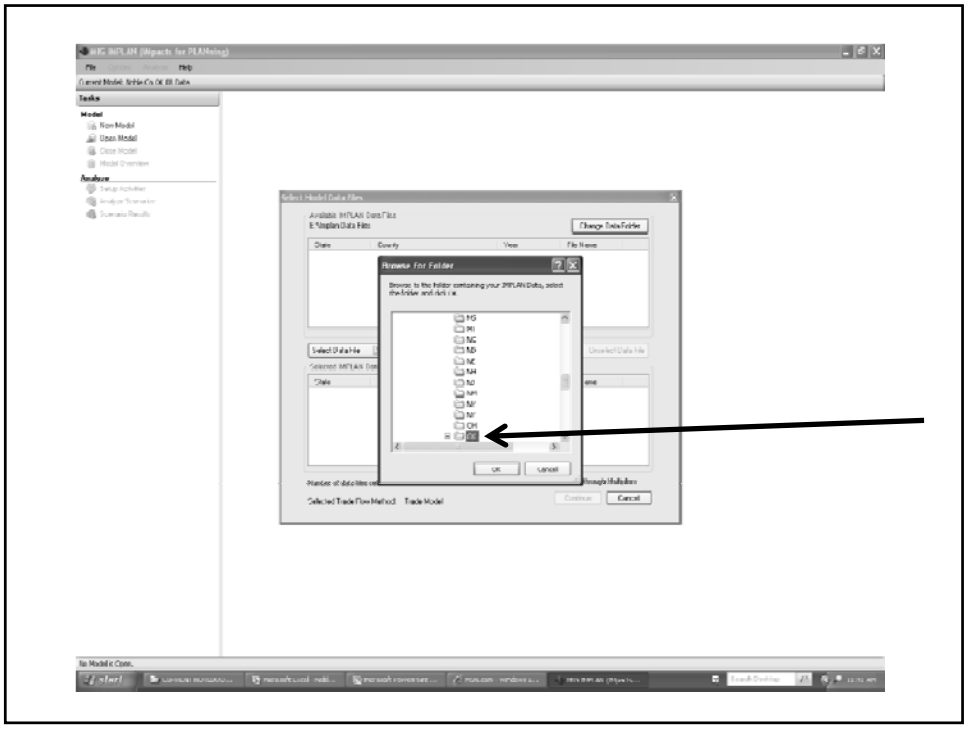
Select state ‘OK’

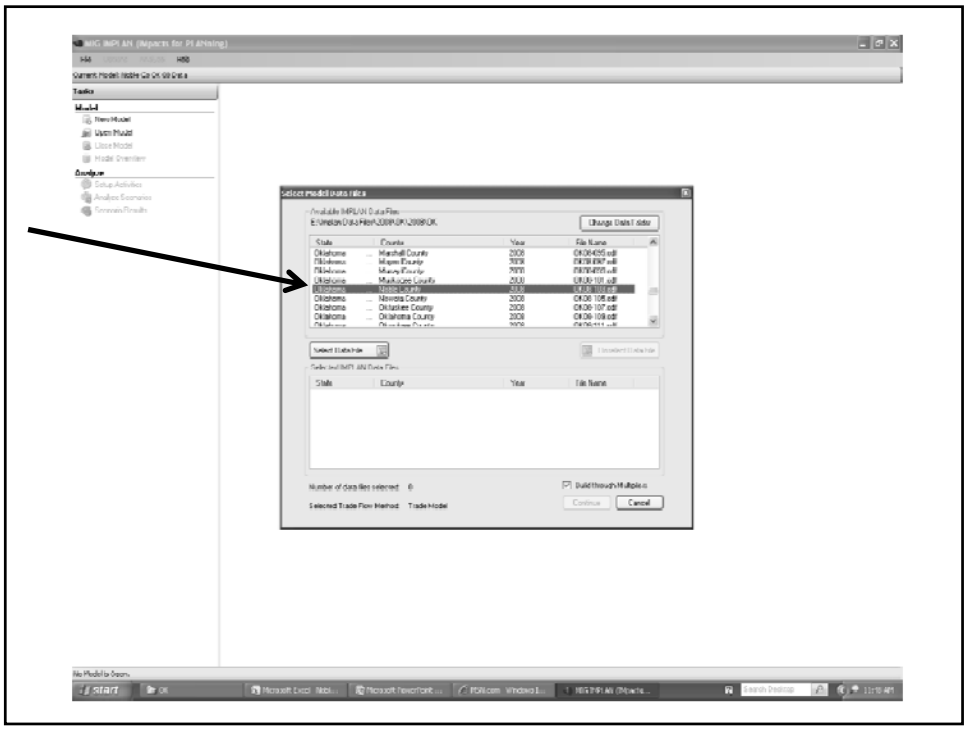
The data for OK will populate the upper window in the ‘Available IMPLAN Data Files’

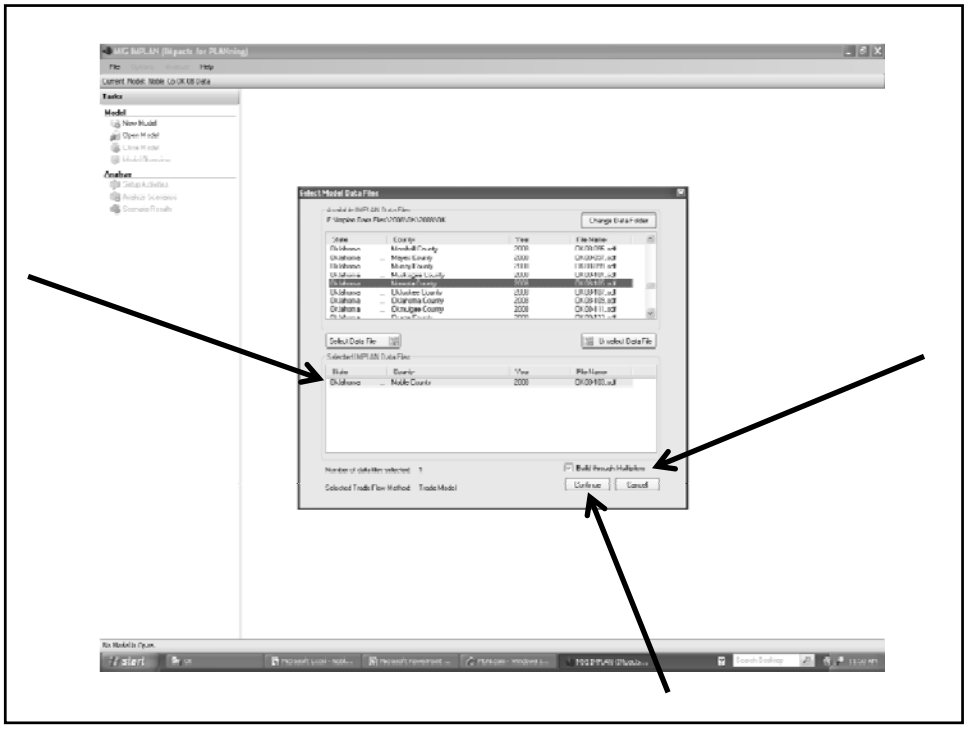


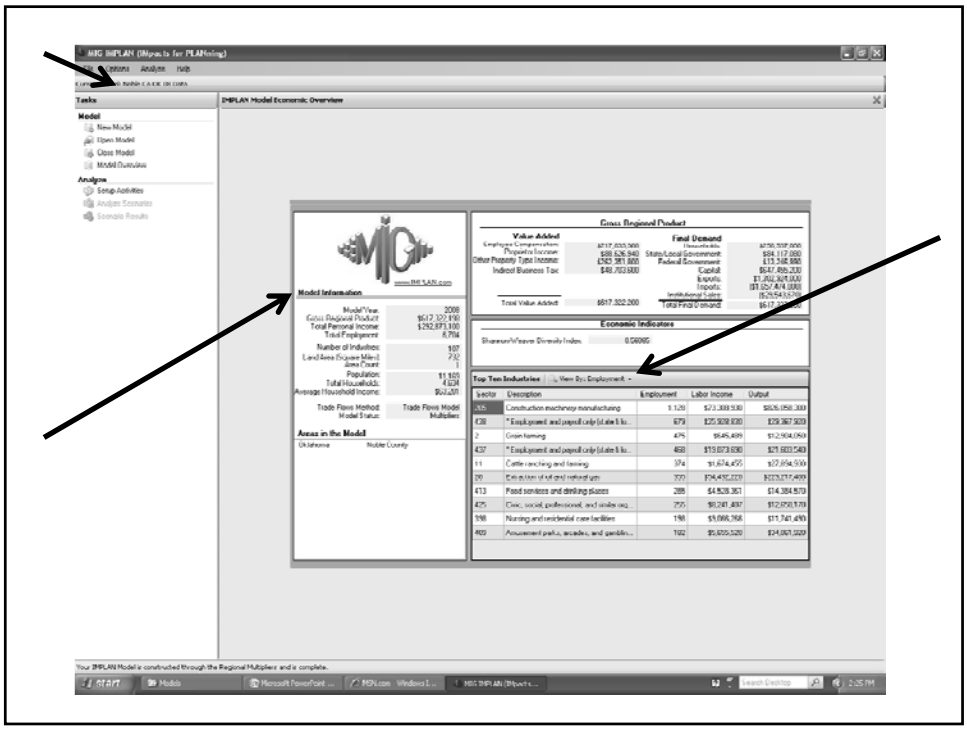








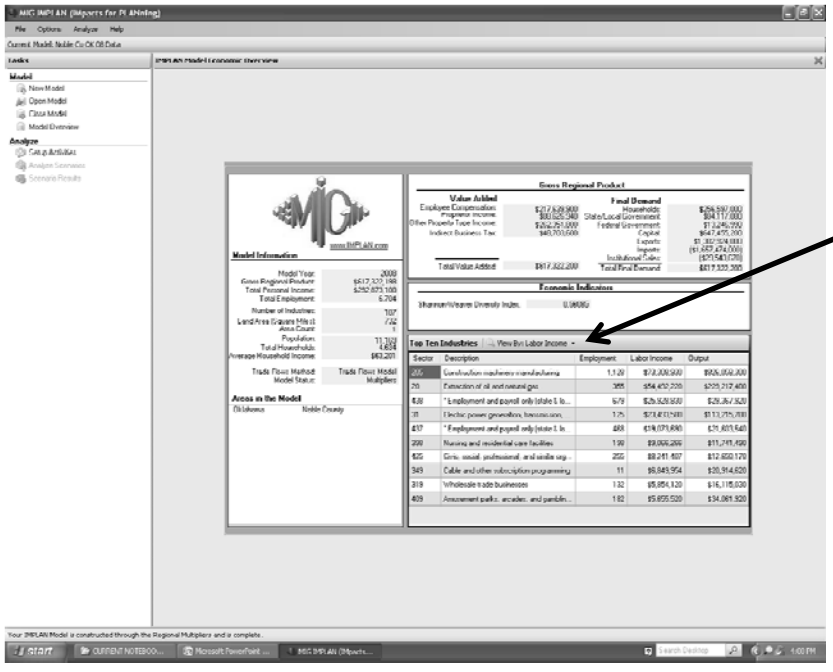

Select Model Data Files
Select Data File
Unselect Data File
Build Person Multipliers
Continue
Cancel

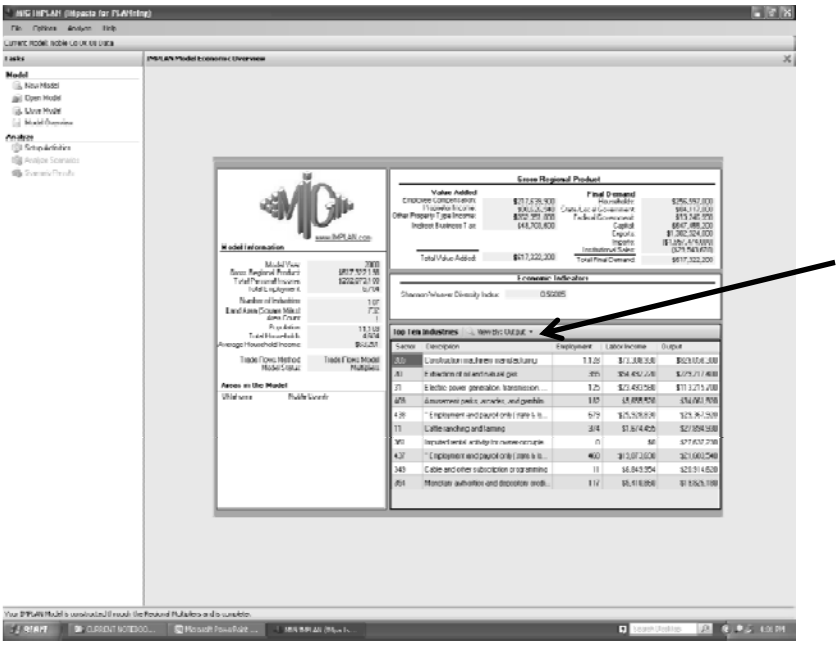

IMPLAN Model Economic Overview
Gross Regional Product
Value Added
Final Demand
Economic Indicators
Model Information
Areas in the Model
Top Ten Industries

Run the IMPLAN Model – Review IMPLAN Data

'IMPLAN Model Economic Overview' screen shows:

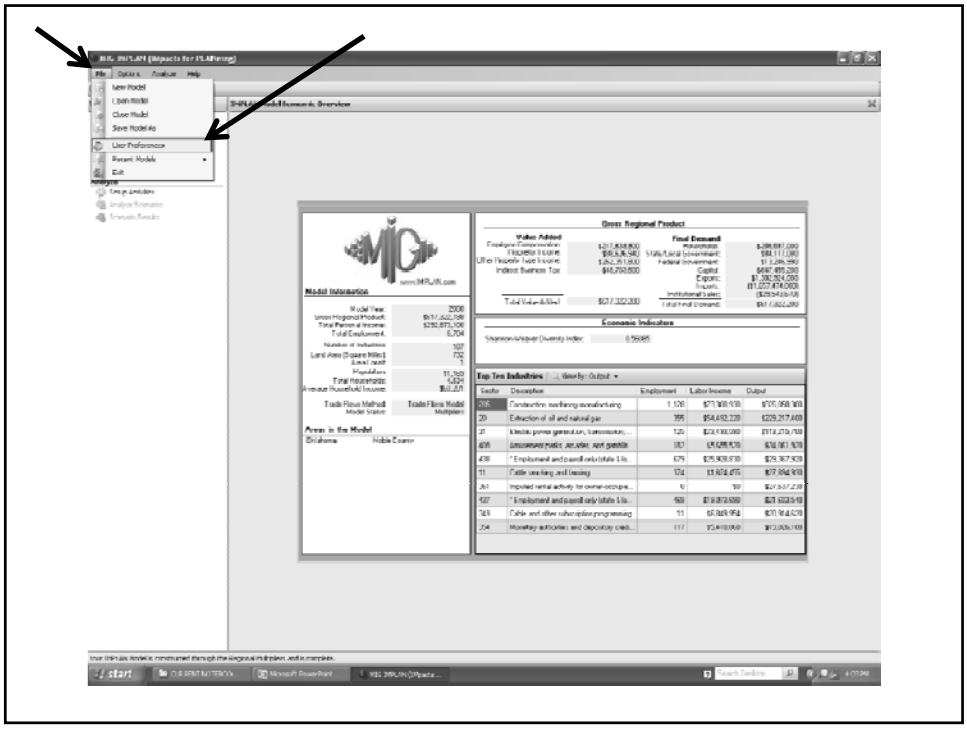
- 'Model Information' on the left hand side
- 'Gross Regional Product' at the top right including 'Value Added' and 'Final Demand' and 'Economic Indicators'
- 'Top Ten Industries' by:
  - Employment
  - Labor income
  - Output

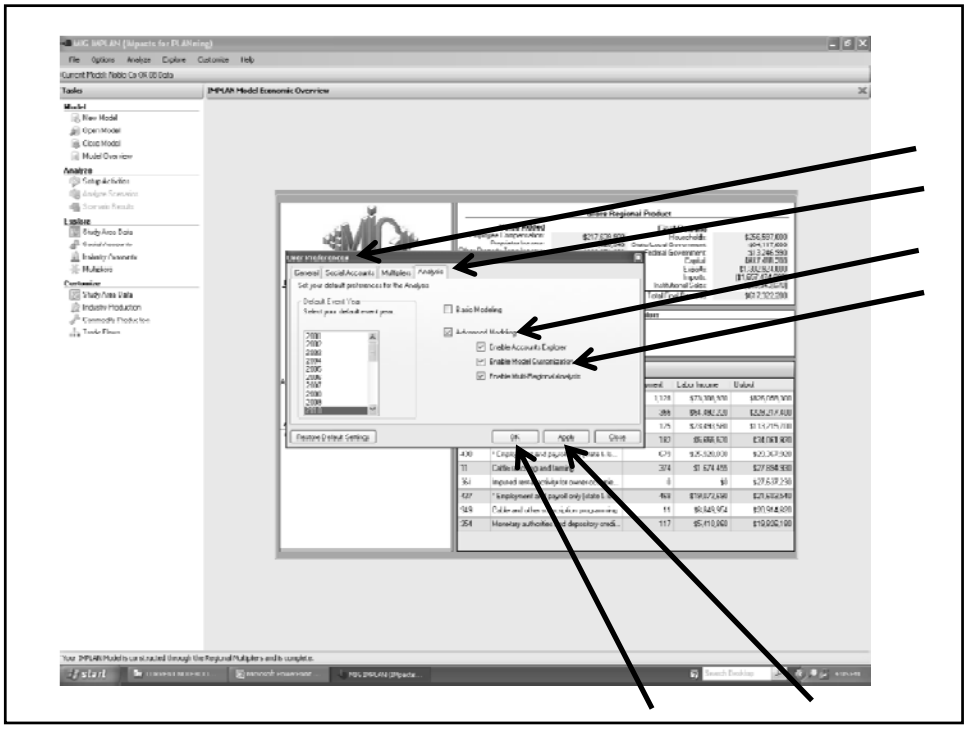


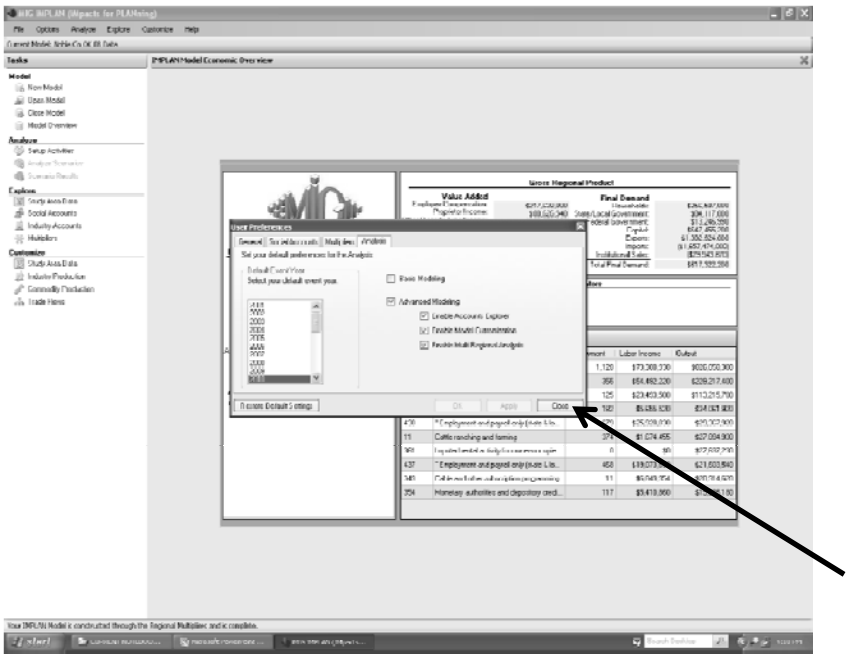


Run the IMPLAN Model – Review IMPLAN Data

To view and modify IMPLAN data,
select ‘File’, then ‘User Preferences’
In ‘User Preferences’ box, select ‘Analysis’
then ‘Advanced Modeling’
Select on all 3 categories under ‘Advanced Modeling’:
‘Enable Accounts Explorer’
‘Enable Model Customization’
‘Enable Multi-Regional Analysis’
Select ‘Close’

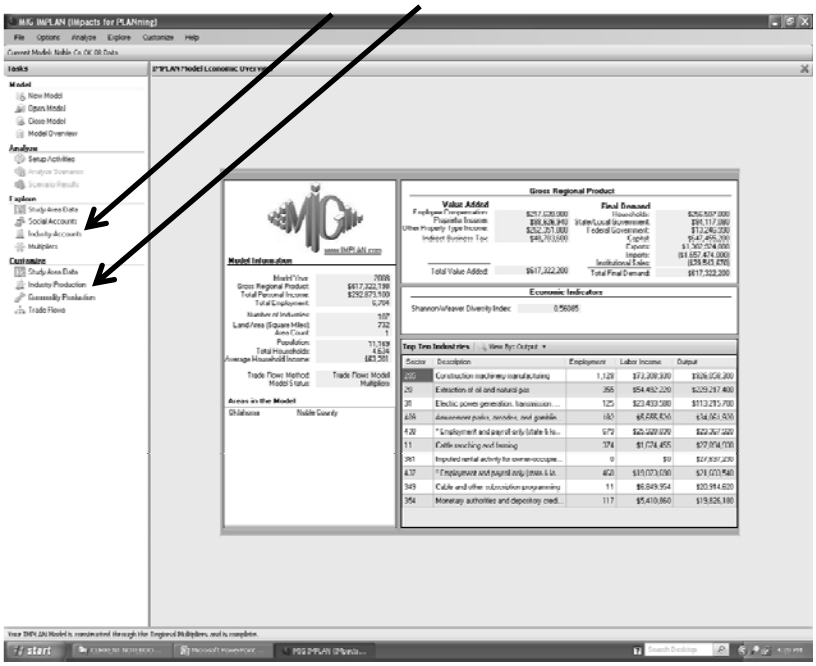






Run the IMPLAN Model – Review IMPLAN Data

Should now have access to the ‘Explore’ and ‘Customize’ fields



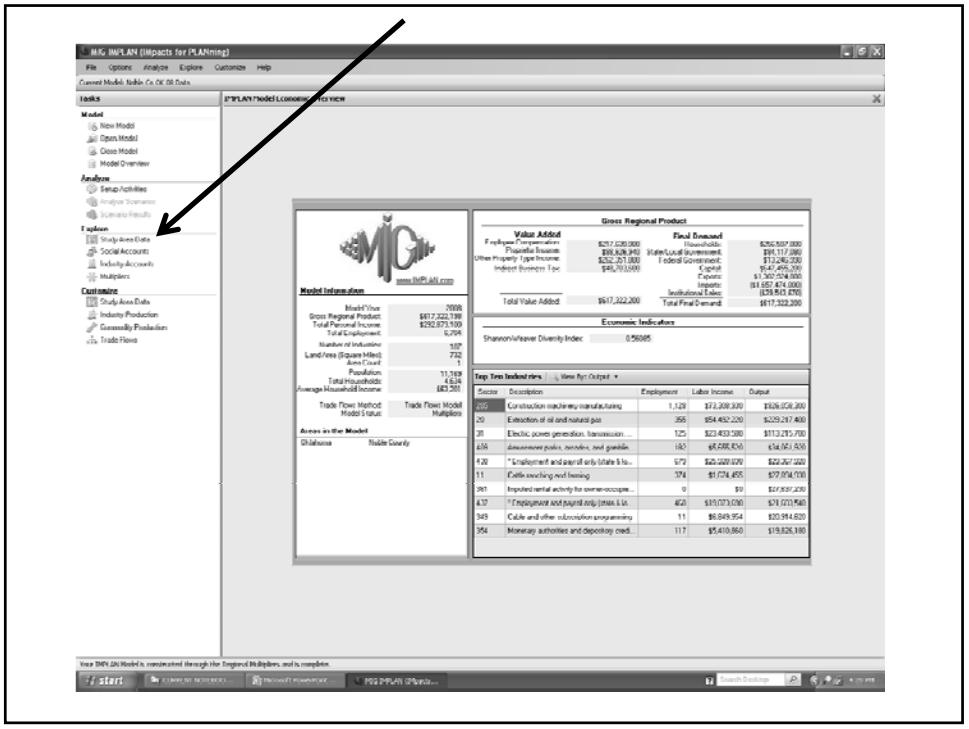
Run the IMPLAN Model – Review IMPLAN Data

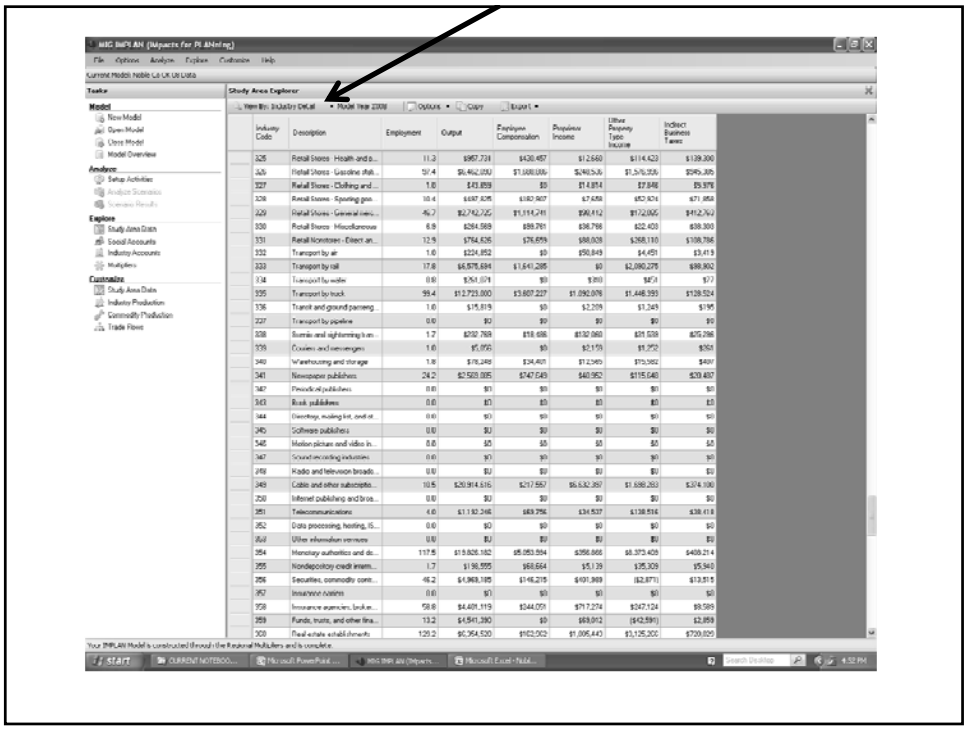
Under ‘Explore’, select ‘Study Area Data’

In the ‘View by:’ menu, select ‘Industry Detail’

This shows each industry sector including:

- Employment
- Output
- Employee Compensation
- Proprietor Income
- Other Property Type Income
- Indirect Business Taxes





Verify Industry Sector Data Needed for Study

First, determine industry sectors needed for study

Direct Economic Activities of the Health Sector in the Perry Memorial Hospital Medical Service Area

Industry Sector	Component	Full-Time & Part-Time Employment	Total Personal Income
397 Private Hospitals	Hospital	88	$3,624,176
394 Offices of physicians, dentists, and other health practitioners	Physicians, Dentists, & Other Medical Professionals	48	$3,132,571
398 Nursing and residential care facilities	Nursing and Protective Care	90	$2,145,417
395 Home health care services	Home Health	5	$181,927
396 Other medical and health services (Med/diag labs; outpatient/other ambulatory care	Other Medical & Health Services	5	$349,524
325 Retail stores – health/personal care (Pharmacies)	Pharmacies	18	$967,961
	Totals	254	$10,401,576

Verify Industry Sector Data Needed for Study

Industry sectors needed for study

- 325 Pharmacies
- 394 Offices of physicians, dentists & other
- 395 Home health
- 396 Other medical & health services
- 397 Private hospitals
- 398 Nursing & residential care facilities

Verify Industry Sector Data Needed for Study

Arrow down to the Industry Sectors needed for the Noble County Study

First, check **325** for Pharmacies

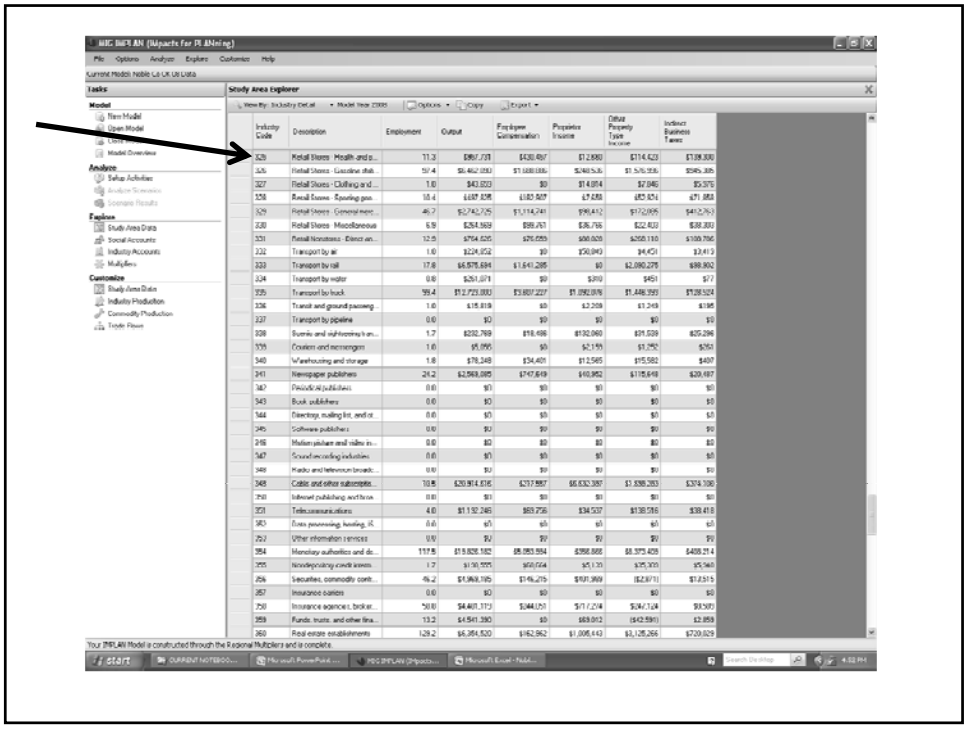
Arrow down to Sector 325; verify sector has data

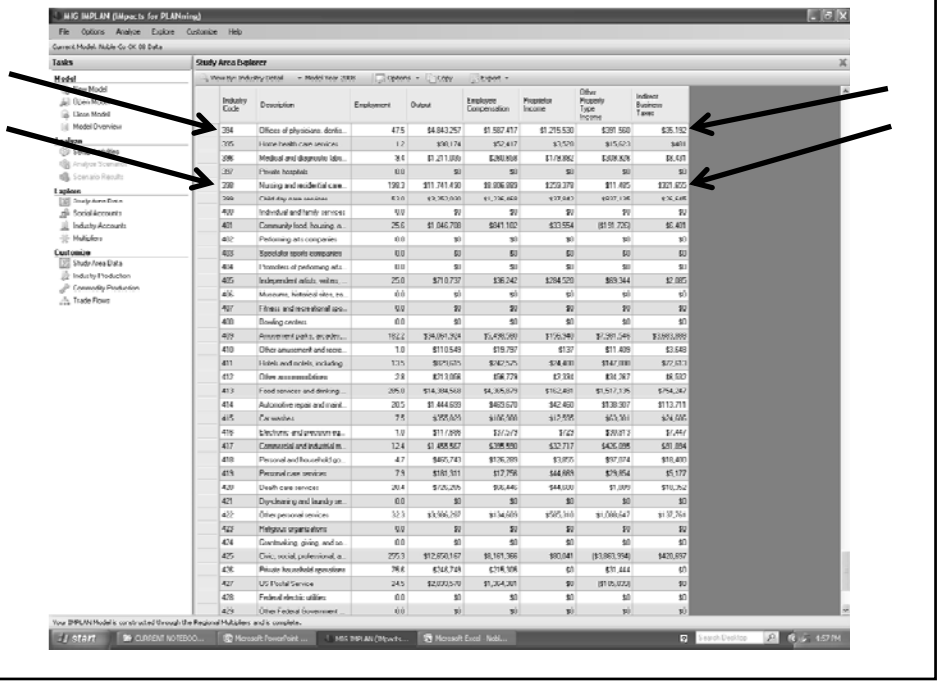
Repeat this step for all the sectors needed:

394, **395**, **396**, **397**, **398**

All sectors have data EXCEPT 397 Private Hospitals

Hospital is a city-owned hospital; does not show under 397 Private Hospitals


MIG IMPLAN (IMpacts For PLANning)
File Options Analyze Explore Customize Help
Tasks
Study Area Explorer
Industry Code
Description
Employment
Output
Employee Compensation
Proprietor Income
Other Property Type Income
Indirect Business Taxes


MIG IMPLAN (IMpacts for PLANning)
File Options Analyze Explore Customize Help
Tasks
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Industry Code
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Employee Compensation
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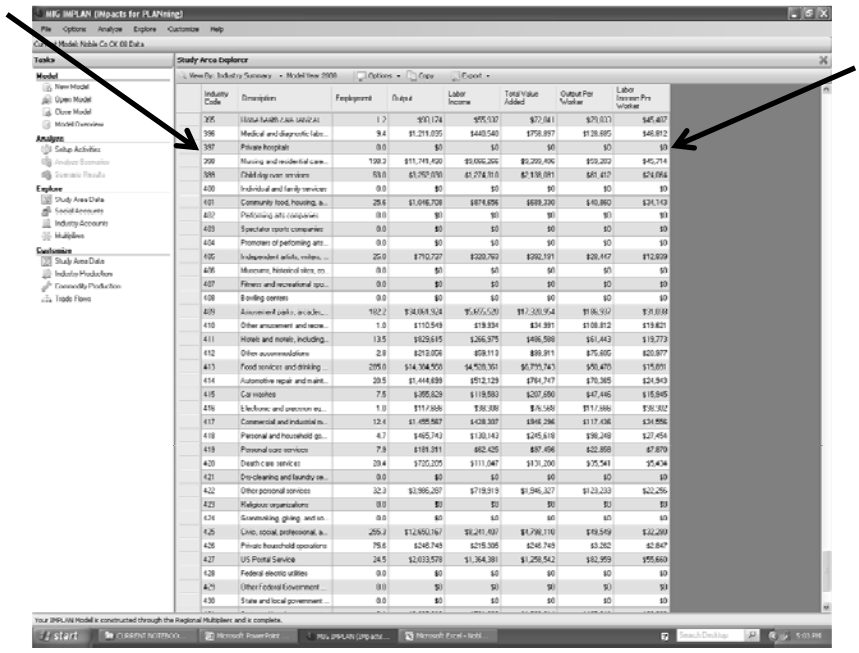
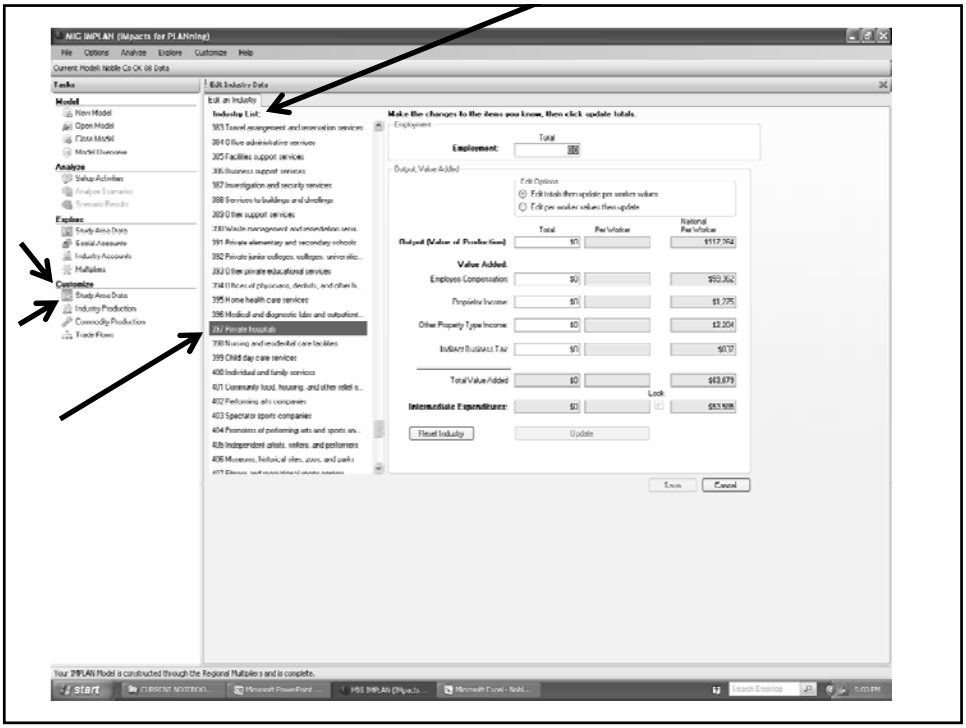


Create Shadow Industry for Hospital

Under ‘Customize’, ‘Study Area Data’, arrow down to ‘Edit an Industry’

Go to ‘Sector 397’, which should have NO data



Data Needed to Edit an Industry

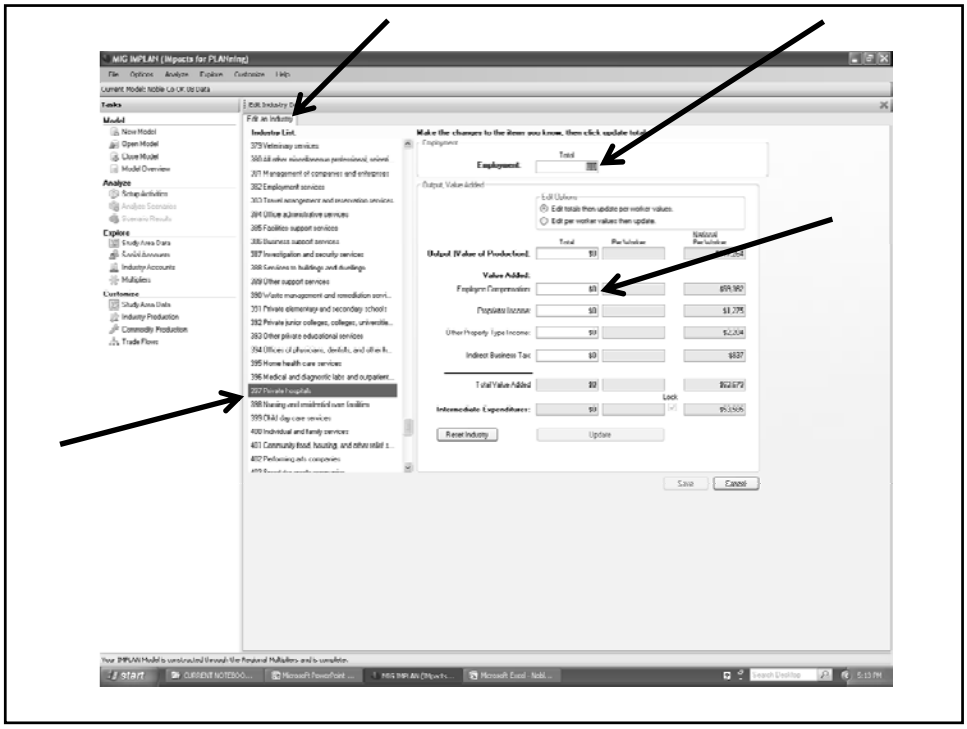
Need:

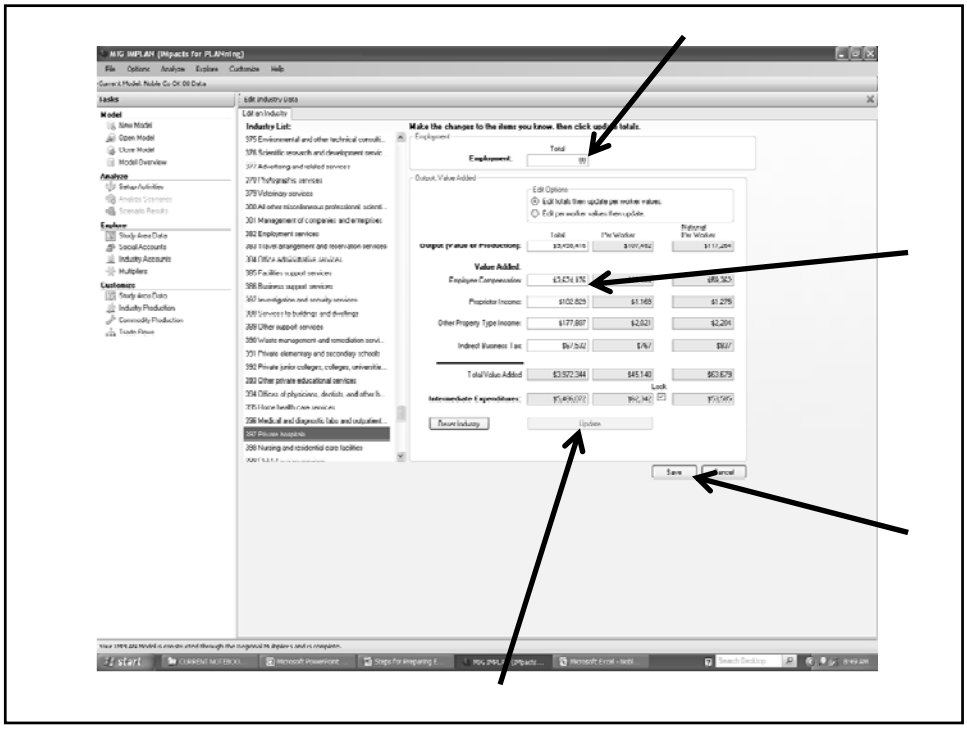
- Employment
- EE Compensation

Have:

- Employment: 88
- EE Compensation: $3,624,176

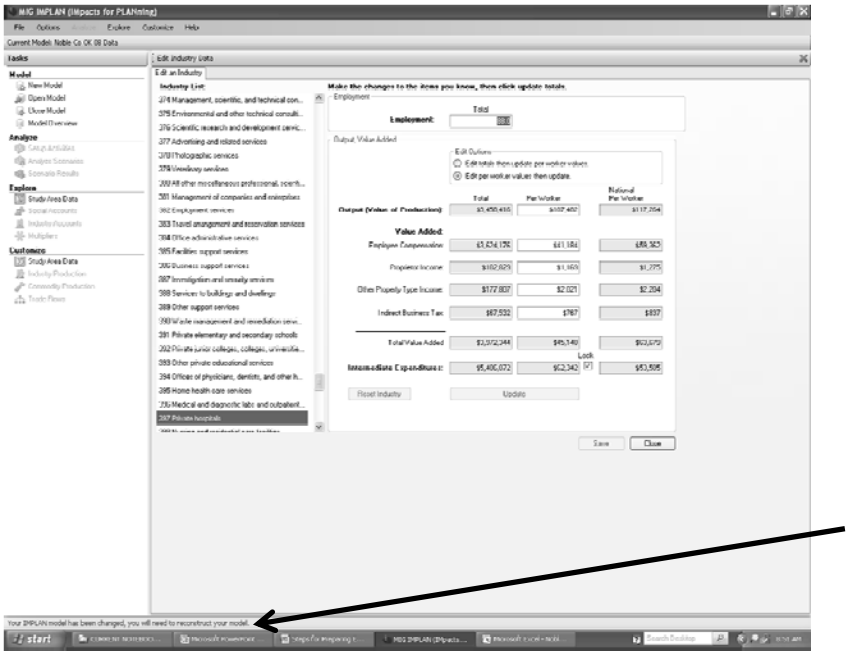
Go back to the Noble County Model, under "Customize'. 'Study Area Data'. 'Edit an Industry,' and edit the hospital industry sector 397


MIG IMPLAN (Impacts for PLANning)
Edit an Industry
Industry List:
Make the changes to the items you know. Then click update totals.
Employment:
Output, Value Added
Edit Options
Edit totals then update per worker values.
Edit per worker values then update.
Total
Per Worker
National Per Worker
Output (Value of Production):
Value Added:
Employee Compensation:
Proprietor Income:
Other Property Type Income:
Indirect Business Tax:
Total Value Added:
Intermediate Expenditures:
Lock
Reset Industry
Update
Save
Cancel


MIG IMPLAN (Impacts for PLANning)
Edit an Industry
Industry List:
Make the changes to the items you know. Then click update totals.
Employment:
Output, Value Added
Edit Options
Edit totals then update per worker values.
Edit per worker values then update.
Value Added:
Employee Compensation:
Proprietor Income:
Other Property Type Income:
Indirect Business Tax:
Total Value Added:
Intermediate Expenditures:
Lock
Reset Industry
Update
Save
Cancel

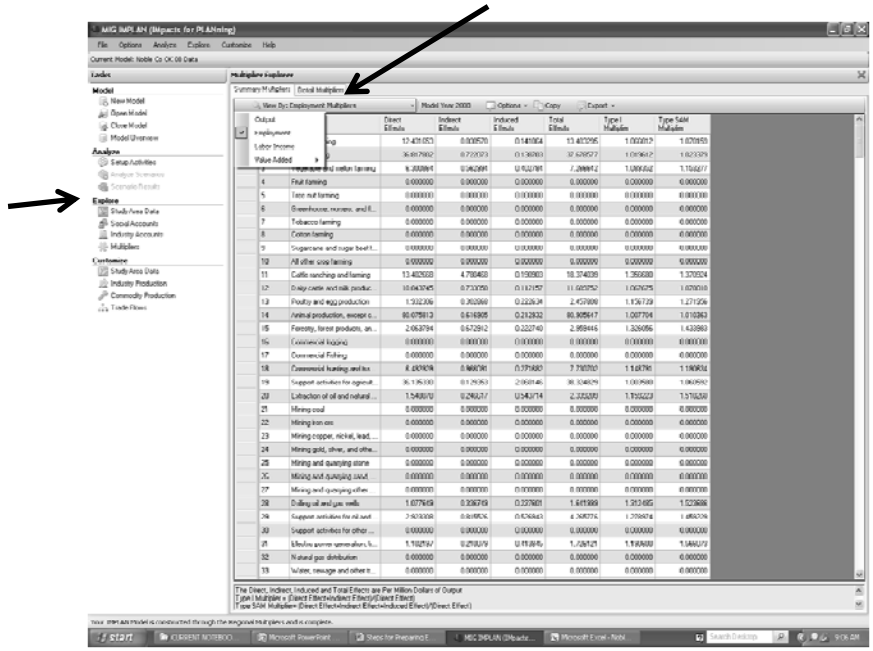
After Editing Hospital Industry

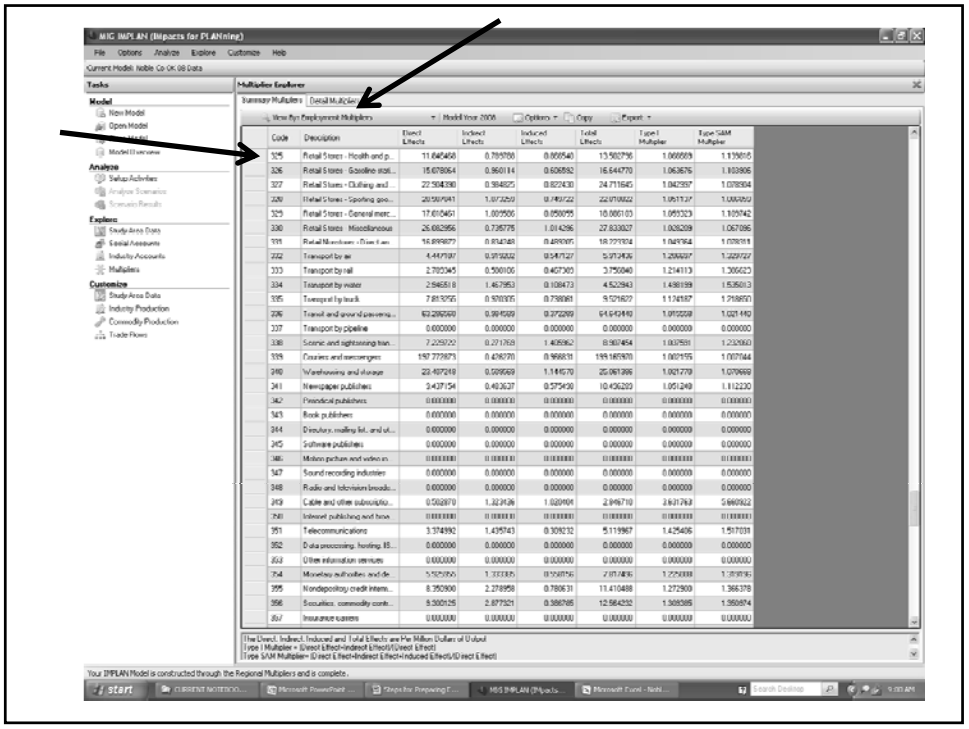
- After saving the edits to the hospital industry, on the bottom of the screen in RED will appear ‘Your IMPLAN model has been changed, you will need to reconstruct your model’
- Then ‘close’ the window

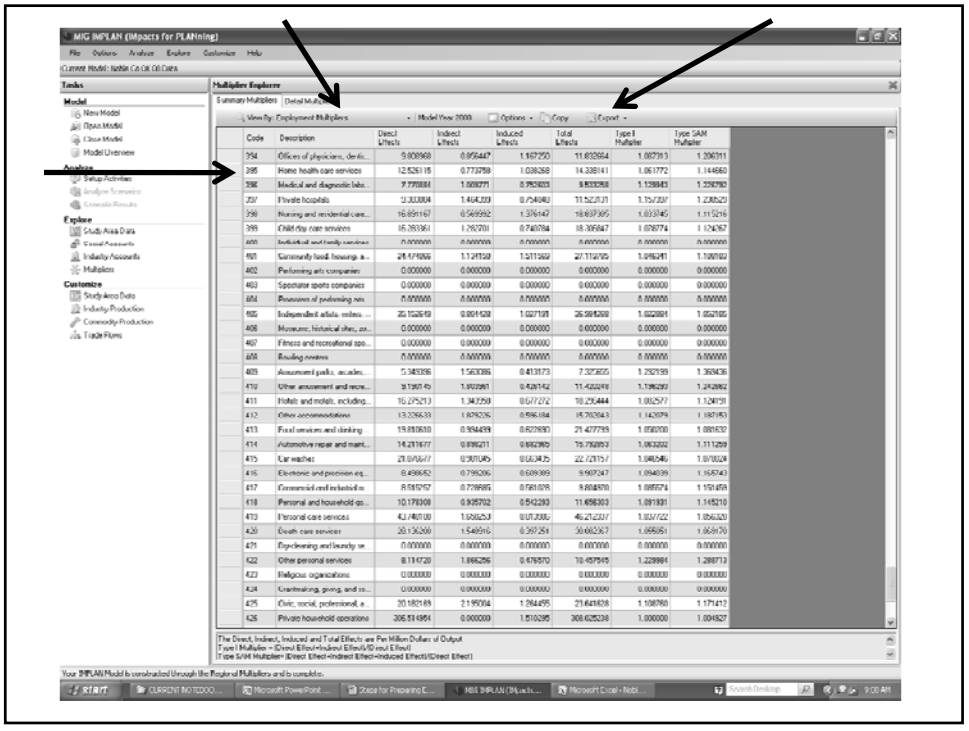


ReConstruct the Multipliers

- To reconstruct the multipliers, go to ‘Options’, ‘Construct’, ‘Multipliers’
- Wait for the model to reconstruct multipliers
- Go to “Explore”, ‘Multipliers”, Select ‘Employment Multipliers’
- Arrow down to each Industry Sector for multipliers or export (download) reports

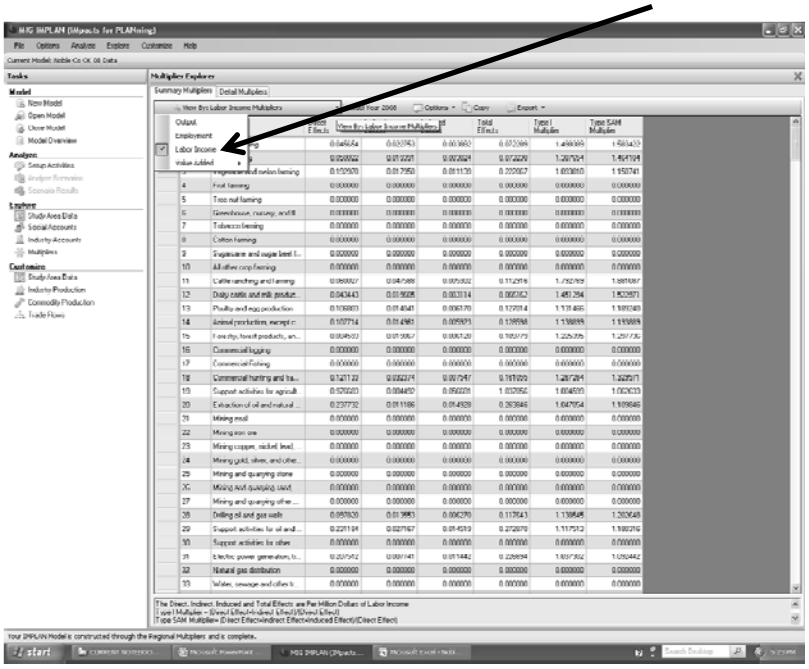


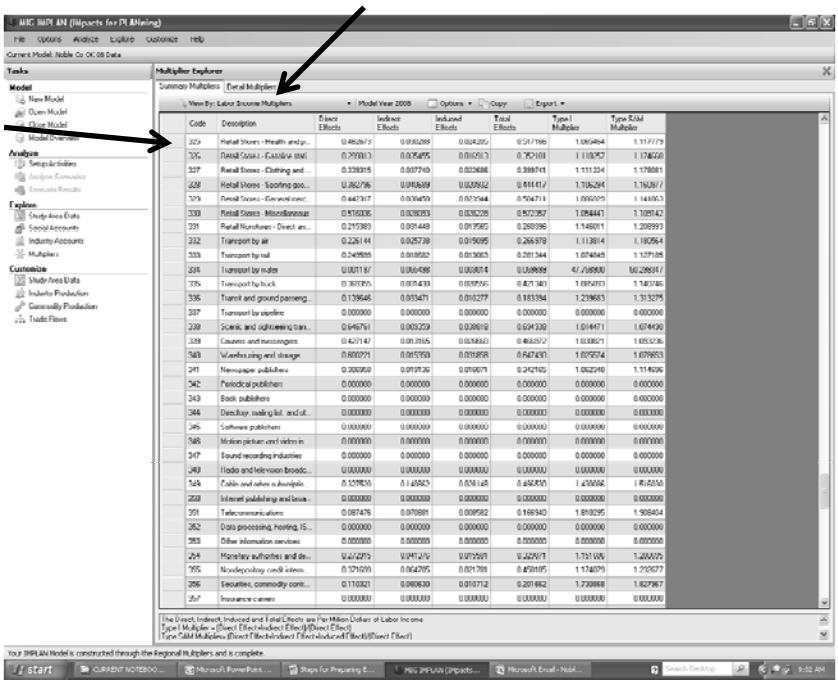

MIG IMPLAN (IMpacts for PLANning)
File Options Analyze Explore Customize Help
Tasks
Model
New Model
Open Model
Close Model
Model Overview
Analyze
Setup Activities
Analyze Scenarios
Scenario Results
Explore
Study Area Data
Social Accounts
Industry Accounts
Multipliers
Customize
Study Area Data
Industry Production
Commodity Production
Trade Flows
Multiplier Explorer
Summary Multipliers
Detail Multipliers
View By: Employment Multipliers
Model Year 2008
Options
Copy
Export
Code
Description
Direct Effects
Indirect Effects
Induced Effects
Total Effects
Type I Multiplier
Type SAM Multiplier
The Direct, Indirect, Induced and Total Effects are Per Million Dollars of Output
Type I Multiplier = (Direct Effect+Indirect Effect)/(Direct Effect)
Type SAM Multiplier= (Direct Effect+Indirect Effect+Induced Effects)/(Direct Effect)
Your IMPLAN Model is constructed through the Regional Multipliers and is complete.
start

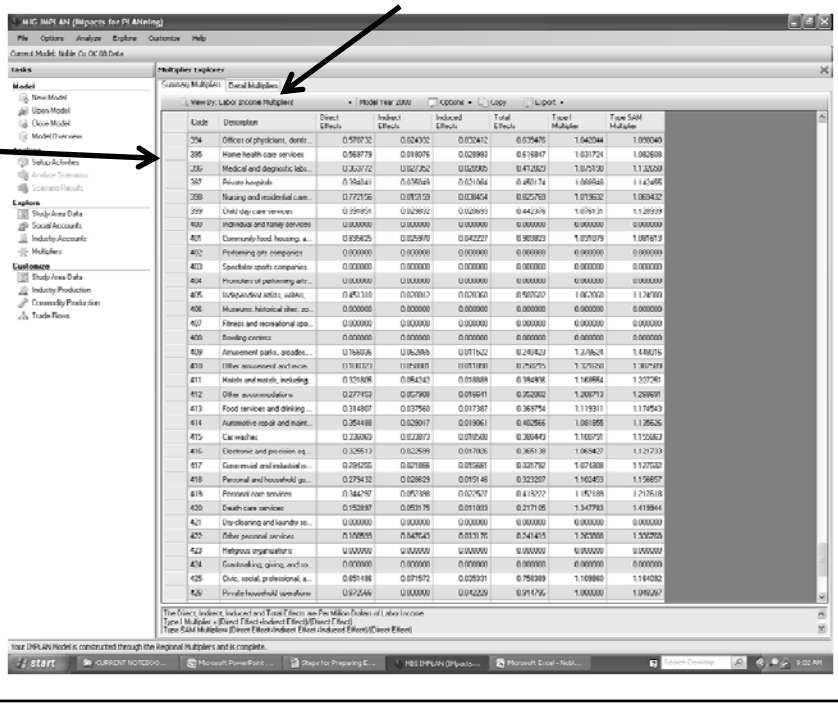

MIG IMPLAN (IMpacts for PLANning)
File Options Analyze Explore Customize Help
Tasks
Model
New Model
Open Model
Close Model
Model Overview
Analyze
Setup Activities
Analyze Scenarios
Scenario Results
Explore
Study Area Data
Social Accounts
Industry Accounts
Multipliers
Customize
Study Area Data
Industry Production
Commodity Production
Trade Flows
Multiplier Explorer
Summary Multipliers
Detail Multipliers
View By: Employment Multipliers
Model Year 2008
Options
Copy
Export
Code
Description
Direct Effects
Indirect Effects
Induced Effects
Total Effects
Type I Multiplier
Type SAM Multiplier
The Direct, Indirect, Induced and Total Effects are Per Million Dollars of Output
Type I Multiplier = (Direct Effect+Indirect Effect)/(Direct Effect)
Type SAM Multiplier= (Direct Effect+Indirect Effect+Induced Effects)/(Direct Effect)
Your IMPLAN Model is constructed through the Regional Multipliers and is complete.
start

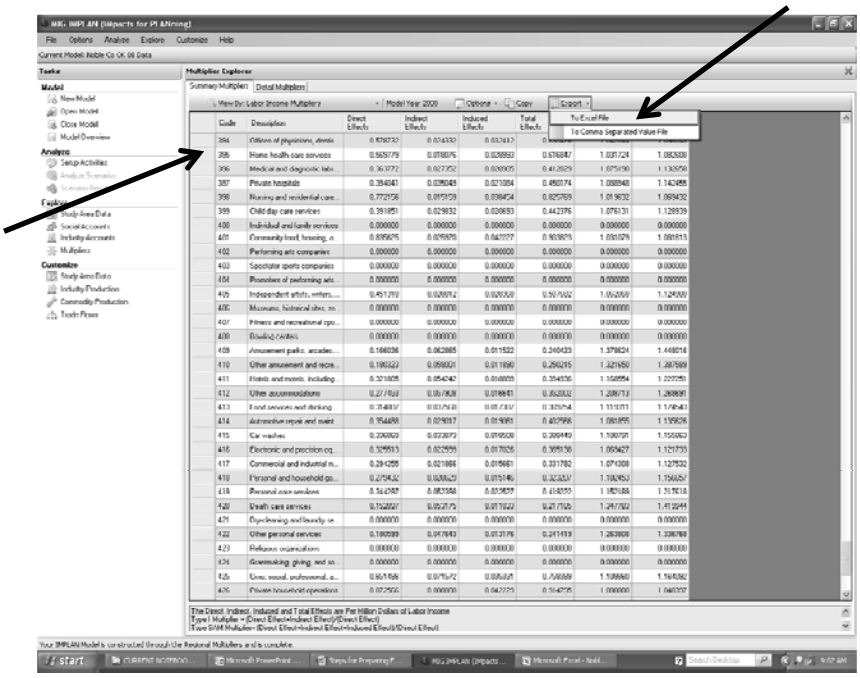
ReConstruct the Multipliers

- Go to “Explore”, ‘Multipliers”, Select ‘Labor Income Multipliers’
- Arrow down to each Industry Sector for multipliers or export (download) reports to Excel









Creating Economic Impact Tables in Excel

Economic impact tables to create:

1. Direct employment and income impact from health sectors
2. Secondary and total employment and income impact from health sectors
3. Direct construction costs for each year of construction

Creating Economic Impact Tables in Excel

4. Direct impact on employment and income for each year derived from construction costs and IMPLAN ratios
5. Secondary and total impact on employment and income for each year

Utilize the multipliers from the IMPLAN reports for the Impact Tables and Industry Detail reports to derive construction employment and income for each year of construction

Noble County Health Sector Impact on Employment

	Employment		
Health Sectors	Employed	Multiplier	Impact
Hospital	88	1.24	109
Physicians, Dentists, & Other Medical Professionals	48	1.21	58
Nursing and Protective Care	90	1.11	100
Home Health	5	1.15	6
Other Medical & Health Services	5	1.23	6
Pharmacies	18	1.14	21
Total	**254**		**300**

Noble County Health Sector Impact
on Income, and Retail Sales and Sales Tax

Health Sectors	Income	Multiplier	Impact	Retail Sales	1 Cent Sales Tax
Hospital	$3,624,176	1.14	$4,131,561	$1,028,759	$10,288
Physicians, Dentists, & Other Medical Professionals	$3,132,571	1.1	$3,445,828	$858,011	$8,580
Nursing and Protective Care	$2,145,417	1.07	$2,295,596	$571,603	$5,716
Home Health	$181,927	1.08	$196,481	$48,924	$489
Other Medical & Health Services	$349,524	1.13	$394,962	$98,346	$983
Pharmacies	$967,961	1.12	$1,084,116	$269,945	$2,699
Total	**$10,401,576**		**$11,548,544**	**$2,875,588**	**$28,755**

Income Impact Table

- Need the local retail sales capture ratio.

$$\frac{\textbf{Total local retail sales subject to sales tax}}{\textbf{Total Personal income}}$$

  Available from state tax agency and the U. S. Department of Commerce, Bureau of Economic Analysis

Results in the ratio of retail sales to personal income

For Noble County: 24.9%

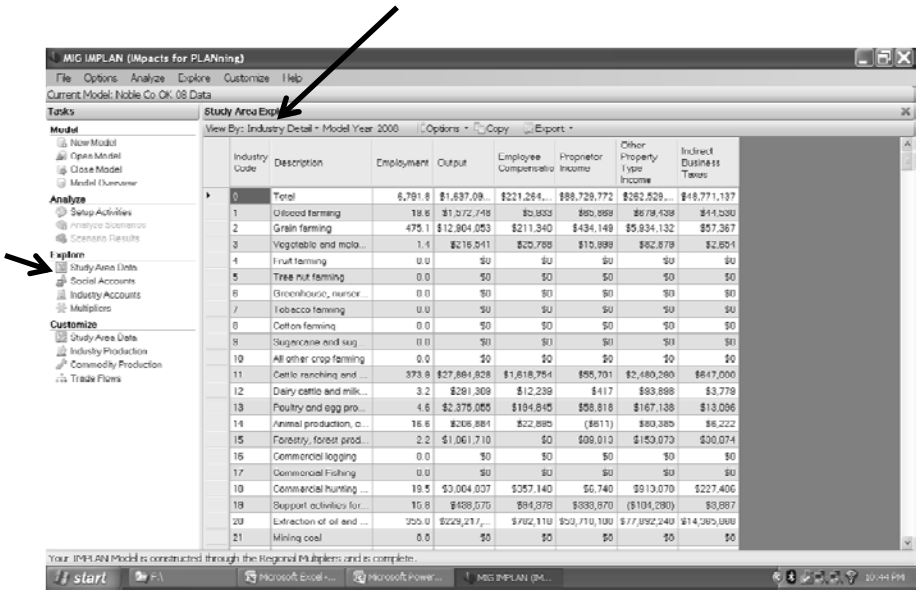
- Need the current county sales tax rate

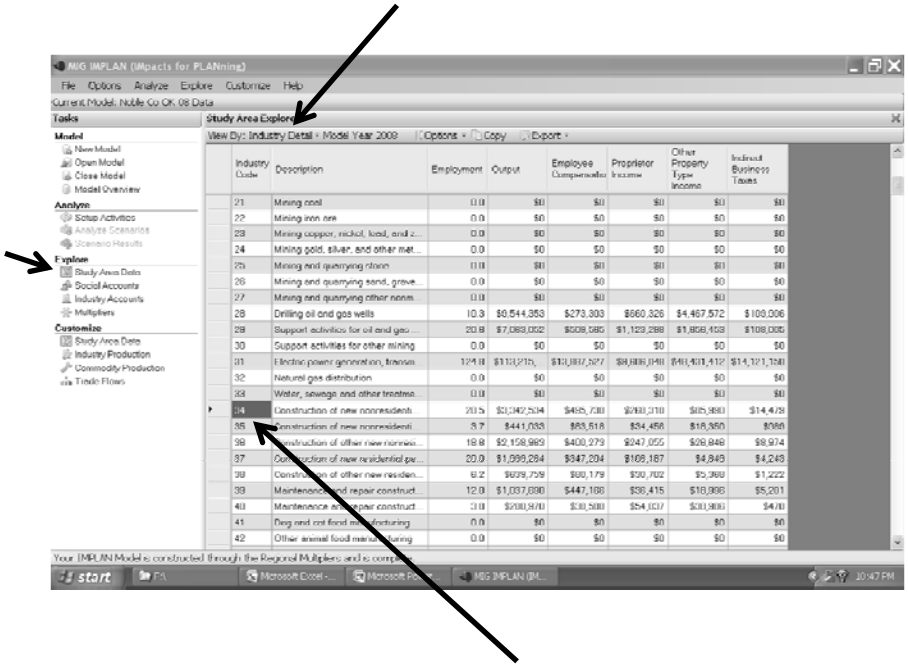
  Available from the state tax agency from reports showing the sales tax returns to local governments

For Noble County: 1.0% County Sales Tax

Derive Construction Employment and Income

- Re-Open Noble County OK 08 Data Model
- Click on ‘Explore’
- Then ‘Study Area Data’
- Should be in ‘View by: Industry Detail’
- Go down to ‘Sector for Health Construction’
- Need selected data for this sector





FROM IMPLAN
Explore - Study Area Data - Industry Detail - Sector 34 - Construction of New Nonresidential Commercial and Health Care Structures

Industry Code	Description	Employment	Output	Employee Compensation	Proprietor Income
34	Health Construction Sector	28.52	3,342,533.50	495,738.19	268,318.03

Derive Construction Employment and Income from IMPLAN

Health Construction Employment
per Million Dollars of Health Construction Output

Formula: $\frac{\text{Health Construction Employment}}{(\text{Health Construction Output} \div 1{,}000{,}000)}$

Utilize numbers from IMPLAN Data, Industry Detail for Health Construction Sector

Calculation: $\frac{28.52}{(3{,}342{,}533.50 \div 1{,}000{,}000)}$

RESULT = **8.532599**

Industry Code	Description	Employment	Output	Employee Compensation	Proprietor Income
34	Health Construction Sector	28.52	3,342,533.50	495,738.19	268,318.03

Calculate Annual Health Construction Employment

Health Construction Employment
per Million Dollars of Health Construction Output
8.532599

	Costs in Million Dollars	Formula	Employment
2008	$6	=$6 x 8.532599	51
2009	$4	=$4 x 8.532599	34

Total Construction Costs / $1,000,000

Costs in Million Dollars x EMP/$Mills of Output

Calculated Construction Employment

Calculate Annual Health Construction Income (Wages, Salaries, and Benefits and Proprietor Income)

Formula = $\dfrac{\text{(Health Construction Employee Compensation + Health Construction Proprietor Income)}}{\text{Health Construction Employment}}$

Utilize numbers from IMPLAN Data, Industry Detail for Health Construction Sector

Calculation: $\dfrac{= \$495{,}738.19 + \$268{,}318.03}{= 28.52}$

RESULT **$26,790**
Avg. Income per Health Construction Employee

Industry Code	Description	Employment	Output	Employee Compensation	Proprietor Income
34	Health Construction Sector	28.52	3,342,533.50	495,738.19	268,318.03

Calculate Annual Health Construction Income (Wages, Salaries, and Benefits and Proprietor Income)

Average Income Per Health Construction Worker
$26,790

	Costs in Million $$$	Estimated Employment	Formula	Estimated Income
2008	$6	51	= 52 x $26,790	$1,366,290
2009	$4	34	= 34 x $26,790	$910,860

Health Construction Employment x Avg Income Per Worker

Calculated Construction Income

Industry Code	Description	Employment	Output	Employee Compensation	Proprietor Income
34	Health Construction Sector	28.52	3,342,533.50	495,738.19	268,318.03

Direct Impact of Construction

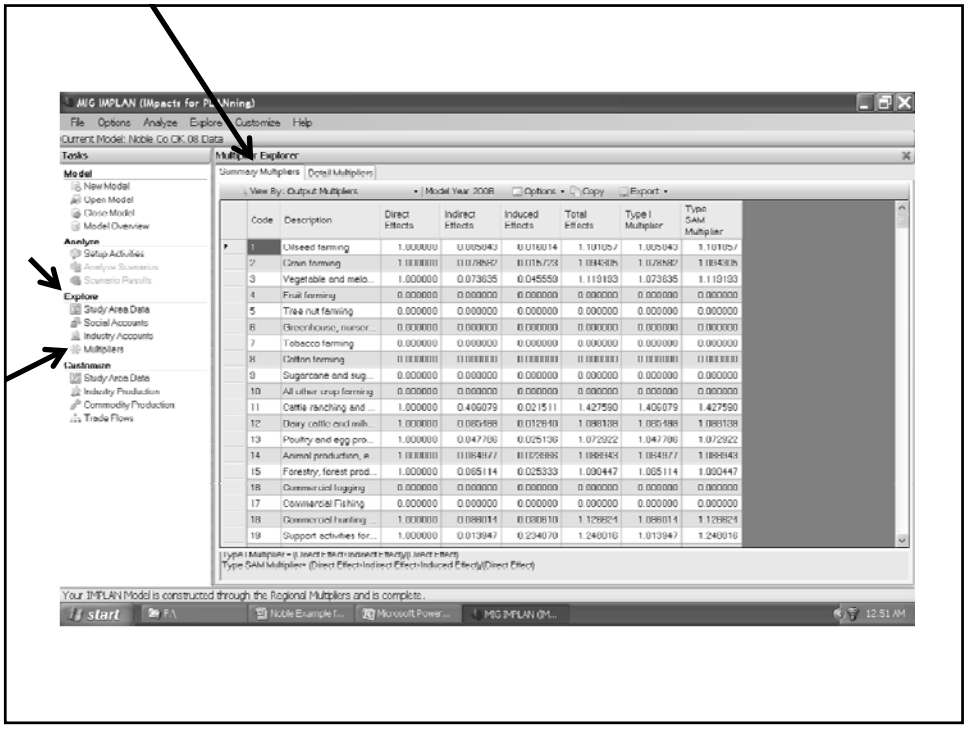
Year	Construction Costs*	Construction Employment	Construction Income
2008	$6,000,000	51	$1,366,290
2009	$4,000,000	34	$910,860

* Does not include land costs or equipment costs

Health Construction Employment and Income Multipliers

From the Noble County IMPLAN Model,

- Go to ‘Explore’
- Then ‘Multipliers’
- Select ‘View by: Employment Multipliers’
- Scroll down to Health Construction Sector
- Employment Multiplier for Health Construction Sector under ‘Type SAM Multiplier’


MIG IMPLAN (IMpacts for PLANning)
File Options Analyze Explore Customize Help
Current Model: Noble Co OK 08 Data
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New Model
Open Model
Close Model
Model Overview
Analyze
Setup Activities
Analyze Scenarios
Scenario Results
Explore
Study Area Data
Social Accounts
Industry Accounts
Multipliers
Customize
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Industry Production
Commodity Production
Trade Flows
Multiplier Explorer
Summary Multipliers
Detail Multipliers
View By: Output Multipliers
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Indirect Effects
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Your IMPLAN Model is constructed through the Regional Multipliers and is complete.
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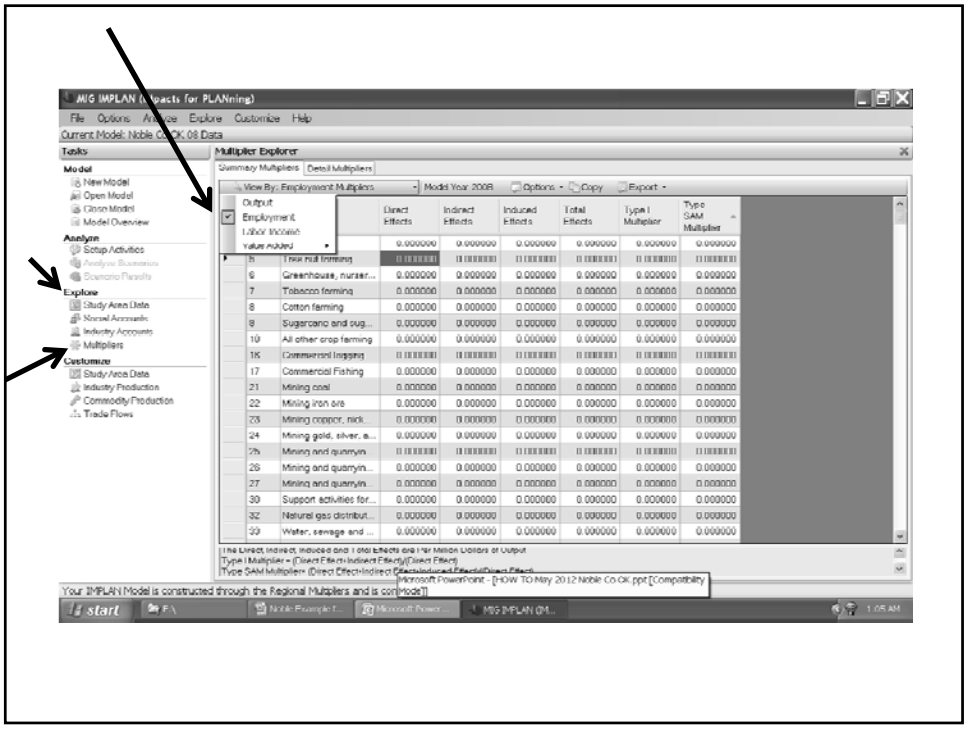
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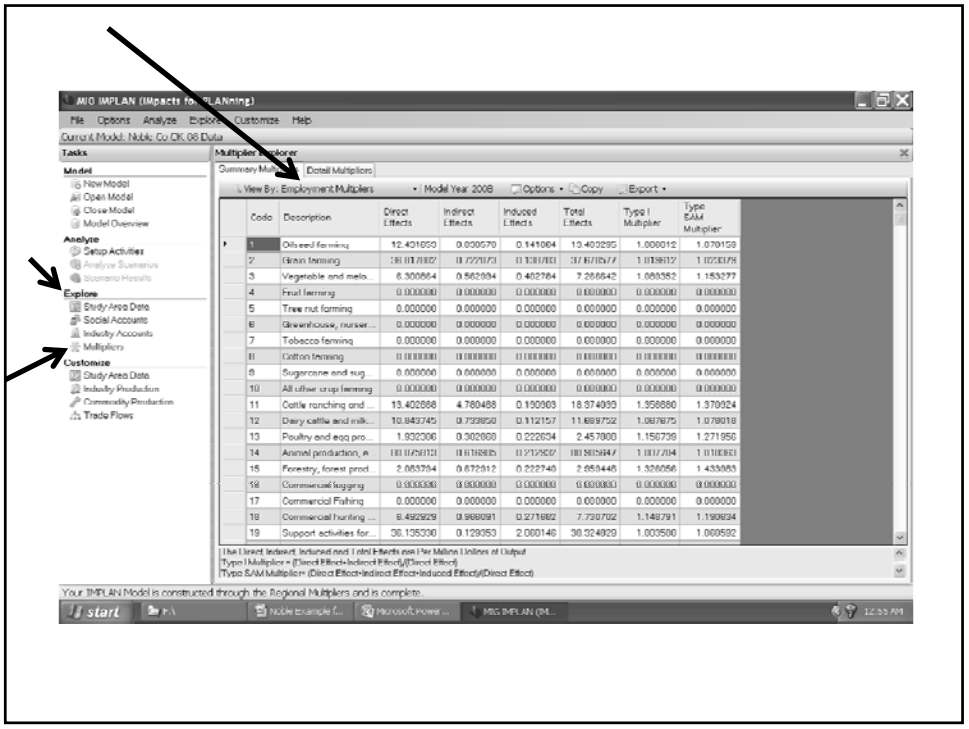
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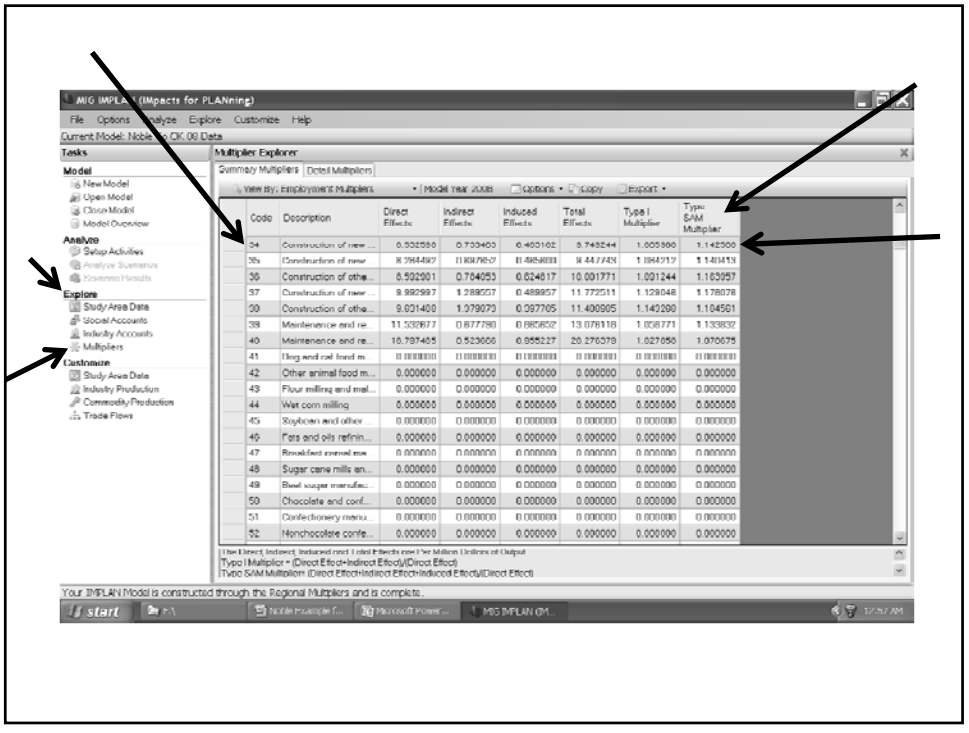
Type SAM Multiplier
Oilseed farming
Grain farming
Vegetable and melo...
Fruit farming
Tree nut farming
Greenhouse, nurser...
Tobacco farming
Cotton farming
Sugarcane and sug...
All other crop farming
Cattle ranching and ...
Dairy cattle and milk...
Poultry and egg pro...
Animal production, e...
Forestry, forest prod...
Commercial logging
Commercial Fishing
Commercial hunting ...
Support activities for...
Type I Multiplier = (Direct Effect+Indirect Effect)/(Direct Effect)
Type SAM Multiplier= (Direct Effect+Indirect Effect+Induced Effect)/(Direct Effect)
Your IMPLAN Model is constructed through the Regional Multipliers and is complete.
start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Total Effects
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Type SAM Multiplier
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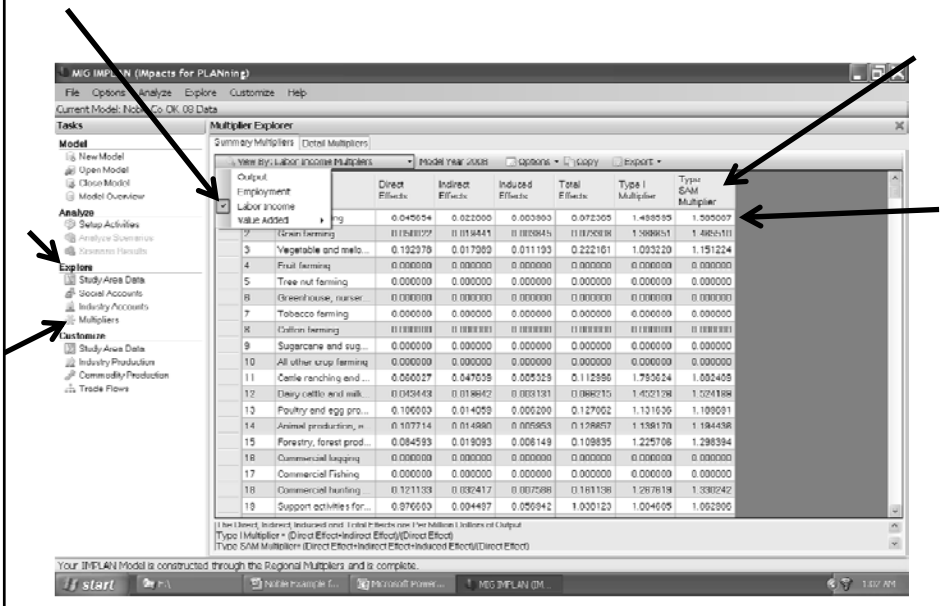
Construction of othe...
Maintenance and re...
Maintenance and re...
Other animal food m...
Flour milling and mal...
Wet corn milling
Soybean and other ...
Fats and oils refinin...
Sugar cane mills an...
Chocolate and conf...
Confectionery manu...
Nonchocolate confe...
Type I Multiplier = (Direct Effect+Indirect Effect)/(Direct Effect)
Type SAM Multiplier= (Direct Effect+Indirect Effect+Induced Effect)/(Direct Effect)
Your IMPLAN Model is constructed through the Regional Multipliers and is complete.
start

Health Construction
Employment and Income Multipliers

- Select ‘View by: Income Multipliers’
- Scroll down to Health Construction Sector
- Income Multiplier for Health Construction Sector under ‘Type SAM Multiplier’



Health Construction Employment and Income Multipliers

Health Construction Employment Multiplier	**1.14**
Health Construction Income Multiplier	**1.18**

Employment Impact of Construction of Noble County Hospital

Year	Construction Costs*	Estimated Construction Employment	Construction Employment Multiplier	Secondary Health Construction Employment	Total Health Construction Employment
2008	$6,000,000	51	1.14	7	58
2009	$4,000,000	34	1.14	5	39

* Does not include land costs or equipment costs

Income Impact of Construction of Noble County Hospital

Year	Construction Costs*	Estimated Construction Income	Construction Income Multiplier	Secondary Health Construction Income	Total Health Construction Income
2008	$6,000,000	$1,366,290	1.14	$191,281	$1,557,571
2009	$4,000,000	$910,860	1.14	$127,520	$1,038,380

* Does not include land costs or equipment costs

Sales Tax Impact of Construction of Noble County Hospital

Year	Construction Costs*	Total Health Construction Income Impact	Estimated Retail Sales Impact	Estimated Sales Tax Impact
2008	$6,000,000	$1,557,571	$387,835	$3,878
2009	$4,000,000	$1,038,380	$258,557	$2,586

* Does not include land costs or equipment costs

Prepare Final Study in Word

Put final study together in Word:

- Cover with picture of local health providers
- Secondary data tables
- Figures: nat'l health & medical service area
- Economic impact tables
- Text
- References
- Appendices, if needed

Economic Impact

- **Mold the model to fit the situation, the service area, and the industry**
- **Medical service area can be zip code area, county, multi-county, state, multi-state, or national**
- **Powerful tool to illustrate the importance of an individual health sector or the total of all health sectors**
- **Powerful tool to illustrate the importance of construction activities on the economy**
- **Use Economic Impact as Tool in Community Health Needs Assessment**

IMPLAN® Information

For additional information contact IMPLAN Group LLC at 651-439-4421
Fax: 651-472-5703
Or visit our website at *www.IMPLAN.com*

DATA PRICE LIST

(note: state agencies using a procurement system charging venders a flat percent must include that fee in the price)

IMPLAN® PRODUCTS – For use with IMPLAN software. IMPLAN V3.1 software

2012 **IMPLAN** ® Individual Data Files – Prices are for five downloads

Individual County File	$390
Individual County Plus Package	$820
US or State Totals File	$720
Individual Congressional District	$840

2012 IMPLAN STATE DATA PACKAGES

IMPLAN Packages includes U.S. total, state total and all related county files
Prices are for five downloads of a Data Order to a registered software installation. Data includes SAM data. Call for site

AK $2,590	ID $3,060	MT $3,280	RI $1,400
AL 3,280	IL 3,850	NC 3,850	SC 3,060
AR 3,280	IN 3,700	ND 3,280	SD 3,280
AZ 1,900	KS 3,850	NE 3,700	TN 3,350
CA 3,280	KY 4,280	NH 1,840	TX 4,790
CO 3,280	LA 3,280	NJ 2,375	UT 2,630
CT 1,840	MA 1,870	NM 2,660	VA 4,360
DC 1,220	MD 2,370	NV 2,040	VT 1,870
DE 1,320	ME 1,980	NY 3,280	WA 2,360
FL 3,280	MI 3,700	OH 3,700	WI 3,280
GA 4,640	MN 3,700	OK 3,420	WV 3,280
HI 1,400	MO 4,070	OR 2,660	WY 2,370
IA 3,850	MS 3,700	PA 3,280	
51 State Totals Package (Call) $15,500		National Package (Call) $50,000	

2012 IMPLAN STATE PLUS PACKAGES

IMPLAN Packages includes U.S. total, state total, all related county files, Congressional Districts and ZIP Code files. Prices are for five downloads of a Data Order to a registered software installation. Data includes SAM data. Call for site licensing prices.

AK $6,460	ID $7,650	MT $8,370	RI $3,470
AL 8,230	IL 9,525	NC 9,530	SC 7,650
AR 8,230	IN 9,230	ND 8,230	SD 8,230
AZ 4,550	KS 9,525	NE 9,230	TN 8,370
CA 8,230	KY 10,670	NH 4,510	TX 11,980
CO 8,230	LA 8,230	NJ 5,925	UT 5,690
CT 4,550	MA 4,910	NM 6,640	VA 10,825
DC 3,180	MD 5,290	NV 5,060	VT 4,650
DE 3,250	ME 5,925	NY 8,230	WA 6,500
FL 8,090	MI 9,230	OH 9,230	WI 8,090
GA 11,540	MN 9,230	OK 8,950	WV 8,090
HI 3,520	MO 10,100	OR 6,640	WY 5,925
IA 9,680	MS 9,230	PA 8,230	
Congressional District Package (Call) $35,000		National Plus Package (Call) $80,000	

2012 MSA PACKAGES

IMPLAN MSA Packages all counties within the defined MSA. Our MSA County definitions are taken from the U.S. Census Bureau, Population Division; Office of Management and Budget of February 2013 delineations released in March 2013. For additional information on pricing and to find out what counties are included in your desired MSA contact Support at 651-439-4421 or orders@implan.com

Top 10 Metropolitan Statistical Areas by Population (February 2013 Delineations)	
New York-Newark-Jersey City, NY-NJ-PA Metropolitan Statistical Area	$5,850
Los Angeles-Long Beach-Anaheim, CA MSA	$780
Chicago-Naperville-Elgin, IL-IN-WI MSA	$3,822
Dallas-Fort Worth-Arlington, TX MSA	$3,549
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD MSA	$3,003
Houston-The Woodlands-Sugar Land, TX MSA	$2,808
Washington-Arlington-Alexandria, DC-VA-MD-WV MSA	$5,616
Miami-Fort Lauderdale-West Palm Beach, FL MSA	$1,170
Atlanta-Sandy Springs-Roswell, GA MSA	$6,786
Boston-Cambridge-Newton, MA-NH MSA	$2,184

COVERED EMPLOYMENT AND WAGES DATA – *IMPLAN software is not required*

CEW (ES202) State Data Packages

Wage and Salary Data packages include U.S. totals files, state totals file, and all related county files. Prices per year. CEW data available for 1988-2000 (SIC Based), 2000-2012 (NAICS Based)

AK $310	ID $370	MT $400	RI $200
AL 400	IL 490	NC 490	SC 380
AR 410	IN 470	ND 400	SD 400
AZ 210	KS 500	NE 480	TN 480
CA 400	KY 550	NH 210	TX 620
CO 400	LA 400	NJ 270	UT 310
CT 210	MA 210	NM 325	VA 560
DC 110	MD 280	NY 400	VT 210
DE 200	ME 220	NV 235	WA 325
FL 400	MI 470	OH 470	WI 410
GA 605	MN 470	OK 410	WV 400
HI 200	MO 530	OR 325	WY 280
IA 490	MS 460	PA 400	
51 State Totals Package $2,820		National Package $8,400	

CEW (ES202) Individual Data Files

Individual County File	$100
US or State Totals File	125

IMPLAN Training OPTIONS AND FURTHER SUPPORT

Please give us a call for questions related to our Training and Support Options so we can help choose the best option for you.

Traveling Workshop (base cost for up to 6 attendees)	$8,100
Onsite Intro Workshop	1,375
Support Level 2 Agreement (1 year from purchase)	1,400
Intro to IMPLAN Training DVD	175
Principles of Impact Analysis & IMPLAN Applications Training Manual	100
Intro DVD and Manual Combo Pack	250
30 Minute Project Consultation With an Economist	175

2011 I-RIMS MULTIPLIERS

I-RIMS is a replacement for the BEA's RIMS II multiplier system, I-RIMS delivers the same outputs as the RIMS II system but is created off of the IMPLAN data sets.

62 Sector I-RIMS Industry Reports	$50
406 Sector I-RIMS Industry Reports	50
62 + 406 Sector County I-RIMS Data	150
62 + 406 Sector I-RIMS MSA Data	150
62 + 406 Sector State Level I-RIMS Data	150
I-RIMS Multipliers generated for Custom Region	500

CUSTOM DATA AND OTHER DATA PRODCUTS AND SERVICES

Call for information

IMPLAN Group LLC
16740 Birkdale Commons Pkwy, Suite 212
Huntersville, NC 28078

Phone: 651-439-4421; Fax: 651-472-5703
www. I M P L A N .com
Sales@implan.com

Community Health Needs Assessment Template
National Center for Rural Health Works

The Economic Impact of
Guadalupe County Hospital
on Santa Rosa and Surrounding Medical Service Area
in Guadalupe County, New Mexico

Prepared for:

Guadalupe County Hospital

Prepared by:

National Center for Rural Health Works
Oklahoma State University
Community Health Needs Assessment Template

February 2012

For additional information on the Community Health Needs Assessment Template, contact National Center for Rural Health Works at 405-744-6083 or email gad@okstate.edu.

The Economic Impact of Guadalupe County Hospital on Santa Rosa and Surrounding Medical Service Area in Guadalupe County, New Mexico

In Santa Rosa and the surrounding medical service area, Guadalupe County Hospital provides vital health care services 24 hours a day, seven days a week, 365 days a year. Guadalupe County Hospital occupies an important role in Santa Rosa and generates significant health care services and contributions to the local residents. But the role Guadalupe County Hospital plays as a major contributor to the economy is often overlooked. Guadalupe County Hospital employs a large number of people with a large payroll. The purpose of this study is to provide national health trend and Guadalupe County demographic data, and to measure the economic impact Guadalupe County Hospital has on Santa Rosa and the surrounding medical service area.

National Health Trend Data

The health care sector is an extremely fast-growing sector in the United States, and based on the current demographics, there is every reason to expect this trend to continue. Data in **Table 1** provide selected expenditure and employment data for the United States. Several highlights from the national data are:

- In 1970, health care services as a share of the national gross domestic product (GDP) were 7.2 percent and increased to 17.9 percent in 2010;
- Per capita health expenditures increased from $356 in 1970 to $8,402 in 2010, an increase of 2,260.1 percent (that is 22.6 times more in 2010 than in 1970);
- Employment in the health sector increased 351.4 percent from 1970 to 2010; and
- Employment increased an average of 2.4 percent per year from 2003 to 2010.

In addition, the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, projects that health care expenditures will account for 18.1 percent of GDP by 2014, increase to 18.8 percent of GDP in 2017, and increase to 19.8 percent in 2020. Per capita health care expenditures are projected to increase to $10,035 in 2014, to $11,664 in 2017, and to $13,709 in 2020. Total health expenditures are projected to increase to over $4.6 trillion in 2020.

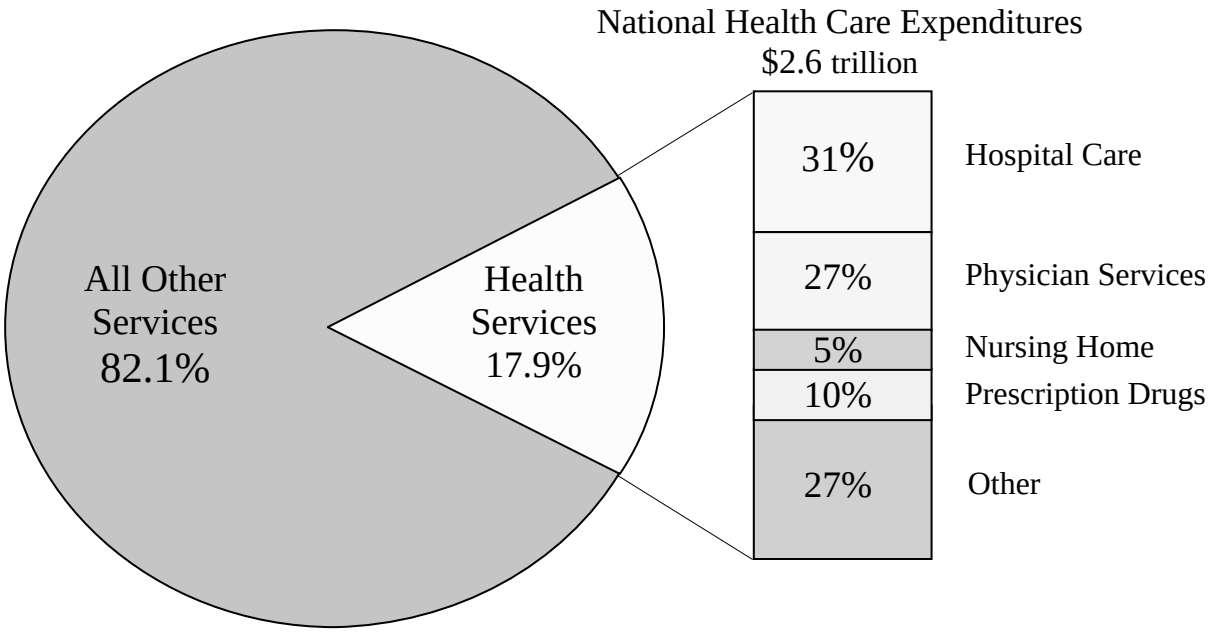
Figure 1 illustrates 2010 health expenditures by percent of GDP and by type of health service. Health services represented 17.9 percent of national GDP in 2010. Total health care expenditures were $2.6 trillion in 2010. The largest category of health services was hospital care, representing 31.0 percent of the total and the second largest category was physician services with 27.0 percent of the total.

Table 1
United States Health Expenditures and Employment Data
1970-2010; Projected for 2014, 2017, & 2020

Year	Total Health Expenditures ($Billions)	Per Capita Health Expenditures ($)	Health as % of GDP (%)	Health Sector Employment (000)		Avg. Annual Increase in Employment (%)
1970	$75.0	$356	7.2%	3,052	[a]	
1980	256.0	1,110	9.2%	5,278	[a]	7.3%
1990	724.0	2,854	12.5%	7,814	[a]	4.8%
2000	1,377.0	4,878	13.8%	10,858	[a]	3.9%
2003	1,774.0	6,114	15.9%	11,817	[b]	N/A
2010	2,594.0	8,402	17.9%	13,777	[b]	2.4%
Projections						
2014	3,227.4	10,035	18.1%			
2017	3,849.5	11,664	18.8%			
2020	4,638.4	13,709	19.8%			

SOURCES: Bureau of Labor Statistics (www.bls.gov [February 2012]); U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, National Health Expenditures 1970-2010 and National Health Expenditure Projections 2010-2020 (http://www.cms.hhs.gov/nationalhealthexpenddata [February 2012]).
N/A - Not Available.
[a] Based on Standard Industrial Classification (SIC) codes for health sector employment.
[b] Based on North American Industrial Classification System (NAICS) for health sector employment.

Figure 1. National Health Expenditures as a Percent of Gross Domestic Product and by Health Service Type, 2010



National Gross Domestic Product

Type of Health Service

Guadalupe County Demographic Data

Populations for Guadalupe County and city, town, census designated places (CDPs), and rural area are illustrated in **Table 2**. Guadalupe County had population of 4,156 in 1990, 4,680 in 2000, and 4,687 in 2010. This represents an increase of 12.6 percent from 1990 to 2000 and an increase of 1.6 percent from 2000 to 2010. The State of New Mexico increased 20.1 percent from 1990 to 2000 and an additional 13.2 percent from 2000 to 2010.

Santa Rosa is the only city in Guadalupe County and increased from 2,263 in 1990 to 2,744 in 2000, a 21.3 percent increase. The population continued to increase to 2,848 in 2010, representing a 3.8 percent increase from 2000 to 2010. The only town in the county is Vaughn and the population decreased 14.8 percent from 1990 to 2000 and decreased 17.3 percent from 2000 to 2010. The 2010 Census provided the populations for the (CDPs) and these are shown in **Table 2**. The rural area population is shown with the CDPs and without the CDPs for better comparison between census years. Without the CDP populations, the rural area of Guadalupe County increased 10.9 percent from 1990 to 2000 and decreased 0.3 percent from 2000 to 2010.

Table 3 shows the population by race and Hispanic origin for the 2000 and 2010 Census years for Guadalupe County, the State of New Mexico, city, town, CDPs, and rural area in Guadalupe County. The white race category represented 54.1 percent of Guadalupe County's population in 2000, as compared to 70.4 percent in 2010. The "Other" race category decreased from 39.6 percent of the county population in 2000 to 22.7 percent in 2010. The Hispanic origin population for Guadalupe County decreased from 81.2 percent in 2000 to 79.6 percent in 2010. This compares to the Hispanic origin population for the State of New Mexico of 42.1 percent of total state population in 2000 and 46.3 percent in 2010.

Table 2
Population and Percent Change for Guadalupe County Cities and Towns, Guadalupe County, and the State of New Mexico

	Populations				
	1990 Census	2000 Census	2010 Census	% Change '90 to '00	% Change '00 to '10
Santa Rosa City	2,263	2,744	2,848	21.3%	3.8%
Vaughn Town	633	539	446	-14.8%	-17.3%
Anton Chico CDP*	NA	NA	**188**	NA	NA
Llano de Medio CDP*	NA	NA	**188**	NA	NA
Newkirk CDP*	NA	NA	**7**	NA	NA
Pastura CDP*	NA	NA	**23**	NA	NA
Puerto de Luna CDP*	NA	NA	**141**	NA	NA
Rural Area	1,260	1,397	846	10.9%	-39.4%
Without the CDPs reported					
Rural Area	1,260	1,397	1,393	**10.9%**	**-0.3%**
Guadalupe County	**4,156**	**4,680**	**4,687**	**12.6%**	**0.1%**
State of New Mexico	**1,515,069**	**1,819,046**	**2,059,179**	**20.1%**	**13.2%**

SOURCE: 2000 and 2010 Census populations, U.S. Census Bureau (www.census.gov [February 2012]).
NA = not available.
* CDP - Census designated places

Table 3
Populations by Race and Hispanic Origin
for Guadalupe County and the State of New Mexico

	White	Black	Native American[1]	Other[2]	Two or More Races[3]	Total	Hispanic Origin[4]
2000 Census							
Santa Rosa City	1,577	60	48	934	125	2,744	2,227
Vaughn Town	284	0	2	237	16	539	469
Anton Chico CDP	NA	NA	NA	NA	NA	NA	NA
Llano de Medio CDP	NA	NA	NA	NA	NA	NA	NA
Newkirk CDP	NA	NA	NA	NA	NA	NA	NA
Pastura CDP	NA	NA	NA	NA	NA	NA	NA
Puerto de Luna CDP	NA	NA	NA	NA	NA	NA	NA
Rural Area	669	2	3	684	39	1,397	1,105
Guadalupe County	2,530	62	53	1,855	180	4,680	3,801
Percent	**54.1%**	1.3%	1.1%	**39.6%**	3.8%	100.0%	**81.2%**
State of New Mexico	1,214,253	34,343	173,483	330,640	66,327	1,819,046	765,386
Percent	66.8%	1.9%	9.5%	18.2%	3.6%	100.0%	**42.1%**
2010 Census							
Santa Rosa City	1,971	68	57	654	98	2,848	2,262
Vaughn Town	304	7	6	114	15	446	385
Anton Chico CDP	115	0	7	60	6	188	167
Llano de Medio CDP	73	1	6	38	0	118	111
Newkirk CDP	7	0	0	0	0	7	2
Pastura CDP	20	0	0	3	0	23	19
Puerto de Luna CDP	114	0	1	23	3	141	107
Rural Area	694	3	13	174	32	916	677
Guadalupe County	3,298	79	90	1,066	154	4,687	3,730
Percent	**70.4%**	1.7%	1.9%	**22.7%**	3.3%	100.0%	**79.6%**
State of New Mexico	1,407,876	42,550	193,222	338,521	77,010	2,059,179	953,403
Percent	68.4%	2.1%	9.4%	16.4%	3.7%	100.0%	**46.3%**

SOURCE: 2000 and 2010 Census population by race and ethnic origin, U.S. Census Bureau (www.census.gov [February 2012]).
[1]Native Americans include American Indians and Alaska Natives.
[2]Other is defined as Asian Americans, Native Hawaiians, Pacific Islanders, and all others.
[3]Two or More Races indicated a person is included in more than one race group, it was introduced as a new category in the 2000 Census.
[4]Hispanic population is not a race but rather a description of ethnic origin; Hispanics are included in the five race groups.

Table 4 shows the population by age groups for Guadalupe County, the State of New Mexico, and the city, town, CDPs, and rural area in Guadalupe County for 2000 and 2010. All age groups under age 44 decreased in percent of total population from 2000 to 2010. The age group 45-64 increased from 21.9 percent of the total in 2000 to 28.6 percent of the total in 2010. The age group 65 and older also increased; from 13.8 percent of the total population in 2000 to 15.5 percent of the total population in 2010. The State of New Mexico is experiencing similar trends in the changes in population by age groups.

Table 4
Populations by Age Group
for Guadalupe County and the State of New Mexico

	Age Groups						
	0-14	15-19	20-24	25-44	45-64	65+	Total
2000 Census							
Santa Rosa City	505	211	205	944	549	330	2,744
Vaughn Town	115	40	24	133	137	90	539
Anton Chico CDP	NA	NA	NA	NA	NA	NA	NA
Llano de Medio CDP	NA	NA	NA	NA	NA	NA	NA
Newkirk CDP	NA	NA	NA	NA	NA	NA	NA
Pastura CDP	NA	NA	NA	NA	NA	NA	NA
Puerto de Luna CDP	NA	NA	NA	NA	NA	NA	NA
Rural Area	288	114	69	360	338	228	1,397
Guadalupe County	908	365	298	1,437	1,024	648	4,680
Percent	**19.4%**	**7.8%**	**6.4%**	**30.7%**	**21.9%**	**13.8%**	100.0%
State of New Mexico	419,108	145,751	121,291	516,100	404,571	212,225	1,819,046
Percent	23.0%	8.0%	6.7%	28.4%	22.2%	11.7%	100.0%
2010 Census							
Santa Rosa City	483	168	202	886	743	366	2,848
Vaughn Town	80	37	10	85	140	94	446
Anton Chico CDP	40	12	10	35	30	61	188
Llano de Medio CDP	29	6	9	21	31	22	118
Newkirk CDP	0	0	0	0	2	5	7
Pastura CDP	1	0	0	2	8	12	23
Puerto de Luna CDP	33	11	5	24	42	26	141
Rural Area	170	53	42	166	343	142	916
Guadalupe County	836	287	278	1,219	1,339	728	4,687
Percent	**17.8%**	**6.1%**	**5.9%**	**26.0%**	**28.6%**	**15.5%**	100.0%
State of New Mexico	429,980	149,861	142,370	515,768	548,945	272,255	2,059,179
Percent	20.9%	7.3%	6.9%	25.0%	26.7%	13.2%	100.0%

SOURCE: 2000 and 2010 Census population by age groups, U.S. Census Bureau (www.census.gov [February 2012]).

The Economic Impact of Guadalupe County Hospital

The economic impact of Guadalupe County Hospital for 2011 is presented in **Table 5**. The top portion of the table presents the employment impact of Guadalupe County Hospital resulting from annual operating activities and construction activities during the year of construction. In 2011, Guadalupe County Hospital had 50 full- and part-time employees. As these employees and the medical center spent money locally, additional jobs were generated in other businesses in Santa Rosa and the surrounding medical service area. These are called secondary jobs and are measured with employment multipliers. The hospital employment multiplier is 1.34 which means that for each job established in the medical center, another 0.34 jobs were generated in other businesses in the medical service area. In 2011, secondary jobs generated annually from operating activities of Guadalupe County Hospital were 17 jobs and the total employment impact was 67 jobs.

Guadalupe County Hospital spent $10.0 million on capital improvement projects in 2011. These were estimated to result in 86 construction jobs. These capital improvement projects resulted in secondary impacts as the construction firms and their employees spent money locally. The construction employment multiplier was 1.23 yielding a secondary employment impact of 20 jobs and a total employment impact of 106 jobs from construction activities. ***In 2011, the total employment impact of Guadalupe County Hospital was 67 jobs from operations and 106 jobs from construction, for a total of 173 jobs.***

The income impact of Guadalupe County Hospital for 2011 is presented in the bottom portion of **Table 5**. Income (wages, salaries, and benefits) paid to Guadalupe County Hospital employees was $2.9 million. With the hospital income multiplier of 1.18, the secondary income impact was $0.5 million and the total income impact was $3.4 million. Construction projects

Table 5
Economic Impact of Guadalupe County Hospital
on Guadalupe County, New Mexico, 2011

	Employment Impact			
	Number Employed	Employment Multiplier	Secondary Impact	Total Impact
From Hospital Operations	50	1.34	17	67
From Hospital Construction	86	1.23	20	106
Total Employment Impact	136		37	173

	Income Impact			
	Direct Income	Income Multiplier	Secondary Impact	Total Impact
From Hospital Operations	$2,909,410	1.18	$523,694	$3,433,104
From Hospital Construction	$3,465,875	1.16	$554,540	$4,020,415
Total Income Impact	$6,375,285		$1,078,234	$7,453,519

Source: Local data for operations employment and income and construction, 2011; Current IMPLAN multipliers, Minnesota IMPLAN Group, Inc.

paid workers an estimated $3.5 million in income, which occurred only during the construction year 2011 and will vary each year by construction activities. The construction income multiplier of 1.16 resulted in $0.6 million in secondary income impact and $4.0 million in total income impact. ***The total income impact from Guadalupe County Hospital in 2011 from both operating activities and construction activities was $7.5 million.***

Summary

In summary, Guadalupe County Hospital not only has an impact on the health and welfare of residents in Santa Rosa and the surrounding medical service area, it also has an impact on the local economy. Hospitals such as Guadalupe County Hospital contribute greatly to the economic development in the geographic areas in which they are located. This occurs because:

- Businesses and industries locate in areas with high quality medical facilities and educational systems;
- Retirees locate in areas with accessible and comprehensive health care services and law enforcement services;
- The health sector is a growing sector and will continue to generate more jobs, and;
- The health sector generally pays above-average salaries and wages.

These points, along with the amount of economic activity generated by Guadalupe County Hospital, demonstrate that local leaders must continue to support Guadalupe County Hospital to ensure development of economic growth and opportunities in Santa Rosa and the surrounding area in Guadalupe County.

The Economic Impact of XYZ Hospital
on Oz County, State

In the medical service area of Oz County, XYZ Hospital provides vital health care services 24 hours a day, seven days a week, 365 days a year. XYZ Hospital occupies a highly prominent role among medical institutions in Oz County and generates significant public interest in many cutting edge medical contributions. But the role XYZ Hospital plays as a major contributor to the economy is often overlooked. XYZ Hospital employs a large number of people and has a huge payroll. The purpose of this report is to specifically measure the economic impact that XYZ Hospital has on Oz County.

For 2010, the economic impact of XYZ Hospital is presented in the following table. The top portion of the table presents the employment impact of XYZ Hospital. In 2010, XYZ Hospital had 1,474.3 full-time equivalent employees (FTEs) from hospital operations. As these employees and the hospital spent money locally, additional FTEs were generated in other businesses in Oz County. These are called secondary FTEs and are measured with employment multipliers for Oz County. The hospital employment multiplier is 2.04, which indicates that for each FTE established in XYZ Hospital, another 1.04 FTEs were generated in other businesses in Oz County. In 2010, secondary FTEs generated annually from operating activities of XYZ Hospital were 1,533.3 FTEs and the total employment impact was 3,007.6 FTEs.

The income impact of XYZ Hospital for 2010 is presented in the middle portion of the table. Income (wages, salaries, and benefits) paid to XYZ Hospital employees was $94.9 million. Applying the hospital income multiplier of 1.84, the secondary income impact was $79.8 million and the total income impact was $174.7 million.

Economic Impact of XYZ Hospital
on Oz County, Illinois, 2010

Employment Impact

Activity	FTEs Employed	Multiplier	Secondary Impact	Total Impact
Hospital Operations	1,474.3	2.04	1,533.3	3,007.6

Income Impact

Activity	Direct Income ($millions)	Multiplier	Secondary Impact ($millions)	Total Impact ($millions)
Hospital Operations	94.9	1.84	79.8	174.7

Retail Sales and Retail Sales Taxes

	Retail Sales ($millions)	6.25% State Sales Tax ($millions)
From Hospital Operations	80.0	5.0

SOURCE: Employment and income data provided by XYZ Hospital , 2010; current IMPLAN multipliers, Minnesota IMPLAN Group, Inc.

The impact of XYZ Hospital on retail sales and sales tax was estimated for 2010. From the $178.2 million in total income impact generated from hospital operations, retail sales are estimated at $80.0 million, resulting in $5.0 million in Illinois state sales taxes of 6.25 percent. Sales tax estimates for each county are not included in this study; county sales tax impacts can be calculated by multiplying the estimated retail sales by the current county sales tax rate.

In summary, XYZ Hospital not only has a huge impact on the health and welfare of residents in Oz County, it also has a large impact on the local economy. Large hospitals such as XYZ Hospital greatly contribute to the economic development in the geographic areas in which they are located. These occur because:

- Businesses and industries locate in areas with high quality medical facilities and educational systems;
- Retirees locate in areas with accessible and comprehensive health care services and law enforcement services;
- The health sector is a growing sector and will continue to generate more jobs, and;
- The health sector generally pays above-average salaries and wages.

These points, along with the large amount of economic activity generated by XYZ Hospital, demonstrate that local leaders must continue to support XYZ Hospital to ensure development of economic growth and opportunities in Oz County.

In summary, hospitals act as an economic engine and generate large impacts. The demand for health services is increasing rapidly and thus a large number of jobs are expected to be generated over the next several years due to growth in hospitals. Economic developers are frequently seeking manufacturing and high-tech industries that will create new jobs. XYZ Hospital is doing just that and should not be overlooked. XYZ Hospital is clearly in a growth mode and creating jobs with above-average wages. Policies should be adopted to enhance and encourage the continued growth of XYZ Hospital.

Appendix J

Example Community Health Survey Questionnaire

INSTRUCTIONS FOR:

Health Survey Questionnaire

for Guadalupe County Hospital

Community Health Needs Assessment Process

Each Community Advisory Committee member will take five copies of the Survey Questionnaire and have them completed by other residents of the community within the Guadalupe County Hospital medical service area. These must be completed and returned TO THE SECOND MEETING on:

Tuesday, March 13, 2012

OR

If you cannot attend the second meeting,

please be sure to submit completed surveys to:

Cristina Campos, Hospital Administrator
Guadalupe County Hospital
117 Camino de Vida, Suite 100
Santa Rosa, NM 88435
Phone: 575-472-3417

Health Survey Questionnaire for Guadalupe County Hospital

1. Have you or someone in your household used the services of a hospital in the past 24 months?
   - ☐ Yes
   - ☐ No **(Skip to Q7)**
   - ☐ Don't know **(Skip to Q7)**

2. At which hospital(s) were services received?
   - ☐ Guadalupe County Hospital **(Skip to Q4)**
   - ☐ Other (CITY where hospital services were received) _____

3. You responded that you or someone in your household received care at a hospital other than Guadalupe County Hospital? Why did you or your family member choose that/those hospital(s)?
   - ☐ Physician referral
   - ☐ Closer, more convenient
   - ☐ Insurance
   - ☐ Quality of care/lack of confidence
   - ☐ Availability of specialty care
   - ☐ Other (Please list below)

_____

(Answer Q3; then Skip to Q7)

4. What hospital service(s) were used at Guadalupe County Hospital?
   - ☐ All radiological imaging (X-rays, MRI, CT scan, ultrasound, mammogram)
   - ☐ Laboratory
   - ☐ Other outpatient services
   - ☐ Physician services
   - ☐ Inpatient services
   - ☐ Emergency room (ER)
   - ☐ Other (Please list)

_____

5. How satisfied were you or someone in your household with the services you received at Guadalupe County Hospital? Would you say you were…
   - ☐ Satisfied
   - ☐ Dissatisfied
   - ☐ Don't know

6. Why were you satisfied/dissatified? _____

_____

7. What type of specialist have you or someone in your household been to and in which city did you receive that care?
   - ☐ Cardiology/Heart in _____city
   - ☐ Orthopedics/Orthopedic Surgery in _____city
   - ☐ Urology in _____city
   - ☐ Obstetrics-Gynecology in _____city
   - ☐ General surgery in _____city
   - ☐ Other (Please list specialist and city)

_____

_____

Please turn over and continue on back page. . . . .

8. Did the specialist request further testing, laboratory work and/or x-rays?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

9. If yes, in which city were the tests or laboratory work performed?

   _____

10. Do you use a family doctor for most of your routine health care?
    - ☐ Yes **(Skip to Q12)**
    - ☐ No
    - ☐ Don't know **(Skip to Q12)**

11. If no, then what kind of medical provider do you use for routine care?
    - ☐ Public Health Office
    - ☐ Emergency Room/Hospital
    - ☐ Specialist
    - ☐ Other (Please list below)

    _____

12. Have you or someone else in your household been to a primary care doctor in Guadalupe County?
    - ☐ Yes
    - ☐ No **(Skip to Q15)**
    - ☐ Don't know **(Skip to Q15)**

13. How satisfied were you or someone in your household with the quality of care received in Guadalupe County? Would you say that you were…?
    - ☐ Satisfied
    - ☐ Dissatisfied
    - ☐ Don't know

14. Why were you satisfied/dissatified? _____

    _____

15. Are you able to get an appointment with your primary care (family) doctor in Guadalupe County when you need one?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

16. Have you or someone in your household delayed health care due to lack of money and/or insurance?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

17. What concerns you most about health care in Guadalupe County?

    _____

    _____

18. What services would you like to see offered in Guadalupe County?

    _____

    _____

National Center for Rural Health Works
Community Health Needs Assessment Template

Health Survey Questionnaire for *Hospital Name*

The Zip Code of my residence is: _____

1. Have you or someone in your household used the services of a hospital in the past 24 months?
   - ☐ Yes
   - ☐ No **(Skip to Q7)**
   - ☐ Don't know **(Skip to Q7)**

2. At which hospital(s) were services received?
   - ☐ ***Hospital Name*** (Skip to Q4)
   - ☐ If services received at another hospital, list the city or cities where the hospital(s) was located:

_____

3. You responded that you or someone in your household received care at a hospital other than ***Hospital Name*** , why did you or your family member choose that/those hospital(s)?
   - ☐ Physician referral
   - ☐ Closer, more convenient
   - ☐ Insurance
   - ☐ Quality of care/lack of confidence
   - ☐ Availability of specialty care
   - ☐ Other (Please list below)

_____

(Answer Q3; then Skip to Q7)

4. What hospital service(s) were used at ***Hospital Name*** ?
   - ☐ Radiological imaging (X-rays, MRI, CT scan, ultrasound, mammogram)
   - ☐ Laboratory
   - ☐ Other outpatient services
   - ☐ Physician services
   - ☐ Rural health clinics
   - ☐ Inpatient services
   - ☐ Emergency room (ER)
   - ☐ Oncology
   - ☐ Other (Please list below)

_____

5. How satisfied were you or someone in your household with the services you received at ***Hospital Name*** ? Would you say you were…
   - ☐ Satisfied
   - ☐ Dissatisfied
   - ☐ Don't know

6. Why were you satisfied/dissatified with the care received at ***Hospital Name*** ?

_____

7. What type of specialist have you or someone in your household been to and in which city did you receive that care?
   - ☐ No specialty care received (**Skip to Q10**)

Specialist	*City Location*	*Specialist*	*City Location*
☐ Cardiology/Heart	_____	☐ Obstetrics-Gynecology	_____
☐ Orthopedics/Orthopedic surgery	_____	☐ General surgery	_____
☐ Urology	_____	☐ Other (Please list below)	
☐ _____	_____	☐ _____	_____

8. Did the specialist request further testing, laboratory work and/or x-rays?
   - ☐ Yes
   - ☐ No ***(Skip to Q10)***
   - ☐ Don't know (**Skip to Q10**)

9. If yes, in which city were the tests or laboratory work performed?

---

10. Do you use a primary care (family) doctor or physician assistant or nurse practitioner for most of your routine health care?
    - ☐ Yes **(Skip to Q12)**
    - ☐ No
    - ☐ Don't know **(Skip to Q16)**

11. If no, then what kind of medical provider do you use for routine care?
    - ☐ Community Health Center
    - ☐ Health Department
    - ☐ Emergency Room/Hospital
    - ☐ Rural Health Clinic
    - ☐ Specialist
    - ☐ Other (Please list below)

---

12. Have you or someone else in your household been to a primary care (family) doctor or physician assistant or nurse practitioner in the service area of ***Hospital Name*** ?
    - ☐ Yes
    - ☐ No **(Skip to Q16)**
    - ☐ Don't know **(Skip to Q16)**

13. How satisfied were you or someone in your household with the quality of physician care (or physician assistant or nurse practitioner care) received in the service area of ***Hospital Name*** ? Would you say you were…
    - ☐ Satisfied
    - ☐ Dissatisfied
    - ☐ Don't know

14. Why were you satisfied/dissatified with the quality of physician care (or physician assistant or nurse practitioner care)?

---

15. Are you able to get an appointment with your primary care (family) doctor or physician assistant or nurse practitioner in the service area of ***Hospital Name*** when you need one?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

16. Have you or someone in your household delayed health care due to lack of money and/or insurance?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

17. What concerns you most about health care in the service area of ***Hospital Name*** ?

---

18. What services would you like to see offered at ***Hospital Name*** ?

---

19. Do you have any kind of healthcare coverage, such as health insurance through an employer or a government plan such as Medicare?
    - ☐ Yes
    - ☐ No

INSTRUCTIONS FOR COMMUNITY HEALTH SURVEY QUESTIONNAIRE

An example is provided. Several files are included in the printed copy:

1 EX Survey Form
2 EX GENERIC Survey Form
3 EX Survey INSTRUCTIONS
4 EX Survey Results FINAL

Also available on the website (www.okruralhealthworks.org):

- EX Survey Form in Excel
- EX GENERIC Survey Form in Excel
- EX Survey Results in Excel
- EX Health Survey Results COVER in Word

The first attachment is an example of a community survey questionnaire. Next, a GENERIC Survey Form is included. This Generic survey form includes the basic questions that are typically asked on all surveys. The local hospital and/or steering committee may choose to add questions to this GENERIC survey form. The community example survey questionnaire may have some additional questions added that are relevant to their community.

The GENERIC survey form is where your hospital should begin and then decide if additional questions are needed. Modifications should be made to the GENERIC survey form; i.e., to add any survey questions specific to your hospital.

The final survey form should be ready for the first meeting of the community advisory committee. Each member of the community advisory committee will be asked to complete the form at the meeting. As the community advisory committee members leave the meeting, they will be handed five or six blank survey forms to take with them to have completed by the constituents that they represent and/or other community members. The "Health Survey INSTRUCTIONS" should be revised for your hospital and also given to each community advisory committee member, along with the five or six blank survey forms.

The INSTRUCTIONS are very basic. There should be included a deadline for the return of the completed survey questionnaires (typically the second meeting of the community advisory committee) and a contact person with address and phone number and/or fax who will receive the completed survey questionnaires.

> ***NOTE:*** *The community facilitator should encourage the community participants to have the survey forms completed prior to the second committee meeting. The cost of employing a private firm to conduct phone surveys is very costly and the community can assist in keeping the costs of the Community Health Needs Assessment to a minimum. These cost savings can be better used in developing programs and activities in meeting the community's health needs.*

The contact person designated in the INSTRUCTIONS should be available to the community participants and should communicate with them to encourage the timely return of completed survey forms. The simplest way to obtain the completed survey forms is to have the members return them at the second committee meeting.

Once all the surveys have been returned, the steering committee should have an individual (or individuals) proficient in Excel ready to analyze and summarize the survey results. Attached is an Excel spreadsheet, "Survey Results in Excel," that can be modified and utilized for the survey results. This spreadsheet is based on an Example Community Survey Questionnaire and should be modified to fit your hospital's survey form.

In the Excel Spreadsheet, the first worksheet is where the survey results will be input. Across the top of the spreadsheet are the questions and possible responses. Down the left side are the survey numbers. As the surveys are received, they should be numbered and then input by survey number. Each row represents the results for one survey form.

The key to analyzing the survey is to be sure to include ONLY RESPONSES that are RELEVANT and CONSISTENT. For instance, if the first question of the survey receives a "No" response, then there should be no additional responses included until Question #7. The person entering the survey results will have to make a judgment call as to whether the Q1 response is consistent with the responses to Questions 2 through 6. There are several instances in the survey that these judgments will need to be made.

> ***NOTE:*** *In the survey responses worksheet, blanks are included in the questions that should not be responded t,o based on the response of "No" for Q1. If Q1 receives a "No" response, then Questions 2 thru 6 should be blank. This can be very confusing but consistency is what is needed to produce the summary results.*

The first worksheet includes the survey responses. The second worksheet then tallies the survey results. If the first worksheet is modified, then the second worksheet will also need to be modified to include all the revisions. Assistance for the modifications can be received from the National Center.

The second worksheet is designed to summarize the responses from the first worksheet. Once all the survey responses have been entered and the second worksheet has been modified to include all modifications, then the survey results should be reviewed for consistency.

Again, consistency is important in validating the survey responses. For example, if Q1 has 78 respondents indicating they used the services of a hospital in the past 24 months; then Q2 should have 78 responses at a minimum. Since respondents may answer more than once, there can be more than the 78 responses but there has to be at least 78 responses.

The third question also has to be consistent with the responses in Q2. If Q2 shows that 78 respondents went to your Hospital; then all other responses (hospitals other than your

hospital) to Q2 will respond to Q3. Let's say that the total responses for Q2 were 102 and 78 of those went to your hospitals. Then, the difference of 24 went to hospitals other than your hospital. Therefore, the responses to Q3 should be at least 24. Again, there can be more than the 24 responses since respondents may answer more than once but there should be at a minimum 24 responses.

Once all the survey questions have been checked and re-checked for consistency, then a COPY of the survey results worksheet are made in the same spreadsheet and PASTE it to reflect "VALUES." This new worksheet becomes the final survey results and all the blanks and zero responses are removed and the responses can be re-ordered to show the results by the largest to the smallest number of responses. This ordering can be done to fit the steering committee's needs.

An example of the survey results COVER in Word is given and the final results have been pulled together in an Adobe Acrobat file entitled, "EX Survey Results FINAL." The Adobe Acrobat is not necessary. The results can be printed from the final survey results in Excel and the survey results cover in Word.

The National Center has found this spreadsheet the simplest way to analyze the survey responses and summarize the results. Assistance is available at any time to modify or assist in utilizing the survey results spreadsheet.

Be sure to call the National Center for Rural Health Works with any questions or for any assistance.

Appendix K

Example Focus Group Questions

Three Focus Group Questions

Based on Catholic Healthcare Community Assessment Process

Question 1

What is your vision for a healthy community?

Ask community members to share their ideas of a healthy community. What is healthy about their community and what is unhealthy?

Question 2

What is your perception of the hospital overall and of specific programs and services?

Community members' views will identify opportunities for improving current programs and services, as well as highlight service and program gaps.

Question 3

What can the hospital do to improve health and quality of life in the community?

This question may be the most important, because it elicits ideas for how to improve services and relationships in the community and provide direction for new activities or strategies.

Appendix L

Example Agendas and PowerPoint Slides for Meetings #1, #2, and #3

Agenda
Guadalupe County Hospital
Community Meeting #1
Wednesday, February 29, 2012
4:00 pm

I. Introduction – Christina Campos, CEO, Guadalupe County Hospital

II. Overview of Community Health Needs Assessment Process – Val Schott, National Center

III. Guadalupe County Hospital Services/Community Benefits – Christina Campos

IV. Economic Impact – Gerald Doeksen, National Center

V. Health Survey Questionnaire – Gerald Doeksen and Val Schott

a. Survey Questionnaire completed at meeting

b. Community Representatives to have survey completed by 4 to 6 local residents

VI. Next Steps

Meeting #2 - Tuesday, March 13, 2012, at 4:00 pm

Meeting #3 - Tuesday, April 10, 2012 at 4:00 pm

AGENDA - Community Meeting #1

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Meeting #3 - Tuesday, April 10, 2012 at 4:00 pm

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Community Health Needs Assessment Template
National Center for Rural Health Works

Overview – Community Health Needs Assessment

- **Involves three meetings**
- **We are resource team and provide data, analysis and facilitation.**
- **You are the community steering committee and decision makers.**

WHAT are we doing?

A community-based assessment of health care needs in the medical service area of Guadalupe County Hospital

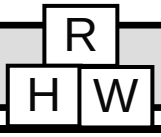
- From the community's perspective as to health care needs
- From analysis of data and information from public health department, other data sources, survey results, and economic impact study

(Cont'd) WHAT are we doing?

Outcomes of the community-based assessment will depend on:

- Community recommendations to Guadalupe County Hospital
- Resource availability

Results of the community needs assessment will be reported to the IRS on Form 990 and related schedules by Guadalupe County Hospital



Community Health Needs Assessment Template

National Center for Rural Health Works

WHY are we doing this?

The Patient Protection and Affordable Care Act (PPACA) requires not-for-profit hospitals to provide a Community Health Needs Assessment, as follows:

- The organization must conduct a "community health needs assessment" not less frequently than every three years and adopt an implementation strategy to meet the community health needs identified through the assessment.

(Cont'd) WHY are we doing this?

- A "community health needs assessment" must include input from persons "represent[ing] the broad interests of the community served by the hospital facility," including those "with special knowledge of or expertise in public health."
- The assessment must be made widely available to the public.

Hospitals are required to fulfill these requirements to preserve their status as not-for-profit facilities.

(Cont'd) WHY are we doing this?

The legislation also includes:

- Financial Assistance Policy Requirements
- Requirements regarding Charges
- Billing and Collection Requirements

Guadalupe County Hospital will fulfill these requirements internally.

WHY we WANT to do this?

Regardless of the legislative requirements, Guadalupe County Hospital wants community-based assessment to become a part of the hospital strategic plan on a long-term, continuing basis.

- Community will provide input to Guadalupe County Hospital as to the community's needs.
- Guadalupe County Hospital will develop communications and relationships with the community to plan and provide for the community's needs.

WHAT is required from the Community Group?

1. To review and analyze data and information provided during process:

   - Guadalupe County Hospital:
     - Medical service area
     - Services and community benefits currently provided
   - From State or Local Public Health:
     - Data on health indicators and outcomes

(Cont'd) WHAT is required from the Community Group?

- From other sources:
  - U. S. Census Bureau and County Business Patterns
  - ESRI
  - U. S. Department of Commerce, Regional Economic Information System, Bureau of Economic Analysis
  - Other agencies and foundations that provide relevant health data

(Cont'd) WHAT is required from the Community Group?

- Information will also be provided concerning:
  - The economic impact of the hospital
  - Jobs and salaries, wages, and benefits generated locally
  - A summary of the importance of the hospital to the local economy

(Cont'd) WHAT is required from the Community Group?

2. Provide input through health survey questionnaire and have other community members complete survey.
3. Review and analyze results of survey.
4. Provide input and recommendations on local community needs in the medical service area.

SUMMARY of Community Group Responsibilities

- ✓ Community members are here to participate in a three-meeting community-based needs assessment
- ✓ Community members will review data and information and identify the health needs of the community
- ✓ Community members will make recommendations to Guadalupe County Hospital

AGENDA - Community Meeting #1

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Meeting #3 - Tuesday, April 10, 2012 at 4:00 pm

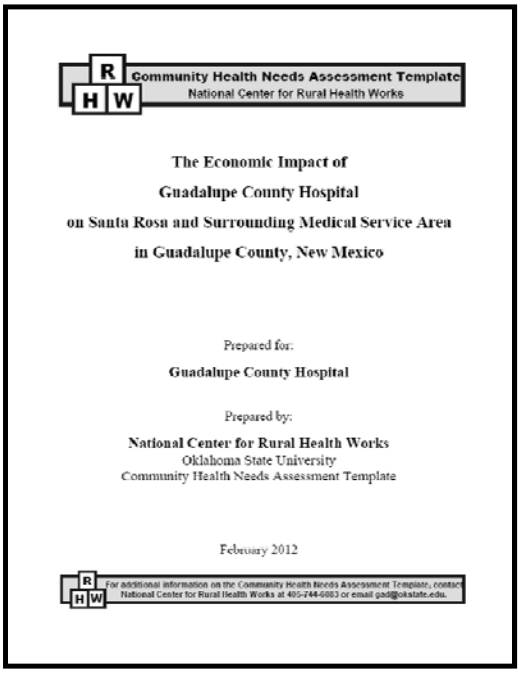
Community Health Needs Assessment Template
National Center for Rural Health Works

Hospital Services and Community Benefits

Guadalupe County Hospital-
Hospital Services and Community Benefits

Presented by:

Cristina Campos, Hospital Administrator,
Guadalupe County Hospital



Community Health Needs Assessment Template
National Center for Rural Health Works

The Economic Impact of
Guadalupe County Hospital
on Santa Rosa and Surrounding Medical Service Area
in Guadalupe County, New Mexico

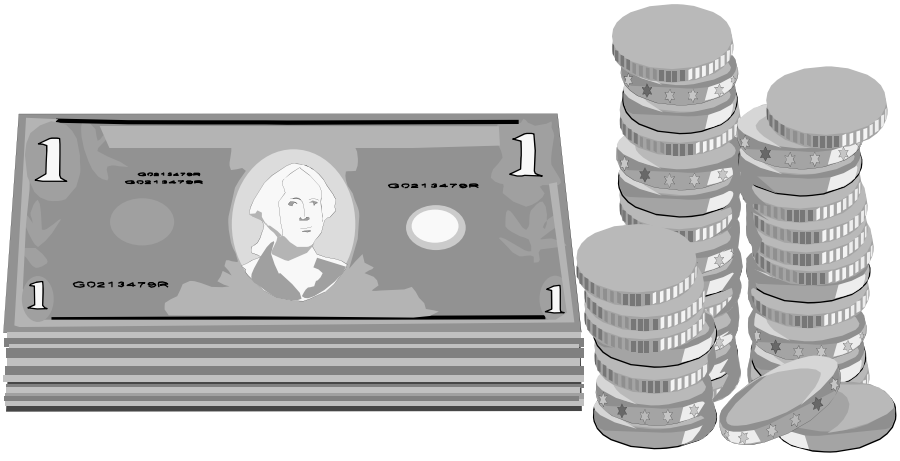
Prepared for:
Guadalupe County Hospital

Prepared by:
National Center for Rural Health Works
Oklahoma State University
Community Health Needs Assessment Template

February 2012

For additional information on the Community Health Needs Assessment Template, contact National Center for Rural Health Works at 405-744-6083 or email gadi@okstate.edu.

What's the Economic Potential for Health Care in Your Community



Health Services Promote Job Growth

To attract business and industry, research indicates the area needs quality:

- **Health services and**
- **Education services**

To attract retirees, research indicates the area needs quality:

- **Health services and**
- **Safety services**



Table 1
United States Health Expenditures and Employment Data
1970-2010; Projected for 2011, 2014, 2017, & 2020

Year	Total Health Expenditures ($Billions)	Per Capita Health Expenditures ($)	Health as % of GDP (%)	Health Sector Employment (000)	Avg. Annual Increase in Employment (%)
1980	256.0	1,110	9.2%	5,278[a]	7.3%
1990	724.0	2,854	12.5%	7,814[a]	4.8%
2000	1,377.0	4,878	13.8%	10,858[a]	3.9%
2003	1,774.0	6,114	15.9%	11,817[b]	N/A
2010	2,594.0	8,402	17.9%	13,777[b]	2.4%
Projections					
2011	2,708.4	8,649	17.7%		
2014	3,227.4	10,035	18.1%		
2017	3,849.5	11,664	18.8%		
2020	4,638.4	13,709	19.8%		

Figure 1.
National Health Expenditures
as a Percent of Gross Domestic Product
and by Health Service Type, 2010

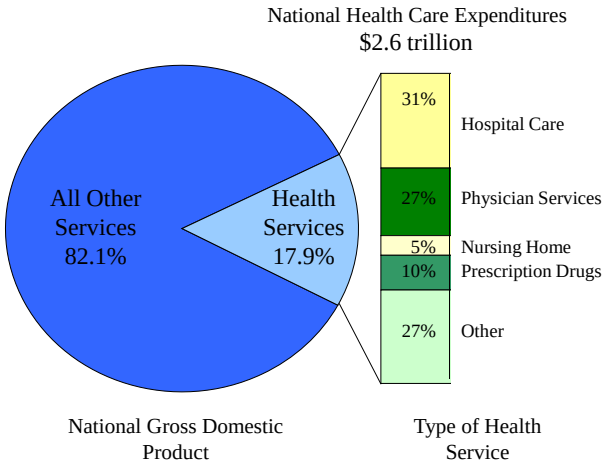


Table 2
Populations by Race and Hispanic Origin
for Guadalupe County and the State of New Mexico

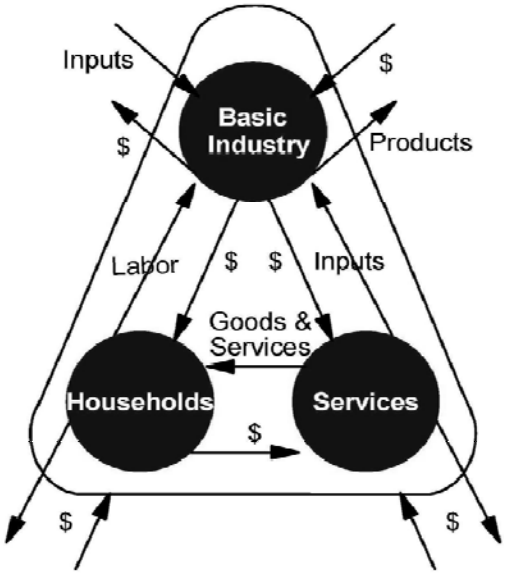
	White	Black	Native American[1]	Other[2]	Two or More Races[3]	Total	Hispanic Origin[4]
2000 Census							
Santa Rosa City	1,577	60	48	934	125	2,744	2,227
Rural Area	669	2	3	684	39	1,397	1,105
Guadalupe County	2,530	62	53	1,855	180	4,680	3,801
Percent	54.1%	1.3%	1.1%	39.6%	3.8%	100.0%	81.2%
State of New Mexico	1,214,253	34,343	173,483	330,640	66,327	1,819,046	765,386
Percent	66.8%	1.9%	9.5%	18.2%	3.6%	100.0%	42.1%
2010 Census							
Santa Rosa City	1,971	68	57	654	98	2,848	2,262
Rural Area	694	3	13	174	32	916	677
Guadalupe County	3,298	79	90	1,066	154	4,687	3,730
Percent	70.4%	1.7%	1.9%	22.7%	3.3%	100.0%	79.6%
State of New Mexico	1,407,876	42,550	193,222	338,521	77,010	2,059,179	953,403
Percent	68.4%	2.1%	9.4%	16.4%	3.7%	100.0%	46.3%

Table 3
Populations by Age Group
for Guadalupe County and the State of New Mexico

	Age Groups						
	0-14	15-19	20-24	25-44	45-64	65+	Total
2000 Census							
Santa Rosa City	505	211	205	944	549	330	2,744
Rural Area	288	114	69	360	338	228	1,397
Guadalupe County	908	365	298	1,437	1,024	648	4,680
Percent	19.4%	7.8%	6.4%	30.7%	21.9%	13.8%	100.0%
State of New Mexico	419,108	145,751	121,291	516,100	404,571	212,225	1,819,046
Percent	23.0%	8.0%	6.7%	28.4%	22.2%	11.7%	100.0%
2010 Census							
Santa Rosa City	483	168	202	886	743	366	2,848
Rural Area	170	53	42	166	343	142	916
Guadalupe County	836	287	278	1,219	1,339	728	4,687
Percent	17.8%	6.1%	5.9%	26.0%	28.6%	15.5%	100.0%
State of New Mexico	429,980	149,861	142,370	515,768	548,945	272,255	2,059,179
Percent	20.9%	7.3%	6.9%	25.0%	26.7%	13.2%	100.0%

Direct Activities of Guadalupe County Hospital
in Guadalupe County, New Mexico, 2011

	Employment Number of Full-time & Part-Time Employees	**Labor Income** Wages, Salaries, and Benefits
From Hospital Operations	50	$2,909,410
From Hospital Construction of $10,000,000	86	$3,465,875
Total Direct Impact	136	$6,375,285



Community Economic System

Employment Impact of Guadalupe County Hospital on Guadalupe County, New Mexico, 2011

	Employment Impact			
	Number Employed	Employment Multiplier	Secondary Impact	Total Impact
From Hospital Operations	50	1.34	17	67
From Hospital Construction	86	1.23	20	106
Total Impact	136		37	173

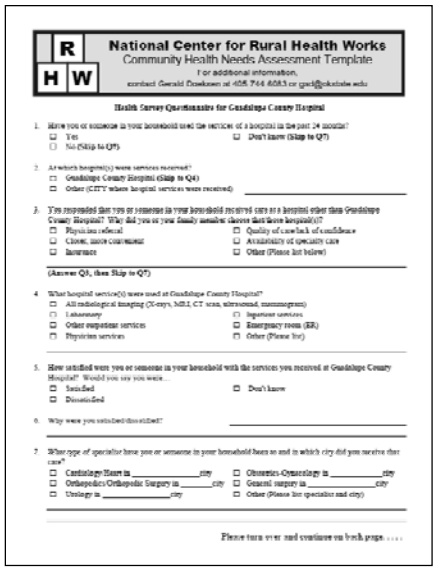
Income Impact of Guadalupe County Hospital on Guadalupe County, New Mexico, 2011

	Income Impact			
	Direct Income	Income Multiplier	Secondary Impact	Total Impact
From Hospital Operations	$2,909,410	1.18	$523,694	$3,433,104
From Hospital Construction	$3,465,875	1.16	$554,540	$4,020,415
Total Income Impact	$6,375,285		$1,078,234	$7,453,519

In summary, Guadalupe County Hospital contributes to economic development:

- Businesses and industries locate in areas with high quality medical facilities and educational systems;
- Retirees locate in areas with accessible and comprehensive health care services and law enforcement services;
- The health sector is a growing sector and will continue to generate more jobs, and;
- The health sector generally pays above-average salaries and wages.

Local leaders must continue to support Guadalupe County Hospital to ensure development of economic growth and opportunities in Guadalupe County.



National Center for Rural Health Works
Community Health Needs Assessment Template
For additional information,
contact Gerald Dunkerson at 405 744 6083 or gard@okstate.edu

Health Survey Questionnaire for Guadalupe County Hospital

1. Have you or someone in your household used the services of a hospital in the past 24 months?
☐ Yes ☐ Don't know (Skip to Q7)
☐ No (Skip to Q5)

2. At which hospital(s) were services received?
☐ Guadalupe County Hospital (Skip to Q4)
☐ Other (CITY where hospital services were received) _____

3. You responded that you or someone in your household received care at a hospital other than Guadalupe County Hospital? Why did you or your family member choose that/those hospital(s)?
☐ Physician referral ☐ Quality of care/lack of confidence
☐ Closer, more convenient ☐ Availability of specialty care
☐ Insurance ☐ Other (Please list below)

(Answer Q8, then Skip to Q7)

4. What hospital service(s) were used at Guadalupe County Hospital?
☐ All radiological imaging (X-rays, MRI, CT scan, ultrasound, mammogram)
☐ Laboratory ☐ Inpatient services
☐ Other outpatient services ☐ Emergency room (ER)
☐ Physician services ☐ Other (Please list)

5. How satisfied were you or someone in your household with the services you received at Guadalupe County Hospital? Would you say you were…
☐ Satisfied ☐ Don't know
☐ Dissatisfied

6. Why were you satisfied/dissatisfied? _____

7. What type of specialist have you or someone in your household been to and in which city did you receive that care?
☐ Cardiology/Heart in _____city ☐ Obstetrics/Gynecology in _____city
☐ Orthopedics/Orthopedic Surgery in _____city ☐ General surgery in _____city
☐ Urology in _____city ☐ Other (Please list specialist and city)

Please turn over and continue on both pages. . . .

8. Did the specialist request further testing, laboratory work and/or tests?
☐ Yes ☐ Don't know
☐ No

9. If yes, in which city were the tests or laboratory work performed?

10. Do you use a family doctor for most of your routine health care?
☐ Yes (Skip to Q12) ☐ Don't know (Skip to Q13)
☐ No

11. If no, then what kind of medical provider do you use for routine care?
☐ Public Health Office ☐ Specialist
☐ Emergency Room/Hospital ☐ Other (Please list below)

12. Have you or someone else in your household been to a primary care doctor in Guadalupe County?
☐ Yes ☐ Don't know (Skip to Q14)
☐ No (Skip to Q14)

13. How satisfied were you or someone in your household with the quality of care received in Guadalupe County? Would you say that you were…?
☐ Satisfied ☐ Don't know
☐ Dissatisfied

14. Why were you satisfied/dissatisfied? _____

15. Are you able to get an appointment with your primary care (family) doctor in Guadalupe County when you need one?
☐ Yes ☐ Don't know
☐ No

16. Have you or someone in your household delayed health care due to lack of money and/or insurance?
☐ Yes ☐ Don't know
☐ No

17. What concerns you most about health care in Guadalupe County?

18. What services would you like to see offered in Guadalupe County? _____

Health Survey Questionnaire

- Community Committee Members complete a survey TODAY
- Each Community Committee Member takes five more surveys to have completed
- Additional surveys are to be completed by the constituents that the Community Member represents

Survey Returns

- Return completed surveys at the Second Meeting, Tuesday, March 13, 2012, or
- Return to Cristina Campos, Hospital Administrator at Guadalupe County Hospital by March 12, 2012

Community Meeting #2, Tuesday, March 13, 2012

Agenda
Guadalupe County Hospital
Community Meeting #2
Tuesday, March 13, 2012
4:00 pm

I. Introductions – Christina Campos, CEO, Guadalupe County Hospital
II. Review of Meeting #1 – Val Schott, National Center
III. Guadalupe County Economic and Demographic Data – Gerald Doeksen, National Center
IV. Guadalupe County Health Indicator/Health Outcome Data – Val Schott
V. Collect Completed Health Survey Questionnaires – Gerald Doeksen
VI. Next Steps

Meeting #3, Tuesday, April 10, 2012, at 4:00 pm

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Community Health Needs Assessment Template
National Center for Rural Health Works

HOSPITAL REPORTING REQUIREMENTS

Community Health Needs Assessment Reporting to Meet IRS Requirements

IRS Forms: Form 990 & Schedule H

Summary Report Outline
Community Health Needs Assessment

Community Members
Need to include name, organization and contact information for:
- Hospital Administrator
- Steering Committee or Leadership Group
- Facilitator
- Community Advisory Committee Members

Medical Service Area
- Describe by county or zip code areas
- Include populations and projected populations of medical service area
- Include demographics of population of medical service area

Community Meetings
- Date
- Agenda
- List reports presented with short summary of each

Community Needs and Implementation Strategies
Include community needs and implementation strategies with responsibilities from community group

Hospital Final Implementation Plan
- Include which needs hospital can address and the implementation strategies
- Include which needs hospital cannot address and reason(s) why

Community Awareness of Assessment
Describe methodology for making assessment widely available to the community

For Additional Information:

Please contact:

Gerald Doeksen, Executive Director
Email: gad@okstate.edu
Phone: 405-744-6083

or

Cheryl F. St. Clair, Associate Director
Email: cheryl@okstate.edu
Phone: 405-744-6083 or 98245

National Center for Rural Health Works
Oklahoma State University

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Community Health Needs Assessment Template
National Center for Rural Health Works

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Community Needs Assessment Template
National Center for Rural Health Works

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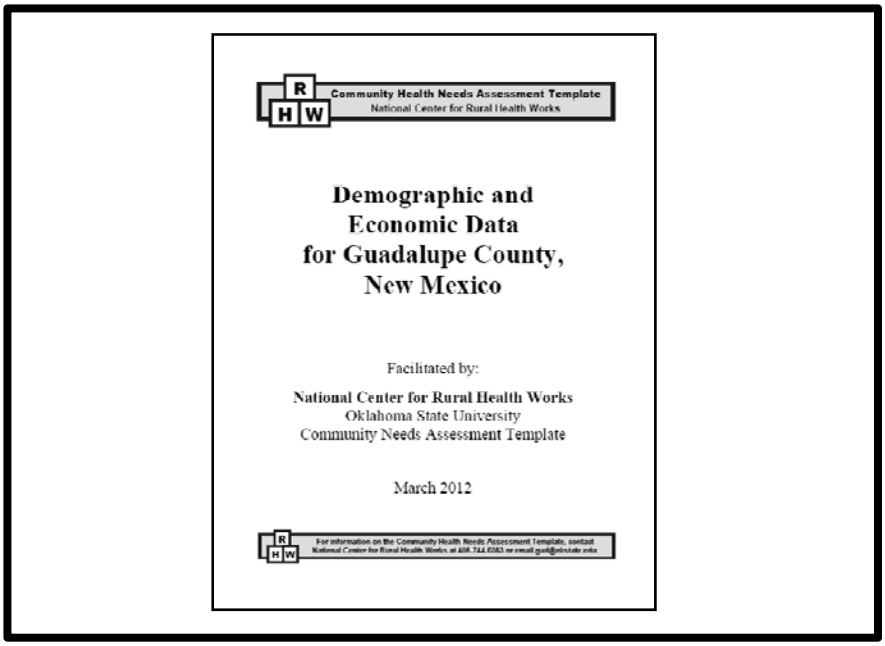
Community Health Needs Assessment Template
National Center for Rural Health Works

Demographic and Economic Data for Guadalupe County, New Mexico

Facilitated by:

National Center for Rural Health Works
Oklahoma State University
Community Needs Assessment Template

March 2012

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Percent	17.8%	6.1%	5.9%	26.0%	28.6%	15.5%	100.0%
State of New Mexico	429,980	149,861	142,370	515,768	548,945	272,255	2,059,179
Percent	20.9%	7.3%	6.9%	25.0%	26.7%	13.2%	100.0%

Table 4
Population, Projections, and Percent Change
for Guadalupe County and the State of New Mexico

	Census	Population Projections			
	2010	2015	2020	2025	2030
Guadalupe County	4,687	5,553	5,961	6,328	6,717
% Change from 2010		18.5%	27.2%	35.0%	43.3%
State of New Mexico	2,059,179	2,356,236	2,540,145	2,707,757	2,864,796
% Change from 2010		14.4%	23.4%	31.5%	39.1%

Table 5
Full- & Part-Time Employment by Type of Employment & by Major Industry (NAICS)[1]
for Guadalupe County and the State of New Mexico, 2009

	Guadalupe County			New Mexico	
	No. of Jobs	% of Total	% of Private	% of Total	% of Private
Total full- & part-time employment	2,019	100.0%		100.0%	
Wage & salary employment	1,439	71.3%		79.1%	
Proprietors' employment	580	28.7%		20.9%	
Farm proprietors' employment	217	37.4%		7.8%	
Nonfarm proprietors' employment[2]	363	62.6%		92.2%	
By Industry:					
Farm employment	258	12.8%		2.3%	
Nonfarm employment	1,761	87.2%		97.7%	
Private employment	1,276	72.5%	100.0%	79.4%	100.0%
Construction	103		8.1%		8.1%
Retail trade	260		20.4%		13.5%
Transportation & warehousing	64		5.0%		2.9%
Health care & social assistance	**156**		**12.2%**		**14.2%**
Accommodation & food services	415		32.5%		9.8%
Other services, except public admin	73		5.7%		6.2%
Sum of (D) and (L) Categories[3]	*205*		*16.1%*		
Government & government enterprises	485	27.5%		20.6%	

Table 6

Personal Income Earnings by Place of Work and by Industry (NAICS)[1] for Guadalupe County and the State of New Mexico, 2009

	Guadalupe County			New Mexico	
	Income ($1,000s)	% of Total	% of Private	% of Total	% of Private
Total earnings by place of work	58,321	100.0%		100.0%	
Wage & salary disbursements	38,422	65.9%		71.6%	
Proprietors' income[2]	9,299	15.9%		9.9%	
All other earnings	10,600	18.2%		18.6%	
Earnings by Industry					
Total earnings by industry	58,321	100.0%		100.0%	
Farm earnings	5,650	9.7%		1.2%	
Nonfarm earnings	52,671	90.3%		98.8%	
Private earnings	32,819	62.3%	100.0%	71.6%	100.0%
Construction	4,128		12.6%		8.6%
Retail trade	6,188		18.9%		9.7%
Transportation & warehousing	2,136		6.5%		3.7%
Educational services	64		0.2%		1.2%
Health care & social assistance	**6,405**		**19.5%**		**15.7%**
Other services, except public admin	2,818		8.6%		5.2%
Sum of (D) & (L) Categories[3]	*3,679*		*11.2%*		
Government & government enterprises	19,852	37.7%		28.4%	

Table 7

Transfer Receipts for Guadalupe County and the State of New Mexico, 2009

	Guadalupe County		State of New Mexico	
	Receipts* ($1,000s)	% of Total	Receipts* ($1,000s)	% of Total
Total personal current transfer receipts	44,879	100.0%	14,345,809	100.0%
Receipts of individuals from govts	44,106	98.3%	13,981,149	97.5%
Ret. & disab. ins. benefits	10,445	23.3%	4,313,600	30.1%
Old-age, surv & disab ins benefits	9,835	21.9%	4,165,644	29.0%
Railroad ret & disab benefits	556	1.2%	86,408	0.6%
Workers' comp	(L)	**	55,809	0.4%
Other govt ret & disab ins benefits[1]	(L)	**	5,739	0.0%
Medical benefits	24,494	54.6%	6,225,189	43.4%
Medicare benefits	8,683	19.3%	2,623,849	18.3%
Public asst medical care benefits[2]	15,761	35.1%	3,524,253	24.6%
Military medical insurance benefits[3]	50	0.1%	77,087	0.5%

Table 8
Economic Indicators
for Guadalupe County and the State of New Mexico

Indicator	Guadalupe County	State of New Mexico
Total Personal Income (2009)	105,946,000	66,856,080,000
Per Capita Income (2009)	24,981	33,267
Employment (2010)	1,618	873,112
Unemployment (2010)	187	80,202
Unemployment Rate (2010)	10.4%	8.4%
Employment (2011)	1,592	873,656
Unemployment (2011)	178	67,227
Unemployment Rate (2011)	10.0%	7.1%
% of People in Poverty (2010)	23.7%	19.8%
% of Under 18 in Poverty (2010)	30.5%	28.5%
Transfer Receipt Dollars (2009)	44,879,000	14,345,809,000
Transfer Dollars as Percentage of Total Personal Income (2009)	42.4%	21.5%

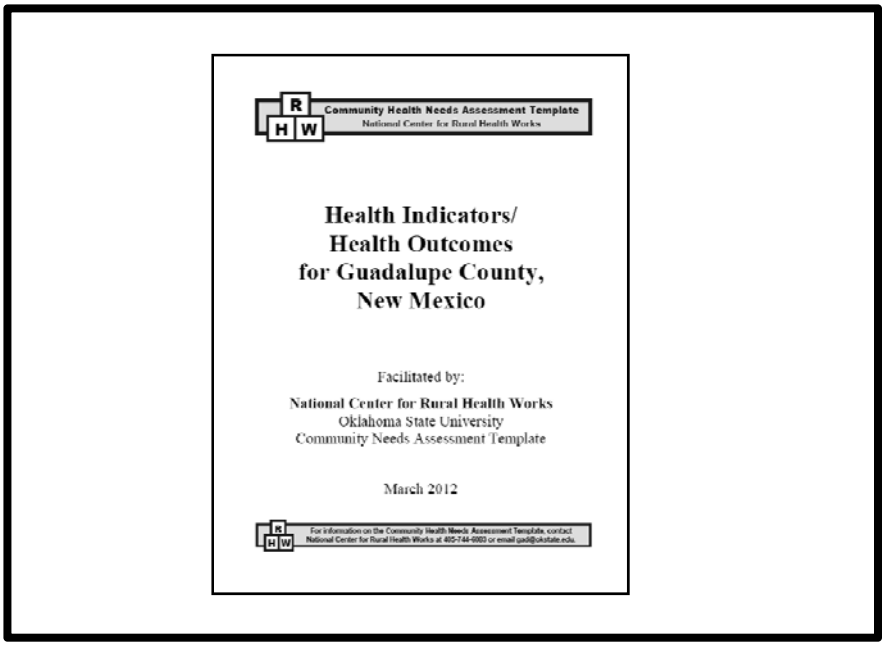


Table 1

County Health Rankings Mobilizing Action Toward Community Health	Guadalupe County	State of New Mexico
Health Factors		
Health Behaviors		
Adult obesity - BMI ≥ 30	23.0%	27.0%
Teen birth rate - ages 15-19	62	64
Clinical Care		
Uninsured adults - under age 65	26.0%	30.0%
Diabetic screening - Diabetic Medicare enrollees	83.0%	70.0%
Children in Poverty-Under 18 in Poverty	31.0%	24.0%

Table 2
Access to Care
for Guadalupe County, New Mexico

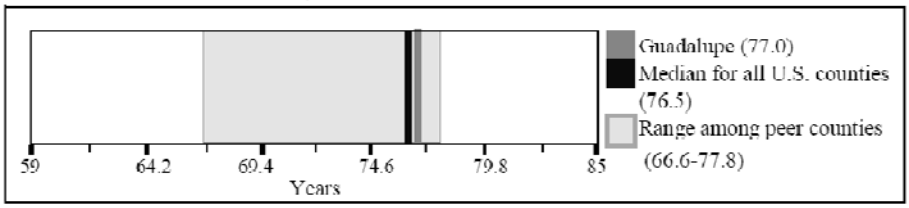
ACCESS TO CARE	
Guadalupe Co., NM	
In addition to use of services, access to care may be characterized by medical care coverage and service availability.	
Uninsured individuals (age under 65)	839
Medicare beneficiaries[2]	
Elderly (age 65+)	662
Disabled	199
Medicaid beneficiaries	1,417
Primary care physicians per 100,000 population	69
Dentists per 100,000 population	0
Community/Migrant Health Centers	Yes
Health Professional Shortage Area	Yes

Table 3

SUMMARY MEASURES OF HEALTH

Guadalupe County, NM

AVERAGE LIFE EXPECTANCY[1]



ALL CAUSES OF DEATH[2]

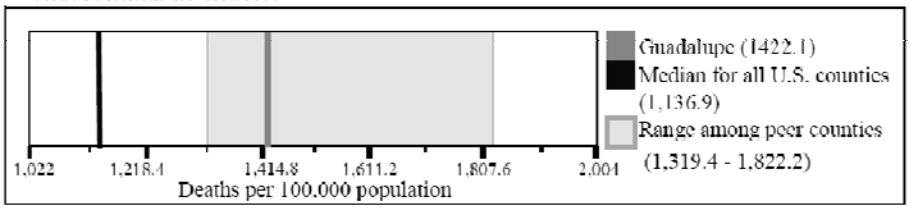
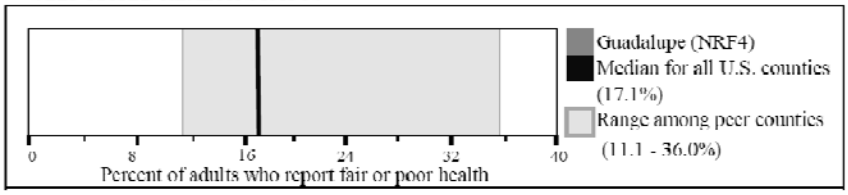


Table 3 Continued

SUMMARY MEASURES OF HEALTH

Guadalupe County, NM

SELF-RATED HEALTH STATUS[3]



AVERAGE NUMBER OF UNHEALTHY DAYS IN PAST MONTH[3]

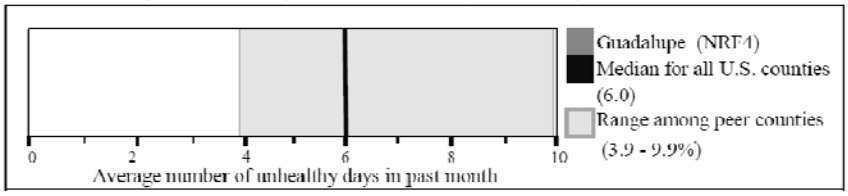


Table 4

RELATIVE HEALTH IMPORTANCE

Guadalupe County, NM

Indicates a status favorable to peer county median value

Indicates that a closer look and perhaps reduction to the percent or rate may be needed. Blank indicates no comparison.

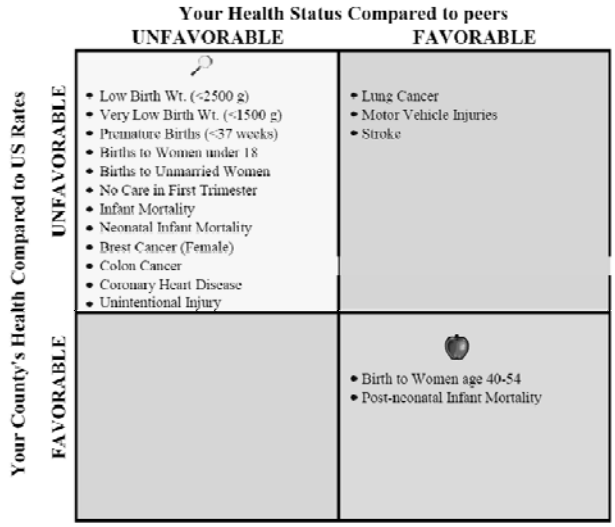


Table 7
Births by Race
for Guadalupe County and the State of New Mexico

	Guadalupe County 2009		New Mexico 2009	
	No.	%	No.	%
White	2	5.6%	8,186	28.4%
Black	0	0.0%	616	2.1%
Hispanic	34	94.4%	15,328	53.1%
Other[1]	0	0.0%	4,558	15.8%
Unknown/Not Reported	0	0.0%	185	0.6%
Total Births	36	100.0%	28,873	100.0%

Table 8
Birth's by Mother's Age
for Guadalupe County and the State of New Mexico

	Guadalupe County		State of New Mexico	
	2009		2009	
Age Groups	No.	%	No.	%
10-17	2	5.6%	1,531	5.3%
18-19	2	5.6%	2,930	10.1%
20-29	22	61.1%	16,580	57.4%
30-39	10	27.8%	7,231	25.0%
40-49	0	0.0%	597	2.1%
50+[1]	0	0.0%	3	0.0%
Unknown/ Not Reported	0	0.0%	4	0.0%
Total Births	36	100.0%	28,873	100.0%

Guadalupe County and State of New Mexico Census Statistics including Births and Deaths (2010) and Leading Causes of Death, 2008-2010

	Guadalupe County	New Mexico
County Seat	Santa Rosa	
Population (July 1, 2010)	4,687	2,060,971
% New Mexico	0.20%	100%
Land Area (Square miles)	3,030.50	121,298
Persons per Sq. Mile (2010)	1.5	17
Births (2010)	46	27,795
Deaths (2010)	59	15,866
Households (2005-2009)	1,416	736,630

SOURCE: U. S. Census Bureau (www.census.gov)

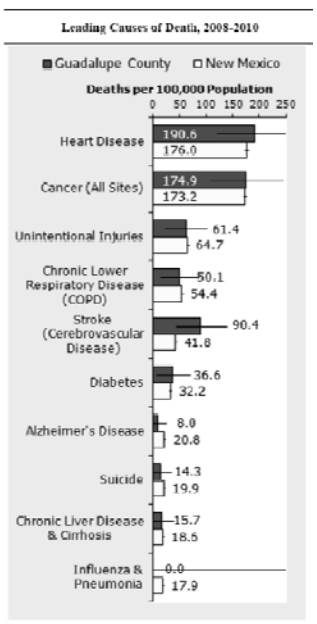


Table 16
Health Characteristics From Community Health Highlights
for Guadalupe County and the State of New Mexico

Health Characteristic	Guadalupe County	New Mexico	Comparison to State
Youth Smoking Prevalence (2009)	19.9	24	Watch
Adolescent Physical Activity (2007)	50.8	43.6	Watch
% of Adolescents who ate 5+ Servings of Fruits and Veggies Daily (2003-2009)	19.6	20.9	Improvement Needed
Youth (Grades 9-12) with Caring and Supportive Relationship in the Family (2009)	72.7	54.1	Excellent
Alcohol-Related Deaths per 100,000 Population (2007-2009)	101.8	52.9	Improvement Needed

Table 16 Continued
Health Characteristics From Community Health Highlights
for Guadalupe County and the State of New Mexico

Alcohol-Related Chronic Disease Deaths per 100,000 Population (2007-2009)	69.5	23.9	Improvement Needed
Alcohol Related Injury Death Rates per 100,000 Population (2007-2009)	32.2	29.0	Improvement Needed
Drug-Induced Deaths per 100,000 Population (2007-2009)	27.1	22.8	Improvement Needed
Health Insurance Coverage; % Uninsured, Under 65 Years (2009)	30.6	22.9	Reason for Concern
Medicaid Enrollment; Avg Monthly % of Population (2010)	26.9	23.4	NA
Primary Care Providers; Ratio of Population to Providers (2008)	1440	832	NA
Prenatal Care in First Trimester (2008-2009)	68.2	52.0	Excellent

Table 16 Continued
Health Characteristics From Community Health Highlights
for Guadalupe County and the State of New Mexico

% of Live Born Infants with Low Birthweight (2008-2010)	12.7	8.5	Improvement Needed
Teen Birth Rate; Births per 1000 Girls Age 15-17 (2007-2009)	21.3	31.6	Watch
Chlamydia Cases per 100,000 Population (2010)	666.7	557.9	NA
Diseases of the Heart Death Rate per 100,000 population (2007-2009)	384.4	203.8	Reason for Concern
Stroke Death Rate per 100,000 population (2005-2009)	73	38.2	Improvement Needed
Diabetes Deaths per 100,000 population (2008-2010)	32.5	32.5	Watch

Table 16 Continued
Health Characteristics From Community Health Highlights
for Guadalupe County and the State of New Mexico

Adolescent Obesity (BMI ≥ 95th percentile) (2001-2009)	18.7	13.5	Reason for Concern
Female Breast Cancer Deaths per 100,000 population (2001-2005)	62	22.1	Improvement Needed
Influenza and Pneumonia Deaths per 100,000 Population (2006-2009)	10.8	20.6	Watch
Unintentional Injury Death Rates per 100,000 population (2003-2007)	88.6	62.3	Improvement Needed
Motor Vehicle Traffic Crash Deaths per 100,000 population (2005-2009)	31	18.3	Improvement Needed
Suicide Death Rates per 100,000 population (2007-2009)	12.9	18.6	Watch

Table 16 Continued

Health Characteristics From Community Health Highlights

for Guadalupe County and the State of New Mexico

Ratio of Total Substantiated Child Abuse Allegations per 1000 child population (2010)	39.4	18.5	Improvement Needed
% of Youth Who Felt Sad or Hopeless Almost Every day (2001-2009)	28.9	29.7	Watch
Life Expectancy from Age 65 in avg. number of years (2005-2009)	17.89	18.7	NA
Children (Under Age 18) Living in Poverty (2009)	32	28.8	Improvement Needed
High School Graduation Rate (2010)	84.7	67.3	Excellent

Agenda
Guadalupe County Hospital - Meeting #2
Tuesday March 13, 2012
4:00 pm

I. Introductions – Christina Campos, CEO, Guadalupe County Hospital

II. Review Prior Two Meetings– Val Schott, National Center

III. Health Survey Results - Gerald Doeksen, National Center

IV. Develop Community Action Plan – Val Schott and Gerald Doeksen
- A. List Community Health Issues
- B. Prioritize Community Health Issues
- C. Discuss Possible Resolution for Health Issues
- D. Summarize Community Recommendations
- E. Hospital CEO Response- Christina Campos

V. Next Steps

R H W

Community Health Needs Assessment Template

National Center for Rural Health Works

For Additional Information:

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or

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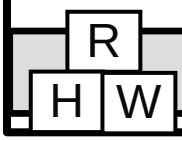
Phone: 405-744-6083 or 98245

National Center for Rural Health Works
Oklahoma State University



Community Health Needs Assessment Template

National Center for Rural Health Works

Agenda
Guadalupe County Hospital
Community Meeting #3
Tuesday, April 10, 2012
4:00 pm

I. Introductions – Christina Campos, CEO, Guadalupe County Hospital

II. Review Prior Two Meetings – Val Schott, National Center

III. Health Survey Results – Gerald Doeksen, National Center

IV. Develop Community Action Plan – Gerald Doeksen and Val Schott

a. List community health issues

b. Prioritize community health issues

c. Discuss possible resolution for health issues

d. Summarize community recommendations

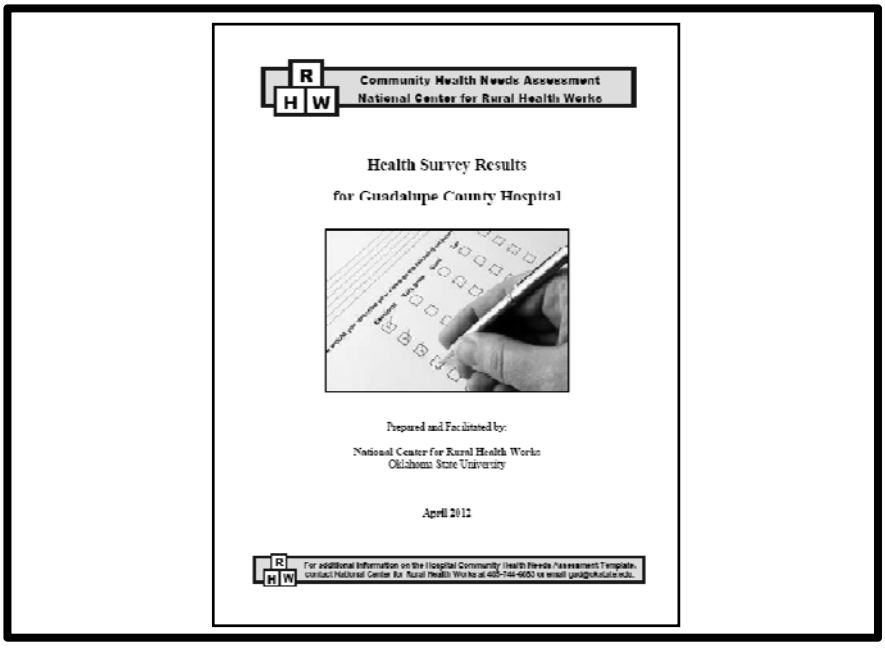
e. Hospital CEO Response – Christina Campos

V. Next Steps

Community Needs Assessment Template
National Center for Rural Health Works

Agenda
Guadalupe County Hospital - Meeting #3
Tuesday April 10, 2012
4:00 pm

I. Introductions – Christina Campos, CEO, Guadalupe County Hospital
II. Review of Prior Meetings – Val Schott, National Center
III. Health Survey Results - Gerald Doeksen, National Center
IV. Develop Community Action Plan – Gerald Doeksen and Val Schott
    I. List Community Health Issues
    II. Prioritize Community Health Issues
    III. Discuss Possible Resolution for Health Issues
    IV. Summarize Community Recommendations
    V. Hospital CEO Response – Christina Campos
V. Next Steps



Q1. Have you or someone in your household used the services of a hospital in the past 24 months?

Response Category	No.	%
Yes	77	81.0%
No	18	19.0%
Totals	95	100.0%

2. At which hospitals/cities were services received?

Response Category	No.	%
Guadalupe County Hospital	72	75.8%
Albuquerque Hospitals	13	13.7%
Las Vegas Hospitals	4	4.2%
Clovis Hospitals	2	2.1%
Santa Fe Hospitals	1	1.1%
Portalis Hospitals	1	1.1%
El Paso Hospitals	1	1.1%
Tucumcari Hospitals	1	1.1%
Totals	95	100.2%

Some respondents received services at more than one hospital.

3. You responded that you or someone in your household received care at a hospital other than Guadalupe County Hospital. Why did you or your family member choose that/those hospital(s)?

Response Category	No.	%
Availability of specialty care	10	35.7%
Physician referral	9	32.1%
Quality of care/lack of confidence	3	10.7%
Closer, more convenient location	3	10.7%
Emergency care	1	3.6%
On vacation	1	3.6%
Son attends school there	1	3.6%
Totals	28	100.0%

Some respondents provided more than one answer.

4. What hospital service(s) were used at Guadalupe County Hospital?

Response Category	No.	%
Laboratory	48	28.6%
Physician services	38	22.6%
All radiological imaging	36	21.4%
Emergency services	27	16.1%
Other outpatient services	9	5.4%
Inpatient services	8	4.8%
No response	2	1.2%
Total	168	100.0%

Many respondents indicated multiple categories of hospital services.

5. How satisfied were you or someone in your household with the services you received at Guadalupe County Hospital? Would you say you were…

Response Category	No.	%
Satisfied	64	88.9%
Dissatisfied	6	8.3%
No response	2	2.8%
Total	72	100.0%

6a. Why were you or someone in your household satisfied with the services received at Guadalupe County Hospital?

Response Category	No.	%
No Response	27	31.8%
Competent care; quality care; quality service	16	18.8%
Good staff care, personal staff care	13	15.3%
Quick response	13	15.3%
Knowledgeable doctors	8	9.4%
Convenient, close to home	5	5.9%
Just satisfied; need more services	1	1.2%
All questions answered	1	1.2%
Beautiful facility	1	1.2%
Total	85	100.0%

Some respondents provided more than one response.

6b. Why were you or someone in your household dissatisfied with the services received at Guadalupe County Hospital?

Response Category	No.	%
No response	2	33.3%
Too long wait for doctor	2	33.3%
Used to getting bad service	1	16.7%
No followup by medical clinic nursing staff	1	16.7%
Total	6	100.0%

7. What type of specialist have you or someone in your household been to and in which city did you receive that care?

Response Category	No.	%
None	20	12.6%
Orthopedics/Orthopedic surgery (Albuquerque [18], Las Vegas [4], Amarillo [1], Clovis [1], Santa Fe [1], Taos [1])	26	16.4%
OB-GYN (Albuquerque [17], Las Vegas [3], Clovis [1], no city specified [1])	22	13.8%
General Surgery (Albuquerque [13], Las Vegas [5], Amarillo [2], Cincinnati [1], El Paso [1])	22	13.8%
Cardiology/Heart (Albuquerque [14], Bernalillo [1], Clovis [1], Cincinatti [1], Las Vegas [1], No City Specified [1])	19	11.9%
Urology (Albuquerque [11], Las Vegas [2], Cincinnati [1], Taos [1], no city specified [1])	16	10.1%

8.Did the specialist request further testing, laboratory work and/or x-rays?

Response Category	No.	%
Yes	50	66.7%
No	17	22.7%
Don't know	6	8.0%
No response	2	2.7%
Total	75	100.0%

9. If yes, in which city were the tests or laboratory work performed?

Response Category	No.	%
Albuquerque	31	47.7%
Santa Rosa	13	20.0%
Las Vegas	8	12.3%
Clovis	3	4.6%
Santa Fe	1	1.5%
El Paso	1	1.5%
Amarillo	1	1.5%
Guadalupe	1	1.5%
Cincinnati	1	1.5%
No response	5	7.7%
Total	65	99.8%

Some respondents indicated more than one city.

10. Do you use a primary care (family) doctor for most of your routine health care?

Response Category	No.	%
Yes	87	91.6%
No	8	8.4%
Total	95	100.0%

11. If no, then what kind of medical provider do you use for routine care?

Response Category	No.	%
Public Health Office	5	55.6%
Specialist	3	33.3%
Whoever is on call or in office	1	11.1%
Total	9	100.0%

Some respondents provided more than one response.

12. Have you or someone else in our household been to a primary care (family) doctor in the Guadalupe County Hospital service area?

Response Category	No.	%
Yes	74	77.9%
No	18	18.9%
Don't know	3	3.2%
Total	95	100.0%

13. How satisfied were you or someone in your household with the quality of physician care received in the Guadalupe County Hospital service area? Would you say you were…

Response Category	No.	%
Satisfied	59	76.6%
Dissatisfied	4	5.2%
Both satisfied and dissatisfied	2	2.6%
No response	9	11.7%
Don't know	3	3.9%
Total	77	100.0%

14a. Why were you or someone in your household satisfied with the quality of physician care received in Guadalupe County?

Response Category	No.	%
Quality care; quality services	8	21.6%
Professional, knowledgeable physicians	5	13.5%
Personal Care	4	10.8%
Services were provided	4	10.8%
Timely service	2	5.4%
Convenience	2	5.4%
Satisfied with specific physician	1	2.7%
No response	11	29.7%
Total	37	100.0%

Some respondents provided more than one response.

14b. Why were you or someone in your household dissatisfied with the quality of physician care received in Guadalupe County?

Response Category	No.	%
Doctor/Staff was rushed	2	33.3%
No response	1	16.7%
No follow-up by physician or nursing staff	1	16.7%
Don't assume viral; need to do bloodwork to see	1	16.7%
If can't provide care, should send you to someone who can	1	16.7%
Total	6	100.0%

15. Are you able to get an appointment with your primary care (family) doctor in the Guadalupe County Hospital service area when you need one?

Response Category	No.	%
Yes	83	87.4%
No	5	5.3%
Don't know	7	7.4%
Total	95	100.0%

16. Have you or someone in your household delayed health care due to lack of money and/or insurance?

Response Category	No.	%
Yes	24	25.3%
No	70	73.7%
No response	1	1.1%
Total	95	100.0%

17. What concerns you most about health care in the Guadalupe County Hospital service area?

Response Category	No.	%
No response	29	27.9%
None	13	12.5%
Physician Concerns (22, 28.8%)		
Lack of doctors/specialists	16	15.4%
Attracting/retaining physicians and staff	4	3.8%
Misdiagnoses	2	1.9%
Lack in thoroughness of care	2	1.9%
Too long of a wait to be seen	2	1.9%
Rushed	1	1.0%
Holdout on referrals	2	1.9%
Physician prejudice to patients	1	1.0%

17 Cont. What concerns you most about health care in the Guadalupe Co Hospital service area?

Hospital Concerns (18, 17.3%)		
HIPPA violations/confidentiality	6	5.8%
Need for dialysis care	3	2.9%
Lack of professionalism	2	1.9%
Need for physical therapy care	2	1.9%
Pharmacy concerns: size/hours	2	1.9%
Low hospital visibility in community projects	1	1.0%
Shortage of ER nurses	1	1.0%
Training/Experience	1	1.0%

17 Cont. What concerns you most about health care in the Guadalupe Co Hospital service area?

General Concerns (14, 13.5%)		
Transportation/ambulance transport services	5	4.8%
Dentistry hours	1	1.0%
Excessive cost of health care	3	2.9%
Childcare	1	1.0%
High birthrate for young unwed mothers	1	1.0%
Little/no insurance	1	1.0%
Need for intermediate and paramedics in EMS	1	1.0%
Obesity epidemic	1	1.0%
Total	104	100.0%

Some respondents provided more than one response.

18. What services would you like to see offered at Guadalupe County Hospital?

Response Category	No.	%
No response	22	14.2%
Don't know	1	0.6%
None	2	1.3%
Physician Services (5, 3.2%)		
More doctors/primary care	5	3.2%
Specialty Services (106, 68.4%)		
More Specialists	16	10.3%
Physical Therapy	22	14.2%
Optometry/Ophthalmology	22	14.2%
Chiropractor	10	6.5%
Dialysis	8	5.2%
Chiropractor	6	3.9%
OB/GYN	4	2.6%

Many respondents provided more than one response.

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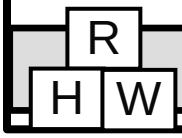
National Center for Rural Health Works
Oklahoma State University



Community Health Needs Assessment Template

National Center for Rural Health Works

Appendix M

Example Demographic and Economic Data Report

Demographic and Economic Data for Guadalupe County, New Mexico

Facilitated by:

National Center for Rural Health Works
Oklahoma State University
Community Needs Assessment Template

March 2012

Table 1
Population and Percent Change for Guadalupe County Cities and Towns, Guadalupe County, and the State of New Mexico

	Populations				
	1990 Census	2000 Census	2010 Census	% Change '90 to '00	% Change '00 to '10
Santa Rosa City	2,263	2,744	2,848	21.3%	3.8%
Vaughn Town	633	539	446	-14.8%	-17.3%
Anton Chico CDP*	NA	NA	188	NA	NA
Llano de Medio CDP*	NA	NA	188	NA	NA
Newkirk CDP*	NA	NA	7	NA	NA
Pastura CDP*	NA	NA	23	NA	NA
Puerto de Luna CDP*	NA	NA	141	NA	NA
Rural Area	1,260	1,397	846	10.9%	-39.4%
Without the CDPs reported					
Rural Area	1,260	1,397	1,393	10.9%	-0.3%
Guadalupe County	**4,156**	**4,680**	**4,687**	**12.6%**	**0.1%**
State of New Mexico	**1,515,069**	**1,819,046**	**2,059,179**	**20.1%**	**13.2%**

SOURCE: 2000 and 2010 Census populations, U.S. Census Bureau (www.census.gov [February 2012]).
NA = not available.
* CDP - Census designated places

Table 2
Populations by Race and Hispanic Origin
for Guadalupe County and the State of New Mexico

	White	Black	Native American[1]	Other[2]	Two or More Races[3]	Total	Hispanic Origin[4]
2000 Census							
Santa Rosa City	1,577	60	48	934	125	2,744	2,227
Vaughn Town	284	0	2	237	16	539	469
Anton Chico CDP	NA	NA	NA	NA	NA	NA	NA
Llano de Medio CDP	NA	NA	NA	NA	NA	NA	NA
Newkirk CDP	NA	NA	NA	NA	NA	NA	NA
Pastura CDP	NA	NA	NA	NA	NA	NA	NA
Puerto de Luna CDP	NA	NA	NA	NA	NA	NA	NA
Rural Area	669	2	3	684	39	1,397	1,105
Guadalupe County	2,530	62	53	1,855	180	4,680	3,801
Percent	54.1%	1.3%	1.1%	39.6%	3.8%	100.0%	81.2%
State of New Mexico	1,214,253	34,343	173,483	330,640	66,327	1,819,046	765,386
Percent	66.8%	1.9%	9.5%	18.2%	3.6%	100.0%	42.1%
2010 Census							
Santa Rosa City	1,971	68	57	654	98	2,848	2,262
Vaughn Town	304	7	6	114	15	446	385
Anton Chico CDP	115	0	7	60	6	188	167
Llano de Medio CDP	73	1	6	38	0	118	111
Newkirk CDP	7	0	0	0	0	7	2
Pastura CDP	20	0	0	3	0	23	19
Puerto de Luna CDP	114	0	1	23	3	141	107
Rural Area	694	3	13	174	32	916	677
Guadalupe County	3,298	79	90	1,066	154	4,687	3,730
Percent	70.4%	1.7%	1.9%	22.7%	3.3%	100.0%	79.6%
State of New Mexico	1,407,876	42,550	193,222	338,521	77,010	2,059,179	953,403
Percent	68.4%	2.1%	9.4%	16.4%	3.7%	100.0%	46.3%

SOURCE: 2000 and 2010 Census population by race and ethnic origin, U.S. Census Bureau (www.census.gov [February 2012])

[1]Native Americans include American Indians and Alaska Natives.

[2]Other is defined as Asian Americans, Native Hawaiians, Pacific Islanders, and all others.

[3]Two or More Races indicated a person is included in more than one race group, it was introduced as a new category in the 2000 Census.

[4]Hispanic population is not a race but rather a description of ethnic origin; Hispanics are included in the five race groups.

Table 3
Populations by Age Group
for Guadalupe County and the State of New Mexico

	Age Groups						
	0-14	15-19	20-24	25-44	45-64	65+	Total
2000 Census							
Santa Rosa City	505	211	205	944	549	330	2,744
Vaughn Town	115	40	24	133	137	90	539
Anton Chico CDP	NA	NA	NA	NA	NA	NA	NA
Llano de Medio CDP	NA	NA	NA	NA	NA	NA	NA
Newkirk CDP	NA	NA	NA	NA	NA	NA	NA
Pastura CDP	NA	NA	NA	NA	NA	NA	NA
Puerto de Luna CDP	NA	NA	NA	NA	NA	NA	NA
Rural Area	288	114	69	360	338	228	1,397
Guadalupe County	908	365	298	1,437	1,024	648	4,680
Percent	19.4%	7.8%	6.4%	30.7%	21.9%	13.8%	100.0%
State of New Mexico	419,108	145,751	121,291	516,100	404,571	212,225	1,819,046
Percent	23.0%	8.0%	6.7%	28.4%	22.2%	11.7%	100.0%
2010 Census							
Santa Rosa City	483	168	202	886	743	366	2,848
Vaughn Town	80	37	10	85	140	94	446
Anton Chico CDP	40	12	10	35	30	61	188
Llano de Medio CDP	29	6	9	21	31	22	118
Newkirk CDP	0	0	0	0	2	5	7
Pastura CDP	1	0	0	2	8	12	23
Puerto de Luna CDP	33	11	5	24	42	26	141
Rural Area	170	53	42	166	343	142	916
Guadalupe County	836	287	278	1,219	1,339	728	4,687
Percent	17.8%	6.1%	5.9%	26.0%	28.6%	15.5%	100.0%
State of New Mexico	429,980	149,861	142,370	515,768	548,945	272,255	2,059,179
Percent	20.9%	7.3%	6.9%	25.0%	26.7%	13.2%	100.0%

SOURCE: 2000 and 2010 Census population by age groups, U.S. Census Bureau (www.census.gov [February 2012]).

Table 4
Population, Projections, and Percent Change
for Guadalupe County and the State of New Mexico

	Census	Population Projections			
	2010	2015	2020	2025	2030
Guadalupe County	4,687	5,553	5,961	6,328	6,717
% Change from 2010		18.5%	27.2%	35.0%	43.3%
State of New Mexico	2,059,179	2,356,236	2,540,145	2,707,757	2,864,796
% Change from 2010		14.4%	23.4%	31.5%	39.1%

SOURCE: 2010 Census population, U.S. Census Bureau (www.census.gov [February 2012]); 2015-2030 New Mexico Population Projections, Bureau of Business and Economic Research (www.bber.unm.edu [February 2012]).

Table 5

Full- & Part-Time Employment by Type of Employment & by Major Industry (NAICS)[1] for Guadalupe County and the State of New Mexico, 2009

	Guadalupe County			New Mexico	
	No. of Jobs	% of Total	% of Private	% of Total	% of Private
Total full- & part-time employment	2,019	100.0%		100.0%	
Wage & salary employment	1,439	71.3%		79.1%	
Proprietors' employment	580	28.7%		20.9%	
Farm proprietors' employment	217	37.4%		7.8%	
Nonfarm proprietors' employment[2]	363	62.6%		92.2%	
By Industry:					
Farm employment	258	12.8%		2.3%	
Nonfarm employment	1,761	87.2%		97.7%	
Private employment	1,276	72.5%	100.0%	79.4%	100.0%
Forestry, fishing, & related activities	(D)		**		0.6%
Mining	(D)		**		3.4%
Utilities	(D)		**		0.6%
Construction	103		8.1%		8.1%
Manufacturing	(D)		**		4.2%
Wholesale trade	(D)		**		3.2%
Retail trade	260		20.4%		13.5%
Transportation & warehousing	64		5.0%		2.9%
Information	(D)		**		2.1%
Finance & insurance	(D)		**		4.3%
Real estate & rental & leasing	(D)		**		4.9%
Professional, scientific, & technical services	(D)		**		9.8%
Management of companies & enterprises	0		0.0%		0.7%
Administrative & waste services	(D)		**		6.6%
Educational services	(L)		**		1.9%
Health care & social assistance	**156**		**12.2%**		**14.2%**
Arts, entertainment, & recreation	(L)		**		2.9%
Accommodation & food services	415		32.5%		9.8%
Other services, except public admin	73		5.7%		6.2%
Sum of (D) and (L) Categories[3]	*205*		*16.1%*		
Government & government enterprises	485	27.5%		20.6%	

SOURCE: U.S. Department of Commerce, Regional Economic Information System, Bureau of Economic Analysis (www.bea.gov [February 2012]).

[1]The estimates are based on the North American Industry Classification System (NAICS).

[2]Excludes limited partners.

[3]All (D) and (L) categories have been totaled to show the total amount of missing data from private employment.
(D) Not shown to avoid disclosure of confidential information, but the estimates for this item are included in the totals.

(L) Less than 10 jobs, but the estimates for this item are included in the totals.

**Due to confidential data not being disclosed, no percentages are available.

Table 6

Personal Income Earnings by Place of Work and by Industry (NAICS)[1]
for Guadalupe County and the State of New Mexico, 2009

	Guadalupe County			New Mexico	
	Income ($1,000s)	% of Total	% of Private	% of Total	% of Private
Total earnings by place of work	58,321	100.0%		100.0%	
Wage & salary disbursements	38,422	65.9%		71.6%	
Proprietors' income[2]	9,299	15.9%		9.9%	
All other earnings	10,600	18.2%		18.6%	
Earnings by Industry					
Total earnings by industry	58,321	100.0%		100.0%	
Farm earnings	5,650	9.7%		1.2%	
Nonfarm earnings	52,671	90.3%		98.8%	
Private earnings	32,819	62.3%	100.0%	71.6%	100.0%
Forestry, fishing, & related activities	(D)		**		0.3%
Mining	(D)		**		6.0%
Utilities	(D)		**		1.4%
Construction	4,128		12.6%		8.6%
Manufacturing	(D)		**		6.4%
Wholesale trade	(D)		**		4.3%
Retail trade	6,188		18.9%		9.7%
Transportation & warehousing	2,136		6.5%		3.7%
Information	(D)		**		2.7%
Finance & insurance	(D)		**		4.5%
Real estate & rental & leasing	(D)		**		1.8%
Professional, scientific, & technical services	(D)		**		16.0%
Management of companies & enterprises	0		0.0%		1.1%
Administrative & waste services	(D)		**		5.3%
Educational services	64		0.2%		1.2%
Health care & social assistance	**6,405**		**19.5%**		**15.7%**
Arts, entertainment, & recreation	(L)		**		0.9%
Accommodation & food services	7,401		22.6%		5.1%
Other services, except public admin	2,818		8.6%		5.2%
Sum of (D) & (L) Categories[3]	*3,679*		*11.2%*		
Government & government enterprises	19,852	37.7%		28.4%	

SOURCE: U.S. Department of Commerce, Regional Economic Information System, Bureau of Economic Analysis (www.bea.gov [February 2012]).

[1]The estimates are based on the North American Industry Classification System (NAICS).

[2]Proprietors' income includes the inventory valuation adjustment and capital consumption adjustment.

[3]All (D) & (L) categories have been totaled to show the total amount of missing data from private earnings.

(D) Not shown to avoid disclosure of confidential information, but the estimates for this item are included in the totals.

(L) Less than $50,000, but the estimates for this item are included in the totals

**Due to confidential data not being disclosed, no percentages are available.

Table 7
Transfer Receipts for Guadalupe County and the State of New Mexico, 2009

	Guadalupe County		State of New Mexico	
	Receipts* ($1,000s)	% of Total	Receipts* ($1,000s)	% of Total
Total personal current transfer receipts	44,879	100.0%	14,345,809	100.0%
Receipts of individuals from govts	44,106	98.3%	13,981,149	97.5%
Ret. & disab. ins. benefits	10,445	23.3%	4,313,600	30.1%
Old-age, surv & disab ins benefits	9,835	21.9%	4,165,644	29.0%
Railroad ret & disab benefits	556	1.2%	86,408	0.6%
Workers' comp	(L)	**	55,809	0.4%
Other govt ret & disab ins benefits[1]	(L)	**	5,739	0.0%
Medical benefits	24,494	54.6%	6,225,189	43.4%
Medicare benefits	8,683	19.3%	2,623,849	18.3%
Public asst medical care benefits[2]	15,761	35.1%	3,524,253	24.6%
Military medical insurance benefits[3]	50	0.1%	77,087	0.5%
Income maintenance benefits	5,184	11.6%	1,675,689	11.7%
Suppl security income (SSI) benefits	1,274	2.8%	327,946	2.3%
Family assistance[4]	224	0.5%	117,853	0.8%
Suppl nutrition asst program (SNAP)	1,301	2.9%	451,766	3.1%
Other income maintenance benefits[5]	2,385	5.3%	778,124	5.4%
Unemp ins compensation	1,088	2.4%	538,822	3.8%
State unemp ins comp	1,070	2.4%	527,901	3.7%
Unemp comp for fed cvln empl (UCFE)	0	0.0%	5,704	0.0%
Unemp comp for railroad empl	(L)	**	1,012	0.0%
Unemp comp for veterans (UCX)	0	0.0%	3,992	0.0%
Other unemp comp[6]	0	0.0%	213	0.0%
Veterans benefits	1,932	4.3%	579,830	4.0%
Veterans pension & disability benefits	1,800	4.0%	528,163	3.7%
Veterans readjustment benefits[7]	84	0.2%	40,703	0.3%
Veterans life ins benefit benefits	(L)	**	10,702	0.1%
Other asst to veterans[8]	(L)	**	262	0.0%
Education & training assistance[9]	448	1.0%	397,780	2.8%
Other receipts of indivs from govts[10]	515	1.1%	250,239	1.7%
Nonprofit institutions' transfer receipts	454	1.0%	214,470	1.5%
Receipts from federal govt	166	0.4%	78,305	0.5%
Receipts from state & local govt	107	0.2%	50,667	0.4%
Receipts from businesses	181	0.4%	85,498	0.6%
Transfer receipts to indivs from businesses[11]	319	0.7%	150,190	1.0%

SOURCE: U.S. Department of Commerce, Regional Economic Information System, Bureau of Economic Analysis (www.bea.gov [February 2012]).

Table 7 Footnotes (Continued)

[1]Consists largely of temporary disability payments, pension benefit guaranty payments, black lung payments, and Panama Canal construction annuity payments.

[2]Consists of Medicaid and other medical vendor payments.

[3]Consists of payments made under the TriCare Management Program (formerly called CHAMPUS) for the medical care of dependents of active duty military personnel and of retired military personnel and their dependents at nonmilitary medical facilities.

[4] Consists of benefits-- generally known as Temporary Assistance for Needy Families (TANF)-- provided under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

[5]Consists largely of general assistance; expenditures for food under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Other Needs Assistance; refugee assistance; foster home care and adoption assistance; Earned Income Tax Credits (EITC); Child Tax Credits; and energy assistance.

[6]Consists of Trade Adjustment Assistance, Redwood Park benefit payments, public service employment benefit payments, and transitional benefit payments.

[7]Consists largely of veterans' readjustment benefit payments, educational assistance to spouses and children of disabled or deceased veterans, payments to paraplegics, and payments for autos and conveyances for disabled veterans.

[8]Consists largely of state and local government payments to veterans.

[9]Consists largely of federal fellowship payments (National Science Foundation fellowships and traineeships, subsistence payments to state maritime academy cadets, and other federal fellowships), interest subsidy on higher education loans, Pell Grants, Job Corps payments, education exchange payments, and state education assistance payments.

[10]Consists largely of Bureau of Indian Affairs payments; Alaska Permanent Fund dividend payments; compensation of survivors of public safety officers; compensation of victims of crime; disaster relief payments; compensation for Japanese internment; the Economic Stimulus Act of 2008 rebates; the American Recovery and Reinvestment Act of 2009 funded Federal Additional Compensation for unemployment, COBRA premium reduction, and the Economic Recovery lump sum payment; and other special payments to individuals.

[11]Consists of personal injury payments to individuals other than employees and other business transfer payments.

*All state and local area dollar estimates are in current dollars (not adjusted for inflation).

(L) Less than $50,000, but the estimates for this item are included in the totals.

Table 8
Economic Indicators
for Guadalupe County, the State of New Mexico, and the United States

Indicator	Guadalupe County	State of New Mexico	United States
Total Personal Income (2009)	105,946,000	66,856,080,000	12,168,161,000,000
Per Capita Income (2009)	24,981	33,267	39,635
Employment (2010)	1,618	873,112	139,064,000
Unemployment (2010)	187	80,202	14,825,000
Unemployment Rate (2010)	10.4%	8.4%	9.6%
Employment (2011)	1,592	873,656	139,869,000
Unemployment (2011)	178	67,227	13,747,000
Unemployment Rate (2011)	10.0%	7.1%	8.9%
% of People in Poverty (2010)	23.7%	19.8%	15.3%
% of Under 18 in Poverty (2010)	30.5%	28.5%	21.6%
Transfer Receipt Dollars (2009)	44,879,000	14,345,809,000	2,169,300,000,000
Transfer Dollars as Percentage of Total Personal Income (2009)	42.4%	21.5%	17.8%

SOURCE: Employment and unemployment data, U.S. Department of Labor, Bureau of Labor Statistics (www.bls.gov [February 2012]); Personal income, per capita income, and transfer receipts, U.S. Department of Commerce, Regional Economic Information System, Bureau of Economic Analysis (www.bea.gov [February 2012]); Poverty data, U.S. Census Bureau (www.census.gov [February 2012]).

Appendix N

Example Community Health Indicator/Health Outcome Data Report

INSTRUCTIONS FOR HEALTH INDICATOR/HEALTH OUTCOME TABLES

The first tables are from two national websites and are described below. These can be copied and pasted and used in the report or these can be typed in the template attached to achieve a cleaner, easier to read copy.

The last tables are from other state sources and are typed into Excel. An Excel spreadsheet is included to show these tables.

The first table in the Health Indicator/Health Outcome Report is from a national website, University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation, County Health Rankings:

http://www.countyhealthrankings.org/

Data for every county in the United States can be accessed on this website. Only one table has been copied from the website to be utilized in this report"

Table 1 - Snapshot 2010 for a Specific County, includes

- Health Outcomes
  - Mortality
  - Morbidity
- Health Factors
  - Health Behaviors
  - Clinical Care
  - Social & Economic Factors
  - Physical Environment

http://www.countyhealthrankings.org/mississippi/scott

The next tables, Tables 2-5b, are from a national website, U.S. Department of Health and Human Services, Community Health Status Indicators:

www.communityhealth.hhs.gov/

Several tables have been copied from this website to illustrate health indicators and outcomes for Labette County, as illustrated below:

Table 2 Risk Factors for Premature Death

http://www.communityhealth.hhs.gov/RiskFactorsForPrematureDeath.aspx?GeogCD=20099&PeerStrat=64&state=Kansas&county=Labette

Table 3 Access to Care

http://www.communityhealth.hhs.gov/AccessToCare.aspx?GeogCD=20099&PeerStrat=64&state=Kansas&county=Labette

Table 4 Summary Measures of Health

http://www.communityhealth.hhs.gov/SummaryMeasuresOfHealth.aspx?GeogCD=20099&PeerStrat=64&state=Kansas&county=Labette

Table 5a Relative Health Importance

http://www.communityhealth.hhs.gov/RelativeHealthImportance.aspx?GeogCD=20099&PeerStrat=64&state=Kansas&county=Labette

Table 5b Measures of Birth and Death

http://www.communityhealth.hhs.gov/MeasuresOfBirthAndDeath.aspx?GeogCD=20099&PeerStrat=64&state=Kansas&county=Labette

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Tables 6 thru the final table are from state specific websites. These tables typically are from the specific state's department of health. These data are typically only available at the county level. These additional tables will vary by state and each state will need to find their state health statistic agency and prepare these tables in Excel.

An Excel spreadsheet is attached for illustration of how to build the tables in Excel.

Health Indicators/ Health Outcomes for Guadalupe County, New Mexico

Facilitated by:

National Center for Rural Health Works
Oklahoma State University
Community Needs Assessment Template

March 2012

Table 1

County Health Rankings
Mobilizing Action Toward Community Health

	Guadalupe County	New Mexico	Rank (of 32)
Health Outcomes			13
Mortality			23
Premature death - Years of potential life lost before age 75 per 100,000 population (age-adjusted)	9,753	8,364	
Morbidity			8
Poor or fair health - Percent of adults reporting fair or poor health (age-adjusted)	17%	17%	
Poor physical health days - Average number of physically unhealthy days reported in past 30 days (age-adjusted)	2.8	3.9	
Poor mental health days - Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.5	3.5	
Low birthweight - Percent of live births with low birthweight (< 2500 grams)		8.4%	
Health Factors			22
Health Behaviors			16
Adult smoking - Percent of adults that report smoking ≥ 100 cigarettes and currently smoking		20%	
Adult obesity - Percent of adults that report a BMI ≥ 30	23%	23%	
Excessive drinking - Binge plus heavy drinking		14%	
Motor vehicle crash death rate - Motor vehicle crash deaths per 100,000 population		23	
Sexually transmitted infections - Chlamydia rate per 100,000 population	460	470	
Teen birth rate - Teen birth rate per 1,000 female population, ages 15-19	62	64	
Clinical Care			23
Uninsured adults - Percent of population under age 65 without health insurance	26%	30%	
Primary care physicians - Ratio of population to primary care physicians	1,440:1	832:1	
Preventable hospital stays - Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	102	61	
Diabetic screening - Percent of diabetic Medicare enrollees that receive HbA1c screening	83%	70%	
Mammography screening - Percent of female Medicare enrollees that receive mammography screening		57%	
Social & Economic Factors			19
High school graduation - Percent of ninth grade cohort that graduates in 4 years	75%	59%	
Some college - Percent of adults aged 25-44 years with some post-secondary education	34%	56%	
Unemployment - Percent of population age 16+ unemployed but seeking work	7.6%	7.2%	
Children in poverty - Percent of children under age 18 in poverty	31%	24%	
Inadequate social support - Percent of adults without social/emotional support		21%	
Children in single-parent households - Percent of children that live in household headed by single parent	41%	37%	
Homicide rate - Deaths due to homicide per 100,000 population (age-adjusted)		8	
Physical Environment			24
Air pollution - particulate matter days - Annual number of unhealthy air quality days due to fine particulate matter	0	0	
Air pollution-ozone days - Annual number of unhealthy air quality days due to ozone	0	3	
Access to healthy foods - Healthy food outlets include grocery stores and produce stands/farmers' markets	20%	38%	
Access to recreational facilities - Rate of recreational facilities per 100,000 population	0	9	

SOURCE: University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation, County Health Rankings (www.countyhealthranking.org).

Table 2
Access to Care
for Guadalupe County, New Mexico

ACCESS TO CARE

Guadalupe County, NM

In addition to use of services, access to care may be characterized by medical care coverage and service availability.

Uninsured individuals (age under 65)[1]	839
Medicare beneficiaries[2]	
Elderly (age 65+)	662
Disabled	199
Medicaid beneficiaries[2]	1,417
Primary care physicians per 100,000 population[2]	69
Dentists per 100,000 population[2]	0
Community/Migrant Health Centers[3]	Yes
Health Professional Shortage Area[3]	Yes

SOURCE: U.S. Department of Health and Human Services, Community Health Status Indicators (www.communityhealth.hhs.gov).

[1]The Census Bureau. Small Area Health Insurance Estimates Program, 2006.

[2]HRSA. Area Resource File, 2008.

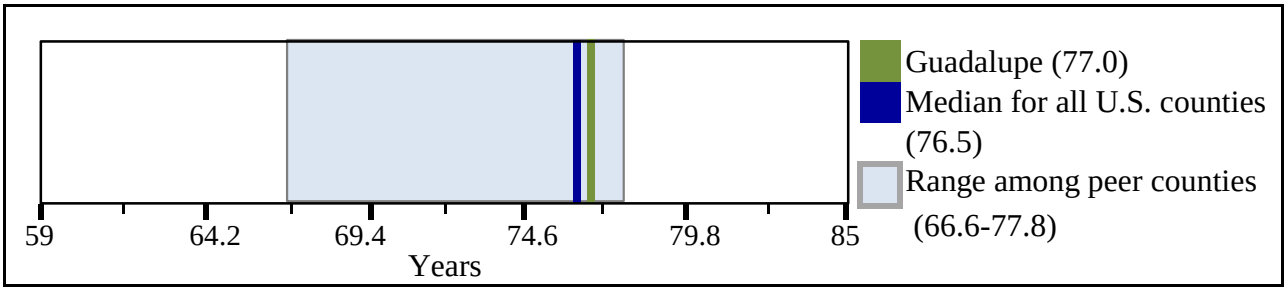
[3]HRSA. Geospatial Data Warehouse, 2009.

Table 3

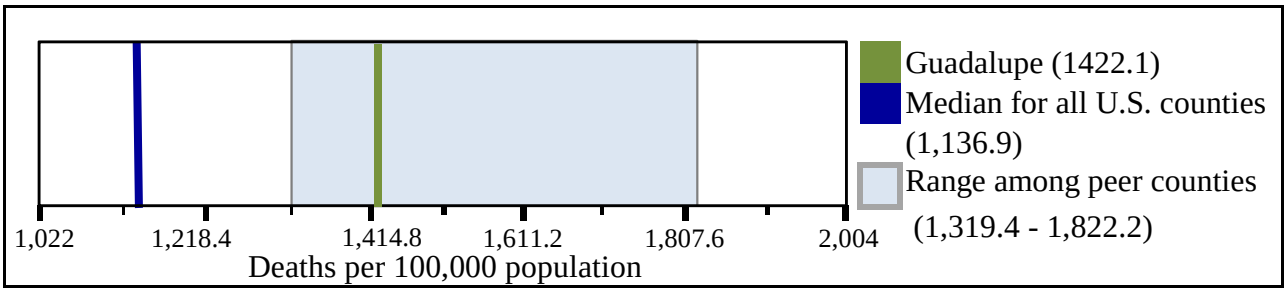
SUMMARY MEASURES OF HEALTH

Guadalupe County, NM

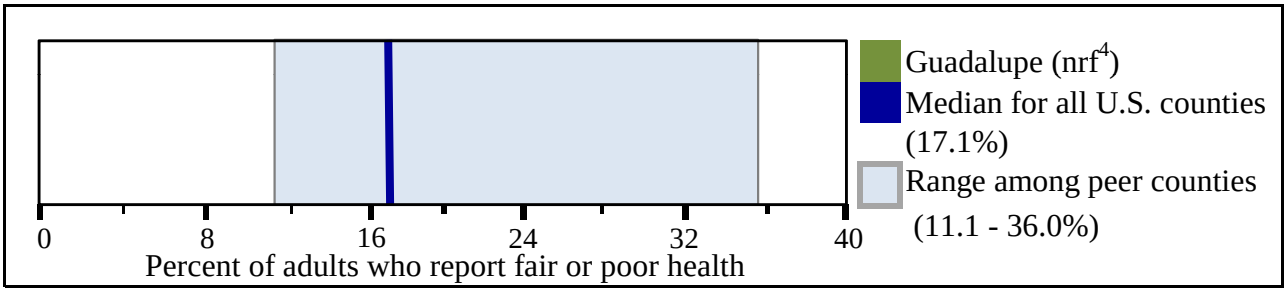
AVERAGE LIFE EXPECTANCY[1]



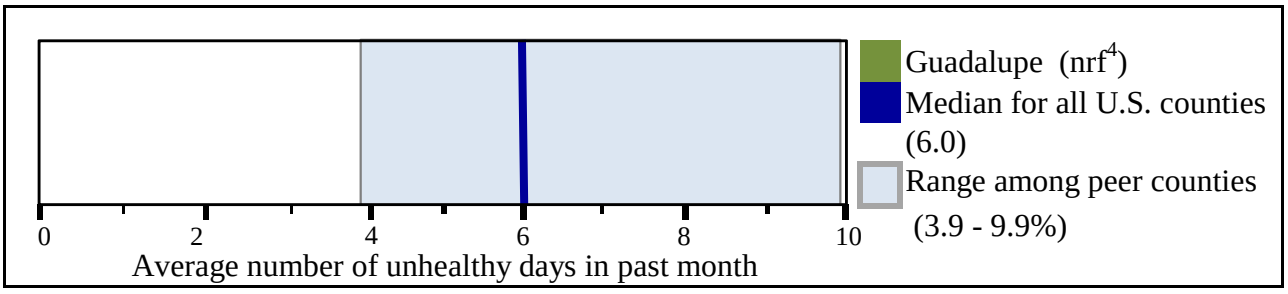
ALL CAUSES OF DEATH[2]



SELF-RATED HEALTH STATUS[3]



AVERAGE NUMBER OF UNHEALTHY DAYS IN PAST MONTH[3]



SOURCE: U. S. Department of Health and Human Services, Community Health Status Indicators (www.communityhealth.hhs.gov/ [February 2012]).

[1] Murray et al., PLoS Medicine 2006 Vol. 3, No. 9, e260 doi:10.1371/journal.pmed.0030260.

[2] NCHS. Vital Statistics Reporting System, 2001-2005.

[3] CDC. Behavioral Risk Factor Surveillance System, 2000-2006.

[4] nrf - No report, survey sample size fewer than 50.

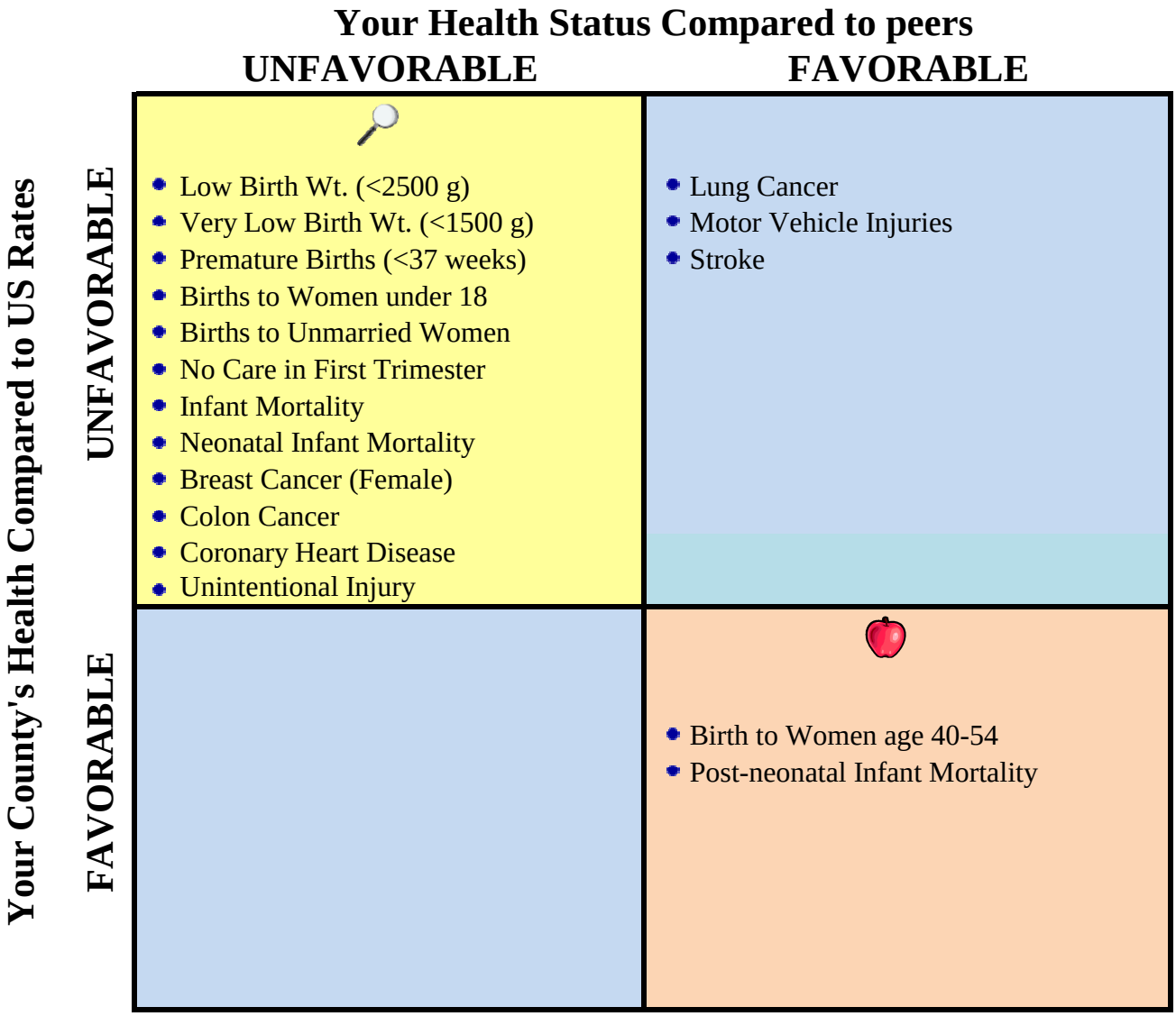
Table 4

RELATIVE HEALTH IMPORTANCE

Guadalupe County, NM

Indicates a status favorable to peer county median value

Indicates that a closer look and perhaps reduction to the percent or rate may be needed. Blank indicates no comparison.



The Relative Health Importance table creates four categories of relative concern by simply comparing a county to its peers and to the U.S.

A county's indicators in the upper left-hand box ( ) are higher than the U.S. and its peers and may warrant more attention. Conversely, indicators in the lower right-hand box ( ) of the table compare favorably to both peers and the U.S. The other boxes represent intermediate levels of health where a county's rate is higher than either its peers or the U.S., but not both.

SOURCE: U.S. Department of Health and Human Services, Community Health Status Indicators (www.communityhealth.hhs.gov/ [February 2012]).

Table 5

Measures of Birth and Death[1]

Guadalupe County, NM

County Percent		Peer County Range	Birth Measures	U.S. Percent 2005	Healthy People 2010 Target
8.6		5.8 - 9.0	Low Birth Wt. (<2500 g)	8.2	5.0
1.8		0.7 - 1.8	Very Low Birth Wt. (<1500 g)	1.5	0.9
15.2		11.4 - 15.8	Premature Births (<37 weeks)	12.7	7.6
9.2		4.6 - 11.0	Births to Women under 18	3.4	No objective
1.5		0.8 - 2.1	Births to Women age 40-54	2.7	No objective
57.6		31.6 - 69.3	Births to Unmarried Women	36.9	No objective
38.3		20.9 - 40.3	No Care in First Trimester[2]	16.1	10.0
County Percent		**Peer County Range**	**Infant Mortality[3]**	**U.S. Percent 2005**	**Healthy People 2010 Target**
9.2		4.3 - 14.7	Infant Mortality	6.9	4.5
nrf[5]		0.0 - 13.7	White non Hispanic Infant Mortality	5.8	4.5
nrf[5]		0.0 - 7.0	Black non Hispanic Infant Mortality	13.6	4.5
nrf[5]		0.0 - 22.2	Hispanic Infant Mortality	5.6	4.5
7.3		2.0 - 8.0	Neonatal Infant Mortality	4.5	2.9
1.8		0.0 - 7.2	Post-Neonatal Infant Mortality	2.3	1.2
County Percent		**Peer County Range**	**Death Measures[4]**	**U.S. Percent 2005**	**Healthy People 2010 Target**
73.2		21.2 - 68.4	Breast Cancer (Female)	24.1	21.3
35.9		7.7 - 48.8	Colon Cancer	17.5	13.7
298.1		182.7 - 365.0	Coronary Heart Disease	154.0	162.0
nrf[5]		0.0 - 24.1	Homicide	6.1	2.8
53.2		51.4 - 126.2	Lung Cancer	52.6	43.3
49.6		34.1 - 135.2	Motor Vehicle Injuries	14.6	8.0
83.2		56.7 - 125.2	Stroke	47.0	50.0
nrf[5]		10.5 - 54.5	Suicide	10.9	4.8
67.0		28.0 - 93.5	Unintentional Injury	39.1	17.1

The total number of births during this time period was 971 and the total number of deaths was 900.

SOURCE: U.S. Department of Health and Human Services, Community Health Status Indicators (www.communityhealth.hhs.gov/ [February 2012]).

Indicates a status favorable to peers.

Indicates a status less than favorable.

[1]NCHS. Vital Statistics Reporting System, 1996-2005.

[2]Include 37 states, New York City and DC (see the Data Sources, Definitions, and Notes for details).

[3]Infant mortality: deaths per 1000 live births (Neonatal: <28 days; post-neonatal: day 28 to under 1 year).

[4]Rates are age-adjusted to the year 2000 standard; per 100,000 population.

[5] nrf - No report, fewer than 500 births and 5 events (birth measures and infant mortality) or fewer than 10 events (death measures) occurred during the specified time period.

Table 6
Natality Characteristics
for Guadalupe County and the State of New Mexico

	Guadalupe County			State of New Mexico		
	2007	2008	2009	2007	2008	2009
	No.	No.	No.	No.	No.	No.
Crude Birth Rate	8.3	10.8	7.5	14.9	14.5	13.8
Percent of All Births	0.1	0.2	0.1	100.0	100.0	100.0
Fertility Rate	46.0	59.7	41.5	71.8	69.9	66.3
Total Male Births	21	34	20	15,719	15,337	14,710
Total Female births	19	18	16	14,886	14,819	14,163
Sex Ratio Male to Female	1.11	1.89	1.25	1.06	1.03	1.04
Total Live Births	40	52	36	30,605	30,156	28,873

SOURCE: New Mexico Selected Health Statistics Annual Report, New Mexico Department of Health (www.vitalrecordsnm.org [February 2012]).

Table 7
Births by Race
for Guadalupe County and the State of New Mexico

	Guadalupe County						State of New Mexico					
	2007		2008		2009		2007		2008		2009	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
White	5	12.5%	4	7.7%	2	5.6%	8,841	28.9%	8,630	28.6%	8,186	28.4%
Black	0	0.0%	0	0.0%	0	0.0%	640	2.1%	598	2.0%	616	2.1%
Hispanic	32	80.0%	47	90.4%	34	94.4%	16,616	54.3%	16,165	53.6%	15,328	53.1%
Other[1]	3	7.5%	1	1.9%	0	0.0%	4,431	14.5%	4,570	15.2%	4,558	15.8%
Unknown / Not reported	0	0.0%	0	0.0%	0	0.0%	77	0.3%	193	0.6%	185	0.6%
Total Births	40	100.0%	52	100.0%	36	100.0%	30,605	100.0%	30,156	100.0%	28,873	100.0%

SOURCE: New Mexico Selected Health Statistics Annual Report, New Mexico Department of Health (www.vitalrecordsnm.org [February 2012]).

[1] Other equals American Indian, Alaska Native, Asian, and Pacific Islander.

Table 8
Birth's by Mother's Age
for Guadalupe County and the State of New Mexico

	Guadalupe County						State of New Mexico					
	2007		2008		2009		2007		2008		2009	
Age Groups	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
10-17	3	7.5%	3	5.8%	2	5.6%	1,677	5.5%	1,660	5.5%	1,531	5.3%
18-19	7	17.5%	6	11.5%	2	5.6%	3,116	10.2%	2,940	9.7%	2,930	10.1%
20-29	24	60.0%	32	61.5%	22	61.1%	17,488	57.1%	17,368	57.6%	16,580	57.4%
30-39	5	12.5%	9	17.3%	10	27.8%	7,729	25.3%	7,539	25.0%	7,231	25.0%
40-49	1	2.5%	2	3.8%	0	0.0%	583	1.9%	641	2.1%	597	2.1%
50+	0	0.0%	0	0.0%	0	0.0%	5	0.0%	4	0.0%	1	0.0%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	7	0.0%	4	0.0%	3	0.0%
Total Births	40	100.0%	52	100.0%	36	100.0%	30,605	100.0%	30,156	100.0%	28,873	100.0%

SOURCE: New Mexico Selected Health Statistics Annual Report, New Mexico Department of Health (www.vitalrecordsnm.org [February 2012]).

Table 9
Births by Birthweight (Grams)
for Guadalupe County and the State of New Mexico

	Guadalupe County						State of New Mexico					
	2007		2008		2009		2007		2008		2009	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Less than 1500	2	5.0%	0	0.0%	0	0.0%	409	1.3%	330	1.1%	354	1.2%
1500 to 2499	NA	NA	8	15.4%	3	8.3%	2,263	7.4%	2,216	7.3%	2,041	7.1%
2500-3999	NA	NA	41	78.8%	30	83.3%	26,369	86.2%	25,964	86.1%	24,919	86.3%
4000+	NA	NA	3	5.8%	3	8.3%	1,469	4.8%	1,593	5.3%	1,529	5.3%
Unknown	NA	NA	0	0.0%	0	0.0%	95	0.3%	53	0.2%	30	0.1%
Total Births	40	NA	52	100.0%	36	100.0%	30,605	100.0%	30,156	100.0%	28,873	100.0%

SOURCE: New Mexico Selected Health Statistics Annual Report, New Mexico Department of Health (www.vitalrecordsnm.org [February 2012]).

Table 10
Number of Births by Level of Prenatal Care
for Guadalupe County and the State of New Mexico

	Guadalupe County						State of New Mexico					
	2007		2008		2009		2007		2008		2009	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No Prenatal Care	0	0.0%	1	1.9%	0	0.0%	665	2.2%	794	2.6%	665	2.3%
Low	4	10.0%	4	7.7%	1	2.8%	2,721	8.9%	2,705	9.0%	2,658	9.2%
Moderate	18	45.0%	21	40.4%	9	25.0%	7,481	24.4%	7,393	24.5%	7,844	27.2%
High	16	40.0%	20	38.5%	24	66.7%	18,112	59.2%	11,581	38.4%	13,756	47.6%
Unknown	2	5.0%	6	11.5%	2	5.6%	1,626	5.3%	7,683	25.5%	3,950	13.7%
Total Births	40	100.0%	52	100.0%	36	100.0%	30,605	100.0%	30,156	100.0%	28,873	100.0%

SOURCE: New Mexico Selected Health Statistics Annual Report, New Mexico Department of Health (www.vitalrecordsnm.org [February 2012]).

Table 11
Number of Births by Trimester Prenatal Care Begun
for Guadalupe County and the State of New Mexico

	Guadalupe County						State of New Mexico					
	2007		2008		2009		2007		2008		2009	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No Prenatal Care	0	0.0%	1	1.9%	0	0.0%	809	2.6%	794	2.6%	665	2.3%
1-3 Months (First Trimester)	28	70.0%	32	61.5%	28	77.8%	22,354	73.0%	14,040	46.6%	16,626	57.6%
4-6 Months (First Trimester)	9	22.5%	11	21.2%	5	13.9%	5,119	16.7%	6,136	20.3%	6,274	21.7%
7-9 Months (First Trimester)	1	2.5%	2	3.8%	1	2.8%	1,379	4.5%	1,674	5.6%	1,667	5.8%
Unknown or Not Reported	2	5.0%	6	11.5%	2	5.6%	944	3.1%	7,512	24.9%	3,641	12.6%
Total Births	40	100.0%	52	100.0%	36	100.0%	30,605	100.0%	30,156	100.0%	28,873	100.0%

SOURCE: New Mexico Selected Health Statistics Annual Report, New Mexico Department of Health (www.vitalrecordsnm.org [February 2012]).

Table 12
Number of Births with Low or No Prenatal Care by Mother's Race
for Guadalupe County and the State of New Mexico

	Guadalupe County						State of New Mexico					
	2007		2008		2009		2007		2008		2009	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
White	0	0.0%	0	0.0%	0	0.0%	659	19.5%	704	20.1%	639	19.2%
Black	0	0.0%	0	0.0%	0	0.0%	76	2.2%	73	2.1%	81	2.4%
Hispanic	4	100.0%	4	80.0%	1	100.0%	1,904	56.2%	1,936	55.3%	1,847	55.6%
Other[1]	0	0.0%	1	20.0%	0	0.0%	722	21.3%	752	21.5%	737	22.2%
Unknown / Not Reported	0	0.0%	0	0.0%	0	0.0%	25	0.7%	34	1.0%	19	0.6%
Total With Low or No Prenatal Care	4	100.0%	5	100.0%	1	100.0%	3,386	100.0%	3,499	100.0%	3,323	100.0%
Percent of Total Births	10.0%		9.6%		2.8%		11.1%		11.6%		11.5%	

SOURCE: New Mexico Selected Health Statistics Annual Report, New Mexico Department of Health (www.vitalrecordsnm.org [February 2012]).

[1]Other equals American Indian, Alaska Native, Asian, and Pacific Islander.

Table 13
No Prenatal Care by Mother's Age
for Guadalupe County and the State of New Mexico

	Guadalupe County						State of New Mexico					
	2007		2008		2009		2007		2008		2009	
Age Groups	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
10-17	0	0.0%	1	20.0%	0	0.0%	290	8.6%	283	8.1%	262	7.9%
18-19	1	25.0%	0	0.0%	0	0.0%	419	12.4%	459	13.1%	454	13.7%
20-29	3	75.0%	1	20.0%	1	100.0%	1,923	56.8%	2,005	57.3%	1,844	55.5%
30-39	0	0.0%	3	60.0%	0	0.0%	691	20.4%	675	19.3%	688	20.7%
40-49	0	0.0%	0	0.0%	0	0.0%	63	1.9%	76	2.2%	75	2.3%
Unknown Age	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%	0	0.0%
Total Low or No Prenatal Care	4	100.0%	5	100.0%	1	100.0%	3,386	100.0%	3,499	100.0%	3,323	100.0%
% of Total Births	10.0%		9.6%		2.8%		11.1%		11.6%		11.5%	

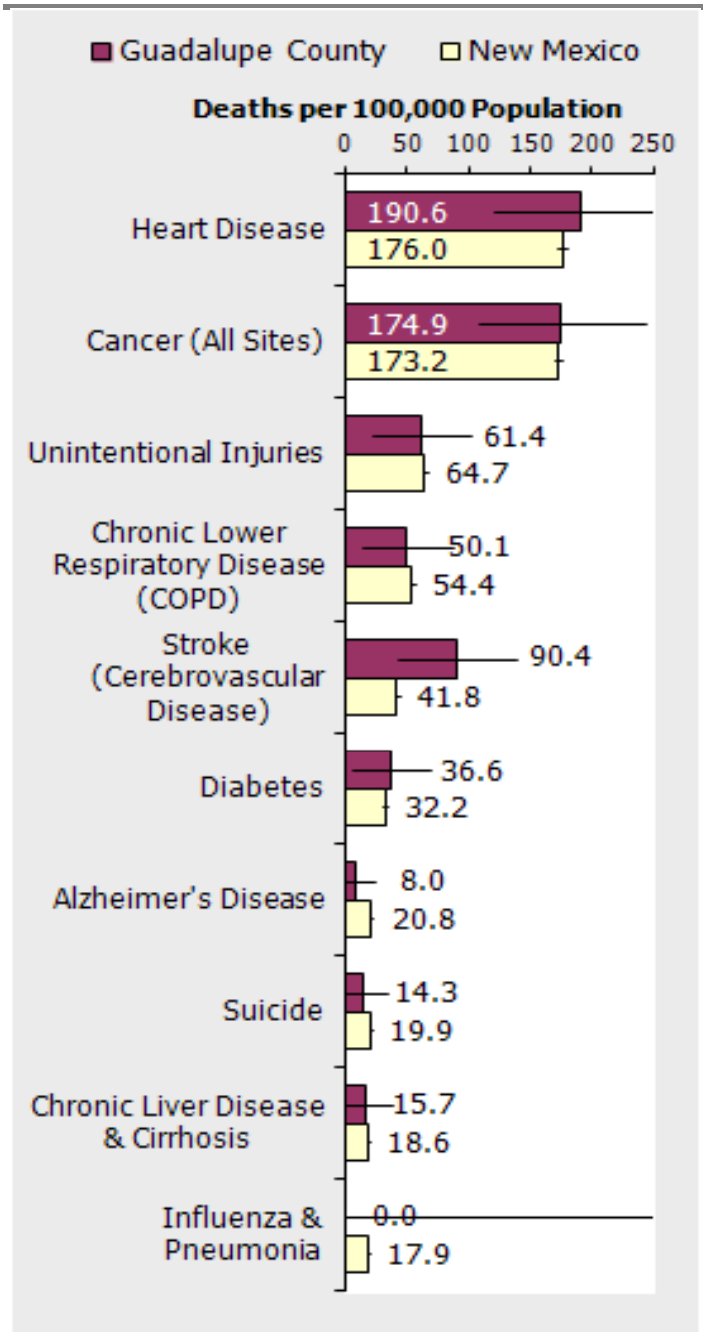
SOURCE: New Mexico Selected Health Statistics Annual Report, New Mexico Department of Health (www.vitalrecordsnm.org [February 2012]).

Table 14
Guadalupe County and State of New Mexico Census Statistics including Births and Deaths (2010) and Leading Causes of Death, 2008-2010

	Guadalupe County	New Mexico
County Seat	Santa Rosa	
Population (July 1, 2010)	4,687	2,060,971
% New Mexico	0.20%	100%
Land Area (Square miles)	3,030.50	121,298
Persons per Sq. Mile (2010)	1.5	17
Births (2010)	46	27,795
Deaths (2010)	39	15,866
Households (2005-2009)	1,416	736,630

SOURCE: U. S. Census Bureau (www.census.gov)

Leading Causes of Death, 2008-2010



Source: New Mexico Death Certificate Database, Office of Vital Records and Health Statistics, New Mexico Department of Health. Retrieved from New Mexico Department of Health, NM-IBIS website, http://ibis.health.state.nm.us, on 12/27/2011.

Table 15
Number of Deaths by Age
for Guadalupe County and the State of New Mexico

	Guadalupe County						State of New Mexico					
	2007		2008		2009		2007		2008		2009	
Age Groups	No.	%	No.	%	No.	%	No.	Rate	No.	%	No.	%
Less than 1	0	0.0%	0	0.0%	0	0.0%	188	1.2%	154	1.0%	145	1.0%
1-14	0	0.0%	0	0.0%	0	0.0%	89	0.6%	90	0.6%	80	0.5%
15-24	3	6.8%	1	2.4%	0	0.0%	323	2.1%	302	2.0%	313	2.4%
25-44	1	2.3%	3	7.3%	1	2.3%	1,062	6.9%	1,118	7.3%	1,059	4.4%
45-54	3	6.8%	3	7.3%	4	9.1%	1,357	8.8%	1,305	8.5%	1,342	8.9%
55-64	8	18.2%	5	12.2%	8	18.2%	1,934	12.6%	1,884	12.2%	2,008	13.4%
65-74	4	9.1%	6	14.6%	9	20.5%	2,521	16.4%	2,515	16.3%	2,519	16.8%
75-84	12	27.3%	13	31.7%	10	22.7%	3,976	25.8%	3,785	24.6%	3,811	25.4%
85+	13	29.5%	10	24.4%	12	27.3%	3,948	25.6%	4,244	27.6%	4,113	27.4%
Unknown	0	0.0%	0	0.0%	0	0.0%	2	0.0%	3	0.0%	2	0.0%
All Ages	44	100.0%	41	100.0%	44	100.0%	15,400	100.0%	15,400	100.0%	15,392	100.2%

SOURCE: New Mexico Selected Health Statistics Annual Report, New Mexico Department of Health (www.vitalrecordsnm.org [February 2012]).

[1] 85+ Also Contains Unknown and Not Reported

Table 16
Health Characteristics From Community Health Highlights
for Guadalupe County and the State of New Mexico

Health Characteristic	Guadalupe County	New Mexico	Comparison to State
Youth Smoking Prevalence (2009)	19.9	24	Watch
Adolescent Physical Activity (2007)	50.8	43.6	Watch
% of Adolescents who ate 5+ Servings of Fruits and Veggies Daily (2003-2009)	19.6	20.9	Improvement Needed
Youth (Grades 9-12) with Caring and Supportive Relationship in the Family (2009)	72.7	54.1	Excellent
Alcohol-Related Deaths per 100,000 Population (2007-2009)	101.8	52.9	Improvement Needed
Alcohol-Related Chronic Disease Deaths per 100,000 Population (2007-2009)	69.5	23.9	Improvement Needed
Alcohol Related Injury Death Rates per 100,000 Population (2007-2009)	32.2	29.0	Improvement Needed
Drug-Induced Deaths per 100,000 Population (2007-2009)	27.1	22.8	Improvement Needed
Health Insurance Coverage; % Uninsured, Under 65 Years (2009)	30.6	22.9	Reason for Concern
Medicaid Enrollment; Avg Monthly % of Population (2010)	26.9	23.4	NA
Primary Care Providers; Ratio of Population to Providers (2008)	1440	832	NA
Prenatal Care in First Trimester (2008-2009)	68.2	52.0	Excellent
% of Live Born Infants with Low Birthweight (2008-2010)	12.7	8.5	Improvement Needed
Teen Birth Rate; Births per 1000 Girls Age 15-17 (2007-2009)	21.3	31.6	Watch
Chlamydia Cases per 100,000 Population (2010)	666.7	557.9	NA
Diseases of the Heart Death Rate per 100,000 population (2007-2009)	384.4	203.8	Reason for Concern
Stroke Death Rate per 100,000 population (2005-2009)	73	38.2	Improvement Needed
Diabetes Deaths per 100,000 population (2008-2010)	32.5	32.5	Watch
Adolescent Obesity (BMI ≥ 95th percentile) (2001-2009)	18.7	13.5	Reason for Concern
Female Breast Cancer Deaths per 100,000 population (2001-2005)	62	22.1	Improvement Needed
Influenza and Pneumonia Deaths per 100,000 Population (2006-2009)	10.8	20.6	Watch
Unintentional Injury Death Rates per 100,000 population (2003-2007)	88.6	62.3	Improvement Needed
Motor Vehicle Traffic Crash Deaths per 100,000 population (2005-2009)	31	18.3	Improvement Needed
Suicide Death Rates per 100,000 population (2007-2009)	12.9	18.6	Watch
Ratio of Total Substantiated Child Abuse Allegations per 1000 child population (2010)	39.4	18.5	Improvement Needed
% of Youth Who Felt Sad or Hopeless Almost Every day (2001-2009)	28.9	29.7	Watch
Life Expectancy from Age 65 in avg. number of years (2005-2009)	17.89	18.7	NA
Children (Under Age 18) Living in Poverty (2009)	32	28.8	Improvement Needed
High School Graduation Rate (2010)	84.7	67.3	Excellent

SOURCE: New Mexico Department of Health Indicator-Based Information System (NM-IBIS) (http://ibis.health.state.nm.us/community/highlight/Selection.html [March 2012]).

Appendix O

Example of Summary Community Input Report (Health Survey Results)

INSTRUCTIONS FOR COMMUNITY HEALTH SURVEY QUESTIONNAIRE

An example is provided. Several files are included in the printed copy:

1 EX Survey Form
2 EX GENERIC Survey Form
3 EX Survey INSTRUCTIONS
4 EX Survey Results FINAL

Also available on the website (www.okruralhealthworks.org):

- EX Survey Form in Excel
- EX GENERIC Survey Form in Excel
- EX Survey Results in Excel
- EX Health Survey Results COVER in Word

The first attachment is an example of a community survey questionnaire. Next, a GENERIC Survey Form is included. This Generic survey form includes the basic questions that are typically asked on all surveys. The local hospital and/or steering committee may choose to add questions to this GENERIC survey form. The community example survey questionnaire may have some additional questions added that are relevant to their community.

The GENERIC survey form is where your hospital should begin and then decide if additional questions are needed. Modifications should be made to the GENERIC survey form; i.e., to add any survey questions specific to your hospital.

The final survey form should be ready for the first meeting of the community advisory committee. Each member of the community advisory committee will be asked to complete the form at the meeting. As the community advisory committee members leave the meeting, they will be handed five or six blank survey forms to take with them to have completed by the constituents that they represent and/or other community members. The "Health Survey INSTRUCTIONS" should be revised for your hospital and also given to each community advisory committee member, along with the five or six blank survey forms.

The INSTRUCTIONS are very basic. There should be included a deadline for the return of the completed survey questionnaires (typically the second meeting of the community advisory committee) and a contact person with address and phone number and/or fax who will receive the completed survey questionnaires.

> ***NOTE:*** *The community facilitator should encourage the community participants to have the survey forms completed prior to the second committee meeting. The cost of employing a private firm to conduct phone surveys is very costly and the community can assist in keeping the costs of the Community Health Needs Assessment to a minimum. These cost savings can be better used in developing programs and activities in meeting the community's health needs.*

The contact person designated in the INSTRUCTIONS should be available to the community participants and should communicate with them to encourage the timely return of completed survey forms. The simplest way to obtain the completed survey forms is to have the members return them at the second committee meeting.

Once all the surveys have been returned, the steering committee should have an individual (or individuals) proficient in Excel ready to analyze and summarize the survey results. Attached is an Excel spreadsheet, "Survey Results in Excel," that can be modified and utilized for the survey results. This spreadsheet is based on an Example Community Survey Questionnaire and should be modified to fit your hospital's survey form.

In the Excel Spreadsheet, the first worksheet is where the survey results will be input. Across the top of the spreadsheet are the questions and possible responses. Down the left side are the survey numbers. As the surveys are received, they should be numbered and then input by survey number. Each row represents the results for one survey form.

The key to analyzing the survey is to be sure to include ONLY RESPONSES that are RELEVANT and CONSISTENT. For instance, if the first question of the survey receives a "No" response, then there should be no additional responses included until Question #7. The person entering the survey results will have to make a judgment call as to whether the Q1 response is consistent with the responses to Questions 2 through 6. There are several instances in the survey that these judgments will need to be made.

> ***NOTE:*** *In the survey responses worksheet, blanks are included in the questions that should not be responded t,o based on the response of "No" for Q1. If Q1 receives a "No" response, then Questions 2 thru 6 should be blank. This can be very confusing but consistency is what is needed to produce the summary results.*

The first worksheet includes the survey responses. The second worksheet then tallies the survey results. If the first worksheet is modified, then the second worksheet will also need to be modified to include all the revisions. Assistance for the modifications can be received from the National Center.

The second worksheet is designed to summarize the responses from the first worksheet. Once all the survey responses have been entered and the second worksheet has been modified to include all modifications, then the survey results should be reviewed for consistency.

Again, consistency is important in validating the survey responses. For example, if Q1 has 78 respondents indicating they used the services of a hospital in the past 24 months; then Q2 should have 78 responses at a minimum. Since respondents may answer more than once, there can be more than the 78 responses but there has to be at least 78 responses.

The third question also has to be consistent with the responses in Q2. If Q2 shows that 78 respondents went to your Hospital; then all other responses (hospitals other than your

hospital) to Q2 will respond to Q3. Let's say that the total responses for Q2 were 102 and 78 of those went to your hospitals. Then, the difference of 24 went to hospitals other than your hospital. Therefore, the responses to Q3 should be at least 24. Again, there can be more than the 24 responses since respondents may answer more than once but there should be at a minimum 24 responses.

Once all the survey questions have been checked and re-checked for consistency, then a COPY of the survey results worksheet are made in the same spreadsheet and PASTE it to reflect "VALUES." This new worksheet becomes the final survey results and all the blanks and zero responses are removed and the responses can be re-ordered to show the results by the largest to the smallest number of responses. This ordering can be done to fit the steering committee's needs.

An example of the survey results COVER in Word is given and the final results have been pulled together in an Adobe Acrobat file entitled, "EX Survey Results FINAL." The Adobe Acrobat is not necessary. The results can be printed from the final survey results in Excel and the survey results cover in Word.

The National Center has found this spreadsheet the simplest way to analyze the survey responses and summarize the results. Assistance is available at any time to modify or assist in utilizing the survey results spreadsheet.

Be sure to call the National Center for Rural Health Works with any questions or for any assistance.

Community Health Needs Assessment
National Center for Rural Health Works

Health Survey Results

for Guadalupe County Hospital

Prepared and Facilitated by:

National Center for Rural Health Works
Oklahoma State University

April 2012

April 2012

SURVEY RESULTS
Guadalupe County Hospital, New Mexico

1 Have you or someone in your household used the services of a hospital in the past 24 months?

Response Category	No.	%
Yes	77	81.0%
No	18	19.0%
Totals	95	100.0%

2 At which hospitals/cities were services received?

Response Category	No.	%
Guadalupe County Hospital	72	75.8%
Albuquerque Hospitals	13	13.7%
Las Vegas Hospitals	4	4.2%
Clovis Hospitals	2	2.1%
Santa Fe Hospitals	1	1.1%
Portalis Hospitals	1	1.1%
El Paso Hospitals	1	1.1%
Tucumcari Hospitals	1	1.1%
Totals	95	100.2%

Some respondents received services at more than one hospital.

3 You responded that you or someone in your household received care at a hospital other than Guadalupe County Hospital. Why did you or your family member choose that/those hospital(s)?

Response Category	No.	%
Availability of specialty care	10	35.7%
Physician referral	9	32.1%
Quality of care/lack of confidence	3	10.7%
Closer, more convenient location	3	10.7%
Emergency care	1	3.6%
On vacation	1	3.6%
Son attends school there	1	3.6%
Totals	28	100.0%

Some respondents provided more than one answer.

4 What hospital service(s) were used at Guadalupe County Hospital?

Response Category	No.	%
Laboratory	48	28.6%
Physician services	38	22.6%
All radiological imaging	36	21.4%
Emergency services	27	16.1%
Other outpatient services	9	5.4%
Inpatient services	8	4.8%
No response	2	1.2%
Total	168	100.0%

Many respondents indicated multiple categories of hospital services.

5 How satisfied were you or someone in your household with the services you received at Guadalupe County Hospital? Would you say you were…

Response Category	No.	%
Satisfied	64	88.9%
Dissatisfied	6	8.3%
No response	2	2.8%
Total	72	100.0%

6a Why were you or someone in your household satisfied with the services received at Guadalupe County Hospital?

Response Category	No.	%
No Response	27	31.8%
Competent care; quality care; quality service	16	18.8%
Good staff care, personal staff care	13	15.3%
Quick response	13	15.3%
Knowledgeable doctors	8	9.4%
Convenient, close to home	5	5.9%
Just satisfied; need more services	1	1.2%
All questions answered	1	1.2%
Beautiful facility	1	1.2%
Total	85	100.0%

Some respondents provided more than one response.

6b Why were you or someone in your household dissatisfied with the services received at Guadalupe County Hospital?

Response Category	No.	%
No response	2	33.3%
Too long wait for doctor	2	33.3%
Used to getting bad service	1	16.7%
No followup by medical clinic nursing staff	1	16.7%
Total	6	100.0%

7 What type of specialist have you or someone in your household been to and in which city did you receive that care?

Response Category	No.	%
None	20	12.6%
Orthopedics/Orthopedic surgery (Albuquerque [18], Las Vegas [4], Amarillo [1], Clovis [1], Santa Fe [1], Taos [1])	26	16.4%
OB-GYN (Albuquerque [17], Las Vegas [3], Clovis [1], no city specified [1])	22	13.8%
General surgery (Albuquerque [13], Las Vegas [5], Amarillo [2], Cincinnati [1], El Paso [1])	22	13.8%
Cardiology/Heart (Albuquerque [14], Bernalillo [1], Clovis [1], Cincinatti [1], Las Vegas [1], No City Specified [1])	19	11.9%
Urology (Albuquerque [11], Las Vegas [2], Cincinnati [1], Taos [1], no city specified [1])	16	10.1%
Oncology/Cancer Care (Albuquerque [4], Santa Fe [1])	5	3.1%
Optometry/Ophthalmology (Albuquerque [1],	4	2.5%
Gastrology/Gastroenterology (Albuquerque [3])	3	1.9%
Physical Therapy (Las Vegas [1], Moriarty [1], no city specified [1])	3	1.9%
Nephrology/Renal (Albuquerque [1], Clovis [1], no city specified [1])	3	1.9%
Rheumatology (Albuquerque [3])	3	1.9%
Chiropractor (Albuquerque [1], no city specified [1])	2	1.3%
Dermatology (Albuquerque [2])	2	1.3%
Endocrinology (Albuquerque [2])	2	1.3%
Vascular (Albuquerque [2])	2	1.3%
ENT (Albuquerque [1])	1	0.6%
Hematology (Albuquerque [1])	1	0.6%
Neurology (Albuquerque [1])	1	0.6%
Pediatric Pulmonology (no city specified [1])	1	0.6%
Podiatry (Albuquerque [1])	1	0.6%
Total	159	100.0%

Some respondents provided more than one response.

8 Did the specialist request further testing, laboratory work and/or x-rays?

Response Category	No.	%
Yes	50	66.7%
No	17	22.7%
Don't know	6	8.0%
No response	2	2.7%
Total	75	100.0%

9 If yes, in which city were the tests or laboratory work performed?

Response Category	No.	%
Albuquerque	31	47.7%
Santa Rosa	13	20.0%
Las Vegas	8	12.3%
Clovis	3	4.6%
Santa Fe	1	1.5%
El Paso	1	1.5%
Amarillo	1	1.5%
Guadalupe	1	1.5%
Cincinnati	1	1.5%
No response	5	7.7%
Total	65	99.8%

Some respondents indicated more than one city.

10 Do you use a primary care (family) doctor for most of your routine health care?

Response Category	No.	%
Yes	87	91.6%
No	8	8.4%
Total	95	100.0%

11 If no, then what kind of medical provider do you use for routine care?

Response Category	No.	%
Public Health Office	5	55.6%
Specialist	3	33.3%
Whoever is on call or in office	1	11.1%
Total	9	100.0%

Some respondents provided more than one response.

12 Have you or someone else in our household been to a primary care (family) doctor in the Guadalupe County Hospital service area?

Response Category	No.	%
Yes	74	77.9%
No	18	18.9%
Don't know	3	3.2%
Total	95	100.0%

13 How satisfied were you or someone in your household with the quality of physician care received in the Guadalupe County Hospital service area? Would you say you were…

Response Category	No.	%
Satisfied	59	76.6%
Dissatisfied	4	5.2%
Both satisfied and dissatisfied	2	2.6%
No response	9	11.7%
Don't know	3	3.9%
Total	77	100.0%

14a Why were you or someone in your household satisfied with the quality of physician care received in Guadalupe County?

Response Category	No.	%
Quality care; quality services	8	21.6%
Professional, knowledgeable physicians	5	13.5%
Personal Care	4	10.8%
Services were provided	4	10.8%
Timely service	2	5.4%
Convenience	2	5.4%
Satisfied with specific physician	1	2.7%
No response	11	29.7%
Total	37	100.0%

Some respondents provided more than one response.

14b Why were you or someone in your household dissatisfied with the quality of physician care received in Guadalupe County?

Response Category	No.	%
Doctor/Staff was rushed	2	33.3%
No response	1	16.7%
No Followup by physician or nursing staff	1	16.7%
Don't assume viral; need to do bloodwork to see	1	16.7%
If can't provide care, should send you to someone who can	1	16.7%
Total	6	100.0%

15 Are you able to get an appointment with your primary care (family) doctor in the Guadalupe County Hospital service area when you need one?

Response Category	No.	%
Yes	83	87.4%
No	5	5.3%
Don't know	7	7.4%
Total	95	100.0%

16 Have you or someone in your household delayed health care due to lack of money and/or insurance?

Response Category	No.	%
Yes	24	25.3%
No	70	73.7%
No response	1	1.1%
Total	95	100.0%

17 What concerns you most about health care in the Guadalupe County Hospital service area?

Response Category	No.	%
No response	29	27.9%
None	13	12.5%
Physician Concerns (22, 28.8%)		
Lack of doctors/specialists	16	15.4%
Attracting/retaining physicians and staff	4	3.8%
Misdiagnoses	2	1.9%
Lack in thoroughness of care	2	1.9%
Too long of a wait to be seen	2	1.9%
Rushed	1	1.0%
Holdout on referrals	2	1.9%
Physician prejudice to patients	1	1.0%
Hospital Concerns (18, 17.3%)		
HIPPA violations/confidentiality	6	5.8%
Need for dialysis care	3	2.9%
Lack of professionalism	2	1.9%
Need for physical therapy care	2	1.9%
Pharmacy concerns: size/hours	2	1.9%
Low hospital visibility in community projects	1	1.0%
Shortage of ER nurses	1	1.0%
Training/Experience	1	1.0%
General Concerns (14, 13.5%)		
Transportation/ambulance transport services	5	4.8%
Dentistry hours	1	1.0%
Excessive cost of health care	3	2.9%
Childcare	1	1.0%
High birthrate for young unwed mothers	1	1.0%
Little/no insurance	1	1.0%
Need for intermediate and paramedics in EMS	1	1.0%
Obesity epidemic	1	1.0%
Total	104	100.0%

Some respondents provided more than one response.

18 What services would you like to see offered at Guadalupe County Hospital?

Response Category	No.	%
No response	22	14.2%
Don't know	1	0.6%
None	2	1.3%
Physician Services (5, 3.2%)		
More doctors/primary care	5	3.2%
Specialty Services (106, 68.4%)		
More Specialists	16	10.3%
Physical Therapy	22	14.2%
Optometry/Ophthalmology	22	14.2%
Chiropractor	10	6.5%
Dialysis	8	5.2%
Chiropractor	6	3.9%
OB/GYN	4	2.6%
Audiology	3	1.9%
Cancer Treatment	2	1.3%
Orthodontics	2	1.3%
Substance Abuse Treatment	2	1.3%
Weight Management/Nutrition Education	2	1.3%
Acupuncture	1	0.6%
Massage Therapy	1	0.6%
Mammograms	1	0.6%
MRIs	1	0.6%
Orthopedics	1	0.6%
Pain management	1	0.6%
General Wellness	1	0.6%
Hospital Services (10, 6.5%)		
Better service at hospital and pharmacy	2	1.3%
Better quality care	1	0.6%
Ambulance for transfesr to other facilities	1	0.6%
Billing issue resolution	1	0.6%
Insurance assistance (filing/claims)	1	0.6%
Labwork	1	0.6%
Less wait for appointments	1	0.6%
Longer pharmacy hours	1	0.6%
Security	1	0.6%

18 (CONTINUED) What services would you like to see offered at Guadalupe County Hospital?

Response Category	No.	%
Other Services (9, 5.8%)		
Assisted living	1	0.6%
Child services	1	0.6%
Home health	1	0.6%
Hospice	1	0.6%
More free screenings	1	0.6%
Nursing home	1	0.6%
Better training/salary for volunteer Fire/EMS	1	0.6%
Transportation	1	0.6%
VA services	1	0.6%
Total	155	100.0%

Many respondents provided more than one response.

Appendix P

Example of Summary Community Health Needs

Community Needs and Suggested Implementation Strategies and Responsibilities

	Community Need	Implementation Strategy	Responsible Org. or Person
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(Continued – Page 2)

Community Needs and Suggested Implementation Strategies and Responsibilities

	Community Need	Implementation Strategy	Responsible Org. or Person
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

(Continued – Page 3)

Community Needs and Suggested Implementation Strategies and Responsibilities

	Community Need	Implementation Strategy	Responsible Org. or Person
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
30.			

Labette Health Center
Parsons, KS
Community Needs Assessment Recommendations
March 25, 2011

- Cost of Health Care
    - Market the Community Clinic – Supported by Labette Health
    - Market availability of services and cost comparisons vs. larger communities
    - Education regarding affordable health screening tools
        - Review target of educational tools
        - Education regarding risk factors
        - Build on successful examples
    - Create a Culture of Health
    - Market quality of care vs. stereotyping of rural providers/facilities

- Smoking/tobacco use is seen as a significant health issue for the Labette Health Center community
    - Focus on education regarding the effects of tobacco use on health
    - Market Smoking Cessation classes

- Cardiovascular heart disease and stroke are seen as significant health problems for the Labette Health Center community
    - Focus education on the benefits of screening and early detection
    - Focus education efforts on behavioral changes proven to help
        - Smoking cessation programs
        - Healthy eating and weight reduction
        - Exercise programs

- Diabetes is seen as a significant health problem for the Labette Health Center community
    - Build on success of the Rector Center
    - Market services of the Rector Center

- Educational programs
    - Review who we are trying to educate and how we are trying to reach them
    - Focus on improving what we currently have:
        - Hospital newsletter
        - Hospital website
    - Focus on new methods of contacting citizens:
        - Look for more electronic methods of informing citizens
        - Look for more focused communication, i.e.: Facebook, Twitter, text messaging to reach local people

- Teen Pregnancy is seen as a significant issue in the community Labette Health Center serves.
    - Provide leadership to engage community factors to discuss and work on this issue including:
        - Faith Community
        - Parents groups
        - Community civic leadership
        - Social service agencies
    - Discuss parental responsibility and ways to enhance it

    Note: This is not a problem that Labette Health Center can solve. This is a problem where Labette Health Center can provide leadership to engage various community groups to understand the problem and engage it as their own.

There was good discussion about the Labette Health Center community and the health problems facing them. The consensus of the group was that Labette Health Center was 'community conscious' regarding health issues facing the community. Labette Health Center has a unique opportunity to become more focused in their educational programs as it celebrates fifty years of service to the community. These efforts can become more successful by focusing on the community they are trying to reach and then reviewing different methods to reach them. This can include upgrading current efforts including newsletters and websites and employing other communication methods such as Twitter, Facebook, and e-news for example.

Appendix Q

Example CHNA Reporting

Summary Report Outline

Community Health Needs Assessment

Community Members Involved

Need to include name, organization and contact information for:

Hospital Administrator

Steering Committee or Leadership Group

Facilitator

Community Advisory Committee Members

Medical Service Area

Describe by county or zip code areas

Include populations and projected populations of medical service area

Include demographics of population of medical service area

Community Meetings #1, #2, and #3 (also any additional meetings)

Date

Agenda

List reports presented with short summary of each

Community Needs and Implementation Strategies

Include community needs and implementation strategies with responsibilities from community group

Hospital Final Implementation Plan

Include which needs hospital can address and the implementation strategies

Include which needs hospital cannot address and reason(s) why

Community Awareness of Assessment

Describe methodology for making assessment widely available to the community

Have Community Advisory Committee Report available to public

Have Hospital Action Plan with each health need addressed available to public

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0047

2010

Open to Public Inspection

A For the 2010 calendar year, or tax year beginning , 2010, and ending , 20

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite

City or town, state or country, and ZIP + 4

D Employer identification number

E Telephone number

G Gross receipts $

F Name and address of principal officer:

H(a) Is this a group return for affiliates? ☐ Yes ☐ No

H(b) Are all affiliates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☐ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶

K Form of organization: ☐ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation:

M State of legal domicile:

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	
5	Total number of individuals employed in calendar year 2010 (Part V, line 2a)	5	
6	Total number of volunteers (estimate if necessary)	6	
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	
b	Net unrelated business taxable income from Form 990-T, line 34	7b	

		Prior Year	Current Year
Revenue			
8	Contributions and grants (Part VIII, line 1h)		
9	Program service revenue (Part VIII, line 2g)		
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)		
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)		
Expenses			
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)		
14	Benefits paid to or for members (Part IX, column (A), line 4)		
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)		
16a	Professional fundraising fees (Part IX, column (A), line 11e)		
b	Total fundraising expenses (Part IX, column (D), line 25) ▶		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24f)		
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)		
19	Revenue less expenses. Subtract line 18 from line 12		

		Beginning of Current Year	End of Year
Net Assets or Fund Balances			
20	Total assets (Part X, line 16)		
21	Total liabilities (Part X, line 26)		
22	Net assets or fund balances. Subtract line 21 from line 20		

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date

▶ Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
Firm's name ▶			Firm's EIN ▶	
Firm's address ▶			Phone no.	

May the IRS discuss this return with the preparer shown above? (see instructions) ☐ Yes ☐ No

Part III **Statement of Program Service Accomplishments**

Check if Schedule O contains a response to any question in this Part III . . . . . ☐

1 Briefly describe the organization's mission:

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ **Yes** ☐ **No**

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ **Yes** ☐ **No**

If "Yes," describe these changes on Schedule O.

4 Describe the exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ including grants of $) (Revenue $)

4b (Code:) (Expenses $ including grants of $) (Revenue $)

4c (Code:) (Expenses $ including grants of $) (Revenue $)

4d Other program services. (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses** ▶

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1		
2	Is the organization required to complete Schedule B, Schedule of Contributors? (see instructions)	2		
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4		
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		
6	Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		
10	Did the organization, directly or through a related organization, hold assets in term, permanent, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a		
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e		
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f		
12 a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a		
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional*	12b		
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		
14 a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, and program service activities outside the United States? *If "Yes," complete Schedule F, Parts I and IV*	14b		
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	16		
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		
20 a	Did the organization operate one or more hospitals? *If "Yes," complete Schedule H*	20a		
b	If "Yes" to line 20a, did the organization attach its audited financial statements to this return? **Note.** Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	20b		

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23		
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25*	24a		
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	26		
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? *If "Yes," complete Schedule L, Part III*	27		
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1*	34		
35	Is any related organization a controlled entity within the meaning of section 512(b)(13)?	35		
a	Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2* ☐ Yes ☐ No	36		
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? **Note.** All Form 990 filers are required to complete Schedule O	38		

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V . . . . . ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a			
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b			
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c			
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? .	2b			
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file*. (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a			
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*	3b			
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			
b	If "Yes," enter the name of the foreign country: ► ---------- See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . .	5a			
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?	6a			
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? .	7f			
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities .	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year . .	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* .	14b			

Part VI **Governance, Management, and Disclosure** *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response to any question in this Part VI . . . . . ☐

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year . .	1a		
b	Enter the number of voting members included in line 1a, above, who are independent .	1b		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	☐	☐
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? . .	3	☐	☐
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	☐	☐
5	Did the organization become aware during the year of a significant diversion of the organization's assets? .	5	☐	☐
6	Does the organization have members or stockholders?	6	☐	☐
7a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?	7a	☐	☐
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons?	7b	☐	☐
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	☐	☐
b	Each committee with authority to act on behalf of the governing body?	8b	☐	☐
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9	☐	☐

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Does the organization have local chapters, branches, or affiliates?	10a	☐	☐
b	If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization? .	10b	☐	☐
11a	Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form?	11a	☐	☐
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Does the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	☐	☐
b	Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	☐	☐
c	Does the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this is done*	12c	☐	☐
13	Does the organization have a written whistleblower policy?	13	☐	☐
14	Does the organization have a written document retention and destruction policy?	14	☐	☐
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	☐	☐
b	Other officers or key employees of the organization	15b	☐	☐
	If "Yes" to line 15a or 15b, describe the process in Schedule O. (See instructions.)			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	☐	☐
b	If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements?	16b	☐	☐

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply.

☐ Own website ☐ Another's website ☐ Upon request

19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response to any question in this Part VII . . . . . ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1)		☐	☐	☐	☐	☐	☐			
(2)		☐	☐	☐	☐	☐	☐			
(3)		☐	☐	☐	☐	☐	☐			
(4)		☐	☐	☐	☐	☐	☐			
(5)		☐	☐	☐	☐	☐	☐			
(6)		☐	☐	☐	☐	☐	☐			
(7)		☐	☐	☐	☐	☐	☐			
(8)		☐	☐	☐	☐	☐	☐			
(9)		☐	☐	☐	☐	☐	☐			
(10)		☐	☐	☐	☐	☐	☐			
(11)		☐	☐	☐	☐	☐	☐			
(12)		☐	☐	☐	☐	☐	☐			
(13)		☐	☐	☐	☐	☐	☐			
(14)		☐	☐	☐	☐	☐	☐			
(15)		☐	☐	☐	☐	☐	☐			
(16)		☐	☐	☐	☐	☐	☐			

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(17)		☐	☐	☐	☐	☐	☐			
(18)		☐	☐	☐	☐	☐	☐			
(19)		☐	☐	☐	☐	☐	☐			
(20)		☐	☐	☐	☐	☐	☐			
(21)		☐	☐	☐	☐	☐	☐			
(22)		☐	☐	☐	☐	☐	☐			
(23)		☐	☐	☐	☐	☐	☐			
(24)		☐	☐	☐	☐	☐	☐			
(25)		☐	☐	☐	☐	☐	☐			
(26)		☐	☐	☐	☐	☐	☐			
(27)		☐	☐	☐	☐	☐	☐			
(28)		☐	☐	☐	☐	☐	☐			
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 in reportable compensation from the organization ▶

		Yes	No
3	Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual* **3**	☐	☐
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual* **4**	☐	☐
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person* **5**	☐	☐

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization.

(A) Name and business address	(B) Description of services	(C) Compensation

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶

Part VIII Statement of Revenue

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d				
	e	Government grants (contributions)	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f				
	g	Noncash contributions included in lines 1a-1f: $					
	h	**Total.** Add lines 1a–1f ▶					
Program Service Revenue			**Business Code**				
	2a						
	b						
	c						
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a–2f ▶					
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) ▶					
	4	Income from investment of tax-exempt bond proceeds ▶					
	5	Royalties ▶					
			(i) Real / (ii) Personal				
	6a	Gross Rents					
	b	Less: rental expenses					
	c	Rental income or (loss)					
	d	Net rental income or (loss) ▶					
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory					
	b	Less: cost or other basis and sales expenses					
	c	Gain or (loss)					
	d	Net gain or (loss) ▶					
	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 a					
	b	Less: direct expenses b					
	c	Net income or (loss) from fundraising events ▶					
	9a	Gross income from gaming activities. See Part IV, line 19 a					
	b	Less: direct expenses b					
	c	Net income or (loss) from gaming activities ▶					
	10a	Gross sales of inventory, less returns and allowances a					
	b	Less: cost of goods sold b					
	c	Net income or (loss) from sales of inventory ▶					
		Miscellaneous Revenue	**Business Code**				
	11a						
	b						
	c						
	d	All other revenue					
	e	**Total.** Add lines 11a–11d ▶					
	12	**Total revenue.** See instructions. ▶					

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.
All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.		(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21				
2	Grants and other assistance to individuals in the U.S. See Part IV, line 22				
3	Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16				
4	Benefits paid to or for members				
5	Compensation of current officers, directors, trustees, and key employees				
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7	Other salaries and wages				
8	Pension plan contributions (include section 401(k) and section 403(b) employer contributions)				
9	Other employee benefits				
10	Payroll taxes				
11	Fees for services (non-employees):				
a	Management				
b	Legal				
c	Accounting				
d	Lobbying				
e	Professional fundraising services. See Part IV, line 17				
f	Investment management fees				
g	Other				
12	Advertising and promotion				
13	Office expenses				
14	Information technology				
15	Royalties				
16	Occupancy				
17	Travel				
18	Payments of travel or entertainment expenses for any federal, state, or local public officials				
19	Conferences, conventions, and meetings				
20	Interest				
21	Payments to affiliates				
22	Depreciation, depletion, and amortization				
23	Insurance				
24	Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24f. If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O.)				
a					
b					
c					
d					
e					
f	All other expenses				
25	**Total functional expenses.** Add lines 1 through 24f				
26	**Joint costs.** Check here ▶ ☐ if following SOP 98-2 (ASC 958-720). Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing			1	
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net			4	
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use			8	
	9	Prepaid expenses and deferred charges			9	
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a			
	b	Less: accumulated depreciation	10b		10c	
	11	Investments—publicly traded securities			11	
	12	Investments—other securities. See Part IV, line 11			12	
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11			15	
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)			16	
Liabilities	17	Accounts payable and accrued expenses			17	
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities. Complete Part X of Schedule D			25	
	26	**Total liabilities.** Add lines 17 through 25			26	
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ ☐ and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets			27	
	28	Temporarily restricted net assets			28	
	29	Permanently restricted net assets			29	
		Organizations that do not follow SFAS 117, check here ▶ ☐ and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building, or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances			33	
	34	Total liabilities and net assets/fund balances			34	

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI . . . . . ☐

1	Total revenue (must equal Part VIII, column (A), line 12)	1	
2	Total expenses (must equal Part IX, column (A), line 25)	2	
3	Revenue less expenses. Subtract line 2 from line 1	3	
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	
5	Other changes in net assets or fund balances (explain in Schedule O)	5	
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII . . . . . ☐

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☐ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a	☐	☐
b	Were the organization's financial statements audited by an independent accountant?	2b	☐	☐
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	☐	☐
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a	☐	☐
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b	☐	☐

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

► Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
► Attach to Form 990. ► See separate instructions.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization

Employer identification number

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	☐	☐
b	If "Yes," was it a written policy?	1b	☐	☐
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care to low income individuals? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____ %	3a	☐	☐
b	Did the organization use FPG to determine eligibility for providing *discounted* care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %	3b	☐	☐
c	If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	☐	☐
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	☐	☐
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	☐	☐
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	☐	☐
6a	Did the organization prepare a community benefit report during the tax year?	6a	☐	☐
b	If "Yes," did the organization make it available to the public?	6b	☐	☐
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheets 1 and 2)						
b Unreimbursed Medicaid (from Worksheet 3, column a)						
c Unreimbursed costs—other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						

Part II **Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	**Total**						

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	☐	☐
2	Enter the amount of the organization's bad debt expense (at cost)	2		
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	
6	Enter Medicare allowable costs of care relating to payments on line 5	6	
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		

☐ Cost accounting system ☐ Cost to charge ratio ☐ Other

Section C. Collection Practices

			Yes	No
9a	Did the organization have a written debt collection policy during the tax year?	9a	☐	☐
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	☐	☐

Part IV **Management Companies and Joint Ventures**

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? _____

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: _____

Line Number of Hospital Facility (from Schedule H, Part V, Section A): _____

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)				
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1	☐	☐
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j	☐ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 __ __			
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	☐	☐
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	☐	☐
5	Did the hospital facility make its Needs Assessment widely available to the public?	5	☐	☐
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	☐ Hospital facility's website			
b	☐ Available upon request from the hospital facility			
c	☐ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a	☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	☐ Execution of the implementation strategy			
c	☐ Participation in the development of a community-wide community benefit plan			
d	☐ Participation in the execution of a community-wide community benefit plan			
e	☐ Inclusion of a community benefit section in operational plans			
f	☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	☐ Prioritization of health needs in its community			
h	☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☐ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7	☐	☐
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	☐	☐
9	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care to low income individuals?	9	☐	☐
	If "Yes," indicate the FPG family income limit for eligibility for free care: __ __ __ %			

Part V Facility Information *(continued)*

			Yes	No
10	Used FPG to determine eligibility for providing *discounted* care to low income individuals?	10		
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: _ _ _ %			
11	Explained the basis for calculating amounts charged to patients?	11		
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	☐ Income level			
b	☐ Asset level			
c	☐ Medical indigency			
d	☐ Insurance status			
e	☐ Uninsured discount			
f	☐ Medicaid/Medicare			
g	☐ State regulation			
h	☐ Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12		
13	Included measures to publicize the policy within the community served by the hospital facility?	13		
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☐ The policy was posted on the hospital facility's website			
b	☐ The policy was attached to billing invoices			
c	☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	☐ The policy was posted in the hospital facility's admissions offices			
e	☐ The policy was provided, in writing, to patients on admission to the hospital facility			
f	☐ The policy was available on request			
g	☐ Other (describe in Part VI)			

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	☐	☐
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☐ Other actions (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year?	16	☐	☐
	If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☐ Other actions (describe in Part VI)			
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):			
a	☐ Notified patients of the financial assistance policy on admission			
b	☐ Notified patients of the financial assistance policy prior to discharge			
c	☐ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	☐ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e	☐ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

			Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	18	☐	☐
	If "No," indicate the reasons why (check all that apply):			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility did not have a policy relating to emergency medical care			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d	☐ Other (describe in Part VI)			

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):			
a	☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b	☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c	☐ The hospital facility used the Medicare rate for those services			
d	☐ Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?	20	☐	☐
	If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?	21	☐	☐
	If "Yes," explain in Part VI.			

Part V **Facility Information** *(continued)*

Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many non-hospital facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

Community Engagement and Needs Assessment Process and Report
Guadalupe County Hospital
Santa Rosa, New Mexico
May 7, 2012

Process:

The hospital CEO, representatives from *HealthInsight,* the New Mexico Office of Rural and Primary Care and consultants conducted three meetings; a variety of community members were invited and in attendance. The group was diverse and represented all segments of the community. Meetings were approximately an hour and a half in length. Consultants prepared and conducted a survey of community attitudes and issues regarding health and health care in the county. Initially, with the hospital staff and with input from *HealthInsight* staff members, consultants determined the primary service area of Guadalupe County Hospital. Community members from this entire service area participated in these meetings. For example, participants included consumers, community leaders, public health officials, health care officials and experts, economic and community development specialists, education leaders and law enforcement. The meetings were conducted on February 29, March 13, and April 10, 2012.

Economic Impact:

Consultants conducted an economic impact study to indicate the value of health care and specifically the hospital to the community's economic environment and viability.

In 2011, Guadalupe County Hospital had 50 full and part time employees from hospital operations with a payroll of $2.9 million (wages, salaries and benefits). The hospital also spent $3.4 million on capital improvements for a total of 86 jobs and a $3.4 million payroll. The secondary multiplier for hospital employment was 1.34 meaning that for every job in the hospital an additional 0.34 job or 17 additional jobs were created in the county for a total employment impact from operations of 67 jobs. The construction multiplier was 1.23 creating an additional 20 jobs for a total of 106 jobs. The grand total for employment impact was 173 jobs.

The income multipliers for hospital operations and hospital construction were 1.18 and 1.16 respectively. That resulted in an additional $523,694 from operations and $554,540 from construction activities for a total of $3.4 million from operations and $4.0 million from construction for a grand total income impact of $7.4 million. While construction varies from year to year, the hospital provides a huge economic impact for Guadalupe County.

Health Indicators/Health Outcomes:

Data compiled by the State of New Mexico and various national databases[1] indicated the following information for discussion at the second community meeting

- Accessibility/availability of primary care physicians (PCPs), county 69 PCPs per 100,000 population
- Births to women under 18, county rate 9.2, peer counties range 4.6-11.0
- A high percentage (77.8% county vs. 57.6% for New Mexico) of pregnant women receive prenatal care in first trimester
- Heart disease #1 leading cause of death, county rate 190.6, state rate 176.0
- Cancer #2 leading cause of death, county rate 174.9, state rate 173.2
- Stroke (cerebrovascular disease) #5 leading cause of death, county rate 90.4, state rate 41.8
- Diabetes #6 leading cause of death high, county rate 36.6, state rate 32.2
- Female breast cancer deaths high, county rate 62, state rate 22.1
- Substantiated child abuse allegations high, county rate 39.4, state rate 18.5
- Youth report caring and supportive family at a very high level, county rate 72.7, state rate 54.1
- Alcohol-related deaths high, county rate 101.8, state rate 52.9
- Uninsured adults high, county rate 30.6, state rate 22.9
- Low birth weight high, county rate 12.7, state rate 8.5
- Adolescent obesity high, county rate 18.7, state rate 13.5
- Motor vehicle traffic crash deaths high, county rate 31.0, state rate 18.3

Economic and Demographic Data and Information:

Economic and demographic data and information were compiled from a variety of data sources[2]:

- Population flat from 2000 – 2010 (county 0.1% increase)

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[1] Health Indicators/Health Outcomes data sources include County Health Rankings from University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation; Community Health Status Indicators from U. S. Department of Health and Human Services; New Mexico Selected Health Statistics Annual Report from the New Mexico Department of Health; New Mexico Death Certificate Database, Office of Vital Records and Health Statistics from the New Mexico Department of Health; and New Mexico's Indicator-Based Information System from the New Mexico Department of Health.

[2] Economic and Demographic data and information sources include population data, County Business Patterns, and poverty data from U. S. Census Bureau; employment, earnings, and transfer receipt reports from the U. S. Department of Commerce, Regional Economic Information System, Bureau of Economic Analysis; and employment and unemployment data from the U. S. Department of Labor, Bureau of Labor Statistics.

- Population growing in 45+ age group (absolute and percentage), county 2000, 35.7% and 2010, 44.1%, state 2000, 33.9% and 2010, 39.9%
- State demographers predicted 27.2% growth for next decade; cannot explain projected growth from the local perspective
- Health sector is very important to economy, represents 12.2% of total county employment and 19.5% of total county earnings
- Transfer receipts as a percent of total personal income high, county 42.4%, state 21.5%; this indicates a high percentage of income comes from federal and state programs.
- High unemployment, county 10%, state 7.1%
- Poverty all people high, county 23.7%, state 19.8%
- Poverty under age 18 high, county 30.5%, state 28.5%

Potential solutions or approaches to the problems and the information gained from the local survey were discussed at the third community meeting.

- Breast cancer education and screening was seen as a solution to the high death rate for breast cancer. Education must be culturally sensitive and timely presented to local women. Guadalupe County Hospital has received some grant monies in the past for these programs and will consider seeking additional grant funding to expand this program.
- The hospital will assist the community to apply for grant programs to provide grant funding for programs to educate the population regarding
    - Decreasing obesity in all population groups
    - Nutrition education to decrease reliance on fatty, high caloric and high cholesterol foods and food preparation
    - Educational programs must be:
        - Age specific
        - Culturally sensitive
        - Provide options, i.e.; classes, webinars
        - Catered to specific target groups, i.e., Diabetes education, stroke and heart disease education, education regarding prenatal care and childcare, etc.

Guadalupe County Hospital is and will continue to pursue a variety of positive changes for health care and access to health care in the Guadalupe County service area. These include:

- Website development with contact list for updates and e-Newsletters
- Telemedicine services
- Care flight – dedicated helicopter
- Physical therapy/ occupational therapy
- Optometrist
- Chiropractor
- New doctors moving to the area
- Scholarships for nursing and allied health personnel

- Mini health fairs
- Outreach to surrounding communities
- Share patient satisfaction scores on a regular basis

While the hospital has and will continue to provide dynamic leadership for the Guadalupe County community, many health and health related issues involve behavioral choices. The ability to change these issues will of necessity involve the entire community including the hospital.

Conclusion:

It should be noted that the population base of the Guadalupe County service area precludes offering a variety of services on site. For instance, a population base of 10,000 to 12,000 people is required as a minimum for a general surgeon. However, Guadalupe County Hospital will continue to work with the community and the hospital board to maximize the array of services available to local consumers. The CEO and the board have already built a new facility that incorporates the county public health office in the same building. They have a state of the art facility that was carefully planned and laid out. They have installed electronic health records systems and have qualified for federal Meaningful Use incentives. The CEO and the board have demonstrated that simply being rural does not mean second-class care or services. By maximizing the service potential of a variety of health and human services, the CEO has demonstrated her connection with and her commitment to this community.