COMMUNITY HEALTH NEEDS ASSESSMENT
September 17 – 18, 2019

Prepared by:
Dave Clark

TORCH
MANAGEMENT
SERVICES, INC.

TORCH Management Services, Inc. (“TORCH”) appreciates Joe Wright, Chief Executive Officer of North Runnels Hospital District (“NRHD” or the “District”), for giving TORCH the opportunity to conduct, and for providing assistance throughout, the compilation of the Community Health Needs Assessment. TORCH also appreciates the time and effort the focus group participants, physician and staff to provide their thoughts and insights concerning the health needs of Winters, Texas and surrounding region.

North Runnels Hospital District
Community Health Needs Assessment
Conducted: September 17 - 18, 2019
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GENERAL OVERVIEW

A Community Health Needs Assessment ("CHNA") was conducted for North Runnels Hospital District on September 18 – 19, 2019. The value of the Assessment is that it allows healthcare organizations to better understand the needs of the communities they serve, with the ultimate goal of improving the overall health of the local citizens. Whether or not an organization is required to conduct a Community Health Needs Assessment, it is an extremely valuable tool for fulfilling its role in the community. An old adage goes, "You can't provide the right kind of services when you haven't asked the customers you serve what they like or not." By listening to members of the community and reviewing demographic data, the Hospital can gain information on health status and where gaps in healthcare delivery currently exist. Further, it solidifies the Hospital's role in the community as a partner in improving overall health status, as well as in areas beyond health, such as education and economic development.

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

ABOUT THIS ASSESSMENT

INTRODUCTION

A Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of our population. Subsequently, this information may be used to formulate strategies to improve health and quality of life in our community. There are three components that are essential in rendering a complete picture of the health of Runnels County with particular attention to Winters, Texas: (1) the community health survey [primary quantitative data]; (2) existing data [secondary quantitative data]; and (3) focus group data [primary qualitative data].

Community Health Survey

The Community Health Survey developed for this study gives us a complete and timely view of the health status and behaviors of area residents. All administration of the

surveys, data selection and data analysis was conducted by TORCH Management Services, Inc. with Dave Clark providing services.

Existing Data

Existing vital statistics and other data are incorporated into this assessment. Comparisons are also made, where available, to state and national benchmarks. Furthermore, wherever possible, health promotion goals outlined in Healthy People 2020 are included.

Community Health Focus Groups

To gain perspective from community members and local organizations, five formal focus groups were conducted which included community health professionals, county/city governmental officials, educators, and general business leaders, public citizens, and community non-profits. One on one meetings were conducted by the facilitator with some of these community representatives. The groups were well attended, enthusiastic, well-informed to community programs, and interested in the well-being of the community. All were very impressive and engaged in the process.

Data Source

The data information remained uniform in county reporting from prior years to this report. The report will continue to have the most recent state reports for the county health statistics.

A History Lesson [1,2]

History in a Pecan Shell

Geography

Winters is located at at the junction of U.S. Highway 83 and Farm Roads 53 and 1770 in north-central Runnels County, about 41 miles (66 km) south of Abilene and 52 miles (84 km) northeast of San Angelo.

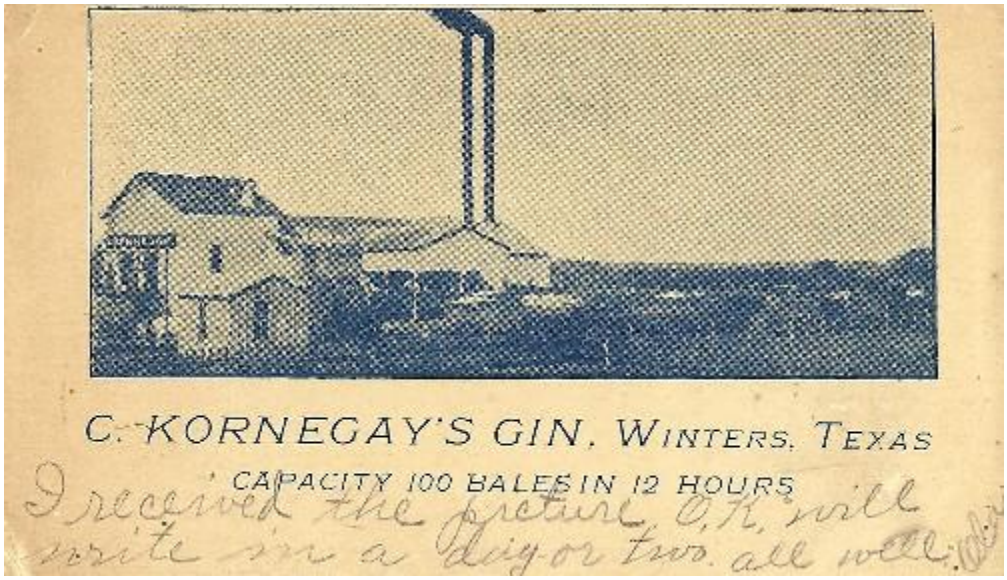
According to the United States Census Bureau, the city has a total area of 2.9 square miles (7.6 km^2), of which 2.4 square miles (6.1 km^2) are land and 0.58 square miles (1.5 km^2), or 19.97%, are covered by water.

Climate

The climate in this area is characterized by hot, humid summers and generally mild to cool winters. According to the Köppen climate classification system, Winters has a humid subtropical climate, *Cfa* on climate maps.

History

In 1880, the families of C.N. Curry and C.E. Bell settled in an area known as Bluff Creek Valley, southwest of the present town. Local cowboy Jack Mackey suggested that the community be named in honor of John N. Winters, a rancher and land agent. A post office was established in 1891 and Mr. Winters donated land for a school soon after. Winters had roughly 163 residents in 1892. It became famous for a traveling brass band that was organized by Charles Tipton Grant in 1901. A newspaper began publishing in 1903. Winters incorporated in 1909, the same year that the Abilene and Southern Railway built an extension from Abilene to Winters. Land values in the city jumped to $7.00 per acre. The first newspaper was the *Recorder* (1903) which underwent a name change to the *Winters Enterprise* in 1905. A cottonseed mill became the first major industry in Winters when it opened in 1909. It remained in operation until 1939. In 1910, the population had risen to 1,247. A public library was constructed in 1964. By 1980, the population stood at 3,061. That number fell slightly to 2,905 in 1990 and 2,880 in 2000. Winters had a total of 140 businesses in 2000, up from 96 in 1970. Today, the city serves as a commercial and distribution center for a large agricultural and ranching area.



Attractions

The Z.I. Hale Museum, housed in the former clinic of a prominent local optometrist, features exhibits of area history, photographs, and documents. A Missouri-Pacific caboose sits outside of the museum.

W. Lee Colburn Park is located 7 miles east of Winters, adjacent to Elm Creek Reservoir. The park has various recreational facilities and 14 spaces for RVs with full hookups.

Every year, on the 1st Saturday of September, Winters celebrates the opening of dove hunting season with “Dovefest”. People come from all over to hunt, listen to live music, or attend the gun show.

Education

Public education in the city of Winters is provided by the Winters Independent School District. The district has three campuses – Winters Elementary School (grades PK-5), Winters Junior High School (grades 6-8), and Winters High School (grades 9-12).

Notable people

- Geoff Connor, 104th Texas Secretary of State, was born and raised in Winters.
- Rogers Hornsby, Major League Baseball great, was born in Winters on April 27, 1896.
- Del Shores, film director and producer, television writer, playwright, and actor, was born in Winters. The play, film, and television series *Sordid Lives*, written by Shores, is loosely based on his life in Winters.

HOSPITAL BIOGRAPHY[3]

North Runnels Hospital District

North Runnels Hospital is in Winters Texas and was founded in December 1972. North Runnels Hospital is a critical access hospital serving all of Runnels County and the surrounding areas. North Runnels hospital provides a variety of outpatient services. Some of the services offered are: Ultrasound, CT, Lab, Radiology/CT, Medicare Swing Bed Program, Physical Therapy and Occupational, Emergency Medical Services and Clinic.

HOSPITAL MISSION STATEMENT

The mission of North Runnels Hospital is to provide high quality health services to the citizens of Runnels, Coke, Taylor, Coleman, and the Surrounding Counties by:

- Providing access to care
- Building collaborative relationships with community organizations and providers
- Emphasizing excellence in all that we do
- Utilizing sound financial principles in all decision making

North Runnels Hospital is licensed for twenty-five beds but downsizing to 10 and currently staffed for 5-6 patient beds.

The United States Department Health and Human Services ("US-HHSC"), Health Resources and Service Administration ("HRSA") division has designated the area where the Hospital is located in Runnels County as a Medically Underserved Area (MUA) and a Health Physician Shortage Area (HPSA) for Dental and Mental Health. The MUA and the HPSA designations are based on a combination of factors, including physician-to-patient population ratios, poverty level, the age of the population, and infant mortality rates within the particular area. Each classification of an MUA and HPSA qualification is compiled, measured, and graded based on the respective qualifying criteria for that classification and the MUA or HPSA is awarded based on the respective grade.

HOSPITAL SERVICES

Anatomical Laboratory Services
Blood Bank Services
Clinical Laboratory Services
Diagnostic Radiology Services
Dietary Services
Outpatient Services
Pharmacy Services
Physical Therapy Services
Occupational Services
Speech Services
Social Services
EKG Services

Emergency Department

- Life Flight Helipad
- EMS provided

Imaging Services

- CT Scanning
- Ultrasound
- General Radiology Services

Home Health Services

Full services including Wound Care

North Runnels Medical Office

- Certified Rural Health Clinic

Scheduled Appointments:
Monday-Friday, 8:00 AM to 5:00 PM

MD Provider: Family Practice

Mark K. McKinnon, MD

Mid-Level Practitioners:

Judy Zuspann, PA
Tami Killough, FNP

Services:

- ➢ Laboratory (CLIA Certified)
- ➢ DOT Exams
- ➢ Workers Compensation

Area Hospital Information

Tertiary Care Hospitals within a 40-mile radius include:

- Abilene Hospitals
  - Abilene Hendrick Hospital: Full Acute Care Hospital Services
  - Abilene Regional Hospital: Full Acute Care Hospital Services
  - Oceans Behavioral Hospital
  - Encompass Rehabilitation Hospital (Formerly HealthSouth)
- San Angelo Hospitals
  - Shannon Hospital: Full Acute Care Hospital Services
  - San Angelo Community Medical Center
  - River Crest Hospital

Critical Access Hospitals include:

- Ballinger Memorial Hospital
- Coleman County Medical Center

Rankings & Ratings at North Runnels Hospital[4]

For consideration in the 12 data-driven rankings, the 2019-20 rankings started with 4,653 hospitals, which represent virtually all U.S. community inpatient facilities.

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U.S. hospitals will admit an estimated 33 million patients in the next 12 months. More than 1 million will have a knee or hip replaced and about 400,000 will undergo heart bypass surgery. Heart failure will account for about 900,000, the respiratory condition called COPD another 700,000 and surgery to remove all or part of the colon some 250,000.

Any hospital should be able to treat such relatively common ailments successfully, and many do – but not all. The Best Hospitals procedures and conditions ratings show consumers how well their local hospitals stand up to scrutiny in those six procedures and conditions and three others. In North Runnels Hospital, it is evaluated only based on those procedures available at its facility.

Chronic Obstructive Pulmonary Disease (COPD) Scorecard

A hospital's COPD score is based on multiple data categories, including patient survival, volume and more. Hospitals received one of three ratings -- high performing, average or below average -- unless they treated an insufficient number of patients to be rated. Hospitals that earned a high performing rating were significantly better than the national average.

Overall

Rating: Below Average

Quality Indicators

Survival: Average
Relative survival 30 days after hospitalization for COPD, compared to other hospitals treating similar patients.

Discharging patients to home: Better than Average
How often patients can go directly home from the hospital rather than being discharged to another facility. Recovery at home is preferred by most patients and families.

Number of patients: Low
Relative volume of Medicare inpatients age 65 and over who had this procedure or condition in 2013-17. Higher volume is associated with better outcomes.

Nurse staffing: Average
More nursing care per patient is associated with better outcomes and better patient experience.

Heart Failure Scorecard

A hospital's heart failure score is based on multiple data categories, including patient survival, volume and more. Hospitals received one of three ratings -- high performing, average or below average -- unless they treated an insufficient number of patients to be rated. Hospitals that earned a high performing rating were significantly better than the national average.

Overall

Rating: Below Average

Quality Indicators

Survival: Average
Relative survival 30 days after hospitalization for heart failure, compared to other hospitals treating similar patients.

Discharging patients to home: Average

Number of patients: Low

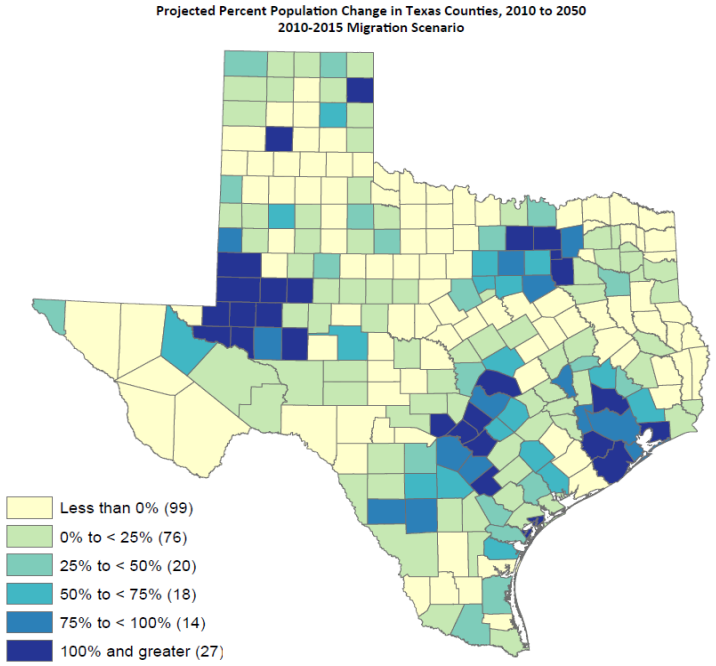
Nurse staffing: Average

Area Hospital Experience[5]

National Survey of Patient Experience in Hospitals. Data not available from North Runnels Hospital.

RUNNELS COUNTY PROFILE[6]

Statistics will be provided for the County of Runnels with an emphasis to single out Winters, Texas to gain a more specific target of needs. Although County statistics involve Winters and other smaller communities, the general premise is that, based on population targets, Winters health issues may still be similar to Runnels County.



COUNTY POPULATION (Census Bureau, 2010)	
County Population	
Estimate 2018:	10,234
Estimate 2017:	10,333
Estimate 2016:	10,291
Estimate 2015:	10,394
Estimate 2014:	10,297
Estimate 2013:	10,200
Estimate 2012:	10,338
Estimate 2011:	10,503
Census 2010:	10,501
Census 2000:	11,495
Population of Places in Runnels County	
Ballinger:	3,631
Miles:	862
Winters	2,460
GENERAL INFORMATION	
County Size in Square Miles (Census Bureau and EPA)	
Land Area:	1,050.9

Water Area:	6.2
Total Area:	1,057.1
Population Density Per Square Mile	
2010:	9.99
Urban and Rural Population of the County, 2010 (Census Bureau)	
Percent Urban:	59.24
Percent Rural:	40.76
DEMOGRAPHICS	
Ethnicity - 2017 (Census Bureau)	
Percent Hispanic:	34.2%
Race - 2017 (Census Bureau)	
Percent White Alone:	92.9%
Percent African American Alone:	2.4%
Percent American Indian and Alaska Native Alone:	1.6%
Percent Asian Alone:	1.7%
Percent Native Hawaiian and Other Pacific Islander Alone:	0.0%
Percent Multi-Racial:	1.3%
Race and Ethnicity - 2017 (Census Bureau)	
Percent Not Hispanic White Alone:	61.1%
Percent Not Hispanic Black Alone:	1.9%
Age - 2017 (Census Bureau)	
17 and Under:	22.8%
65 and Older:	20.8%
85 and Older:	2.8%
Median Age:	41.9
Income	
Per Capita Income - 2017 (BEA):	$39,215
Total Personal Income - 2017 (BEA):	$402,578,000
Median Household Income - 2017 (Census Bureau):	$41,830
Poverty - 2017 (Census Bureau)	
Percent of Population in Poverty:	17.3%
Percent of Population under 18 in Poverty:	26.1%
Educational Attainment (Census Bureau, 2012-2016 American Community Survey 5-Year Estimate)	
Percent high school graduate and higher:	78.5%
Percent bachelor's degree or higher:	19.1%
Pay (BLS)	
Average Annual Pay - 2017:	$35,849
Average Annual Pay - 2016:	$34,882
Average Annual Pay - 2015:	$33,642
Average Annual Pay - 2014:	$34,988
Average Annual Pay - 2013:	$35,321
Annual Unemployment Rate, Not Adjusted (Texas Workforce Commission)	
Unemployment Rate - 2018:	3.1

Unemployment Rate - 2017:	3.7
Unemployment Rate - 2016:	4.0
Unemployment Rate - 2015:	3.7
Unemployment Rate - 2014:	4.2

COUNTY FINANCES (Texas Comptroller of Public Accounts)

Property Taxes - 2017

Total County Tax Rate:	$0.615188
Total Market Value:	$1,523,774,840
Total Appraised Value Available for County Taxation:	$738,064,024
Total Actual Levy:	$4,540,481

Winters, TX Economic and Demographic Data[7]

Population (2018 Est.)	2,571
Population in Households	2,542
Population in Families	2,102
Population in Group Qrtrs	29
Population Density (pop. per square mile)	1,091
Diversity Index[a]	74
Median Household Income	$37,605
Average Household Income	$54,819
Per Capita Income	$21,691
Total Housing Units	1,274 (100%)
Owner Occupied HU	693 (54.4%)
Renter Occupied HU	315 (24.7%)
Vacant Housing Units	266 (20.9%)
Median Home Value	$44,716
Housing Affordability Index[b]	350
Total Households	1,008
Average Household Size	2.52
Family Households	679
Average Family Size	3

NOTES

Demographics are point estimates for July 1st of the current year and each for the forecast years.

[a] The Diversity Index is a scale of 0 to 100 that represents the likelihood that two persons, chosen at random from the same area, belong to different race or ethnic groups. If an area's entire population belongs to one race AND one ethnic group, then the area has zero diversity. An area's diversity index increases to 100 when the population is evenly divided into two or more race/ethnic groups.

[b] The Housing Affordability Index base is 100 and represents a balance point where a resident with a median household income can normally qualify to purchase a median price home. Values above 100 indicate increased affordability, while values below 100 indicate decreased affordability.

Winters Population[8]

According to the most recent demographics data available from the Census Bureau released in December of 2018, Winters has an estimated population of 2,571. From 2010 to 2017 the population is estimated to have remained stagnant. The median age is 31.6. Comparing the median age of men versus women we find a sizeable gap, with the median age of men at 27.2 and that of women at 35. The overall population is split evenly between men and women.

Looking at the breakdown of the population by age and race in the area, Winters has the largest proportion of people under 20 years old at 31.4% of the population. It also has the largest Hispanic or Latino population in the area at 49.5% (the area includes Bronte, Ballinger, Lawn, and Midland/Odessa as statistical comparisons).

The Average Size of a Typical Family

The average family size in Winters is 3.3 people, and 69% of people in Winters are in a family. The city with the highest percent of people who are in a family in the area is Lawn at 82%. 65% of families in Winters are led by a husband and wife. 21% of families are led by a female alone, while 14% are led by men alone. The area with the highest percent of people in a husband and wife family in the area is Lawn with 74%.

Single People by Never Married, Divorced, and Widowed

30% of people in Winters have never been married, 10% have been widowed and 12% have been divorced. The divorce rate is fairly equal to the rest of Texas. 32% of Texans have never been married.

46% of single men are between the ages of 18-24, and 33% of single females are in the same age group. The next largest group of single men at 14% are between the ages of 50-60, while the next largest group of single females at 14% are between the ages of 45-49..

Winters, TX Citizenship

3% of people in Winters were born in another country. The US average is 13.4%, and the Texas average is 17%. One-third of those born in another country have become citizens. 100% of non-citizens are over 18 years old, and the median age of foreign-born residents in Winters is 53.3. 94.9% are born in Mexico with the remaining from Asia.

Most Common Occupations in Winters (2016)[9]

Males

- Laborers and material movers, hand (10.1%)
- Other production occupations, including supervisors (9.5%)
- Metal workers and plastic workers (8.8%)
- Driver/sales workers and truck drivers (5.6%)
- Agricultural workers, including supervisors (5.0%)
- Other management occupations, except farmers and farm managers (4.7%)
- Law enforcement workers, including supervisors (4.1%)

Females

- Secretaries and administrative assistants (12.5%)
- Health technologists and technicians (7.1%)
- Assemblers and fabricators (5.4%)
- Metal workers and plastic workers (4.5%)
- Other food preparation and serving workers, including supervisors (4.0%)
- Laborers and material movers, hand (3.8%)
- Supervisors and other personal care and service workers, except child care workers (3.6%)

Crime[10]

Crime rates are approximate and based on the FBI Uniform Crime Report.

- There is less than one daily crime per 1,000 people in Winters.
- The overall crime rate in Winters is 12% lower than the national average of 27 crimes per 1,000 people.
- Winters is safer than 9% of cities in the United States.
- In Winters you have a 1 in 42 chance of becoming a victim of any crime.
- The number of total year over year crimes in Winters has increased by 11%.

Education in Runnels County for ages 25 and over[9]

- High school/GED or higher: 65.6%
- Bachelors degree or higher: 12%

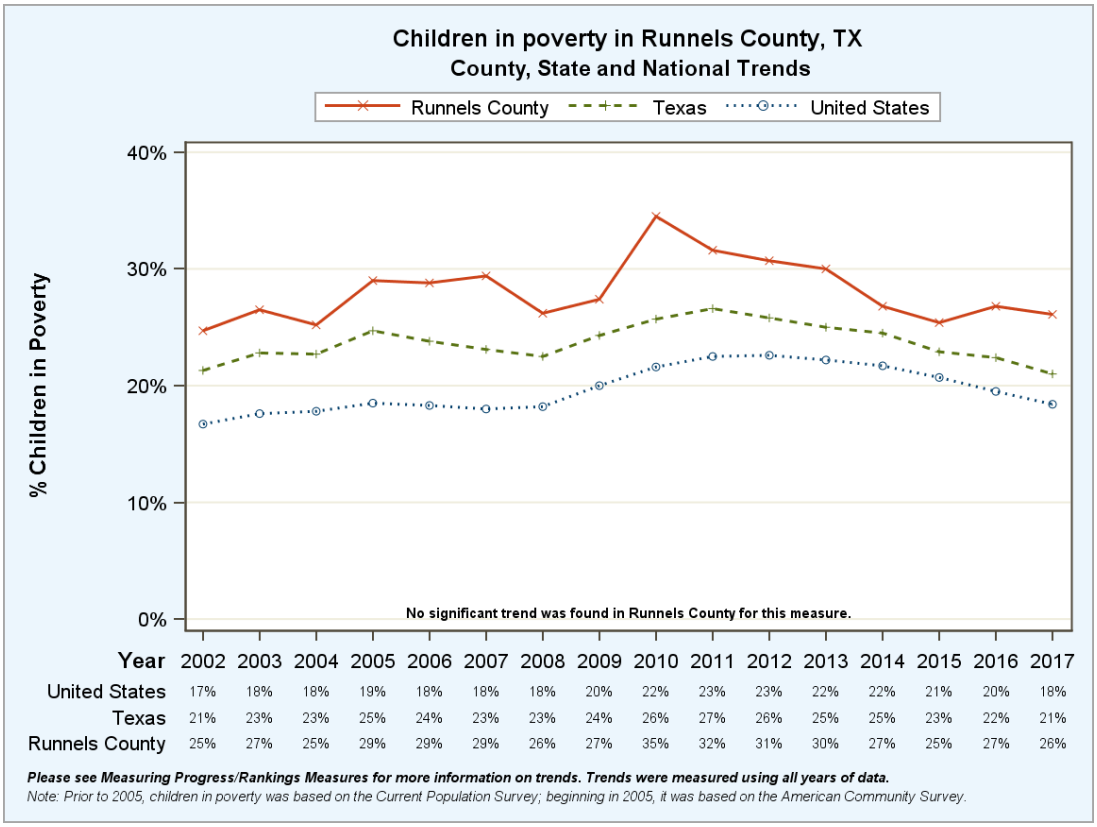
Some Demographic Comparisons[9]

Estimated median household income (2016):

Winters: $35,789
Runnels County: $42,727
Texas: $56,565

2019 estimated unemployment[11; see note]*:*

Winters: 3.3%
Runnels County: 2.9%
Texas: 4.4%



Children in Poverty[12]

Runnels County: 26%
Texas: 21%
Top US counties: 11%

Children in Single Parent Households

Runnels County: 40%
Texas: 33%
Top US counties: 20%

Runnels County Health Insurance

This section healthcare data based on the most recent 2017 data from the Census Bureau which was released in December of 2018 and tracks healthcare in the United States.[9] [14]

Adults without health insurance coverage:

Runnels County: 17.4%
Coleman County: 24.3%
Texas: 23%
Top U.S.: 6%

Children without health insurance coverage:

Runnels County: 9%
Coleman County: 13%
Texas: 10.9%
Top U.S. 5.9%

The Percentage of People Who Had Some Form of Health Care Insurance Coverage in the Area

Runnels County shows it has 83% health insurance coverage which is the 5th in health insurance coverage out of 10 total in the area. The county with the highest health insurance coverage in the area is Taylor County with an insured of 84% is only slightly larger.

Percent of People with Health Insurance Coverage	
Runnels County	82.6%
Coleman County	75.6%
Texas	80.7%
United States	88.3%

Detailed Types of Health Insurance Coverage in Runnels County, TX

Types of Health Insurance Coverage					
	Employer Based	Direct Purchase Insurance	Medicare	Medicaid or Public	None
Runnels County	51%	18%	29%	10%	20%
Coleman County	43%	14%	32%	11%	28%
Texas	53%	12%	17%	9%	22%
United States	56%	15%	21%	13%	14%

The Percentage of Men and Women with Coverage

82% of men have health care insurance coverage which is the sixth highest of all other places in the area. Concho County has the highest number of men with health care insurance coverage in the area with coverage of 85%. 81% of women in Runnels County have health care insurance coverage. Taylor County leads coverage of women at 100%. Overall, Runnels County, like other rural counties across the country, has health insurance coverage below national rates.

Percentage of Men and Women with Coverage		
	Men	**Women**
Runnels County	82%	84%
Coleman County	76%	76%
Texas	80%	82%
United States	87%	89%

The Percentage of People Who Do Not Have Health Insurance

By income, the highest percentage of people who do not have health insurance are those earning under $25K. Insurance coverage between 2015-2016 declined for all of those making below $75,000.

Percent of People with No Health Insurance by Income					
	Under $25k	$25k - $50k	$50k - $75k	$75k - $100k	Over $100k
Runnels County	32%	17%	15%	9%	9%
Coleman County	32%	30%	21%	13%	8%

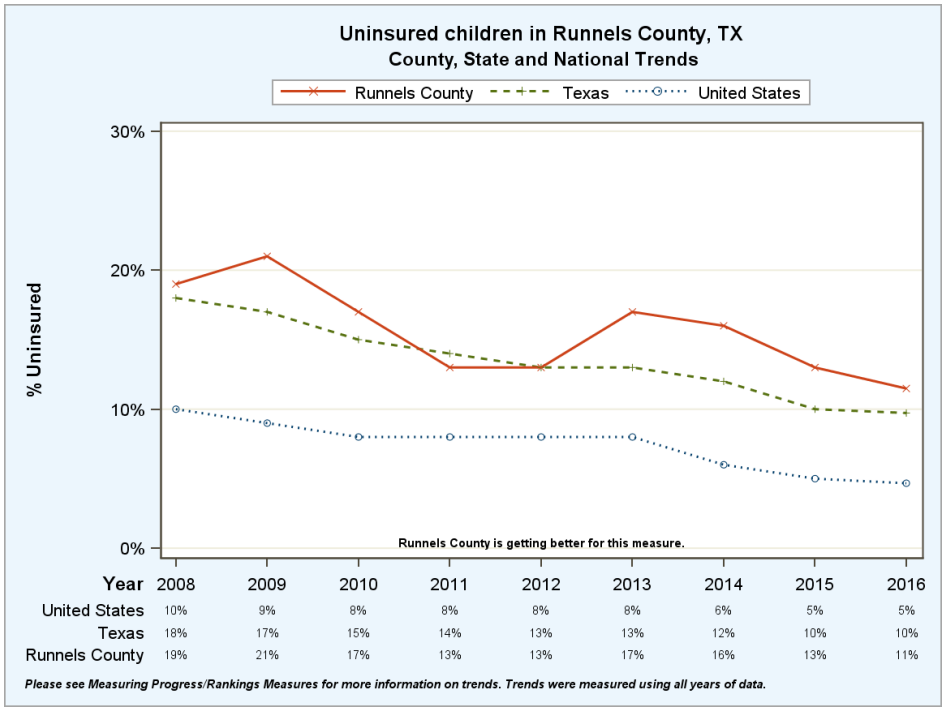
People in the Area Who Do Not Have Health Insurance by Race/Children

When combined with demographic racial data the overall rates of uninsured Minorities are higher overall than that of White residents, even though the percentage number may be higher. For example, though 51% of uninsured residents are White that represents a smaller proportion of White residents who are without health insurance than Black residents.

Not seen below but of interest is that Ganado has the highest rate of children without health insurance at 17%. This county and the state of Texas have poor rates of insured children.

People Without Health Insurance by Race					
	Black	**Hispanic**	**White**	**Native American**	**Asian**
Runnels County	1%	31%	64%	1%	3%
Coleman County	1%	22%	76%	0%	1%
Texas	7%	41%	50%	0%	2%
United States	12%	29%	54%	1%	4%

Children Without Health Insurance Coverage	
Runnels County	9%
Coleman County	13%
Texas	10.9%
United States	5.9%



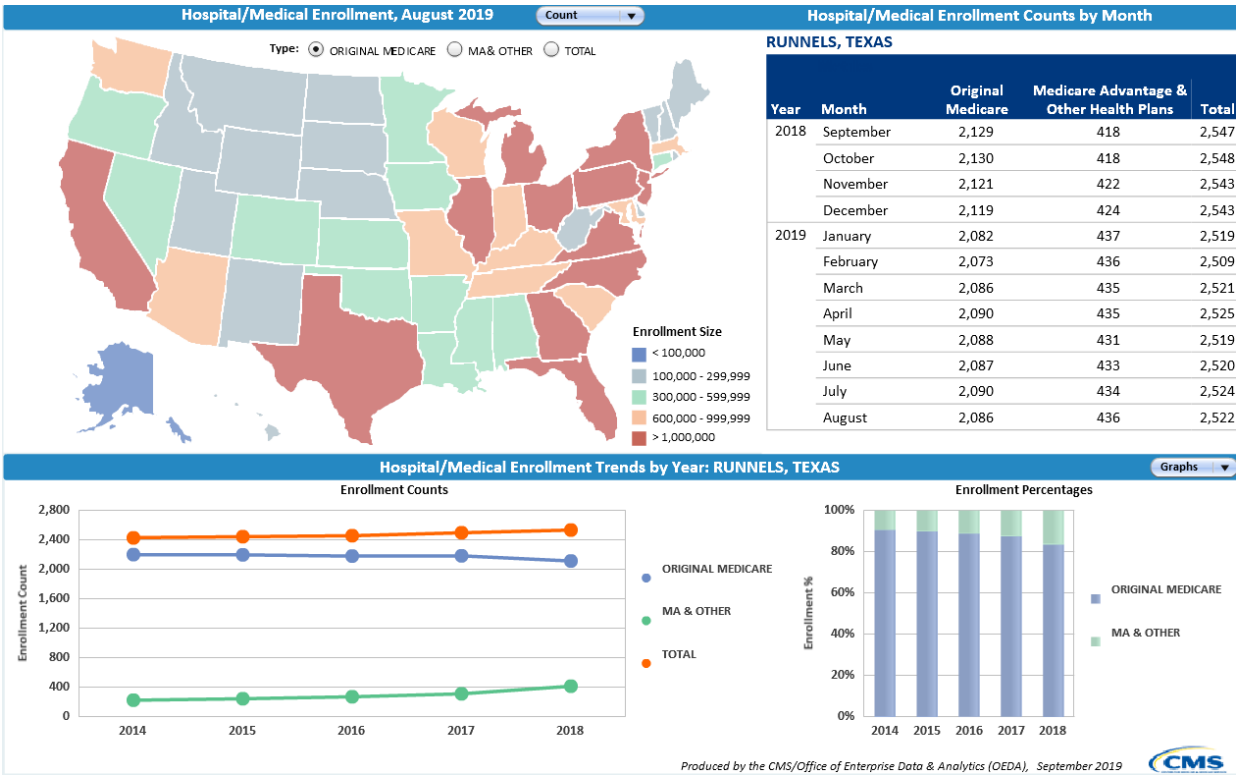
Medicare/Medicaid in Runnels County

Medicaid

7% of Runnels County residents are covered by Medicaid. Those states that expanded Medicaid by 2016 experience lower rates of cardiovascular deaths. [15] Additionally, Medicaid expansion also correlates with a reduction in racial disparities in cancer care, reducing the gap in the early diagnosis of cancer. [16] Texas is one of 14 states that did not expand Medicaid in 2016. Though politically volatile, the Affordable Care Act has resulted in a drop in the rates of the uninsured, especially children.

Medicare Snapshot

18.1% of Winters residents are covered by Medicare. Medicare Advantage Plans are not a positive incentive for a Critical Access Hospital in its Annual Financial Cost Report. It is considered a "Commercial Insurance" and works as a 'disadvantage' to the Hospital Cost Report. A Critical Access Hospital thrives with high basic Medicare & Medicaid patient services. Rates remain basically stable.[17]



Year	Month	Original Medicare	Medicare Advantage & Other Health Plans	Total
2018	September	2,129	418	2,547
	October	2,130	418	2,548
	November	2,121	422	2,543
	December	2,119	424	2,543
2019	January	2,082	437	2,519
	February	2,073	436	2,509
	March	2,086	435	2,521
	April	2,090	435	2,525
	May	2,088	431	2,519
	June	2,087	433	2,520
	July	2,090	434	2,524
	August	2,086	436	2,522

County Health Rankings

Texas Health Ranking[12]

Runnels County: #90 (of 244 rated Texas Counties) which is indicative of length of life and quality of life. Ten Texas counties have no data.

Other Health Outcomes rankings:

- Length of Life: #88 of 244
- Quality of Life: #115 of 244
- Health Behaviors: #108 of 244
- Clinical Care: #124 of 244
- Social and Economic Factors: #110 of 244
- Physical Environment: #88 of 244

Food Environment[9]

Adult diabetes rate:

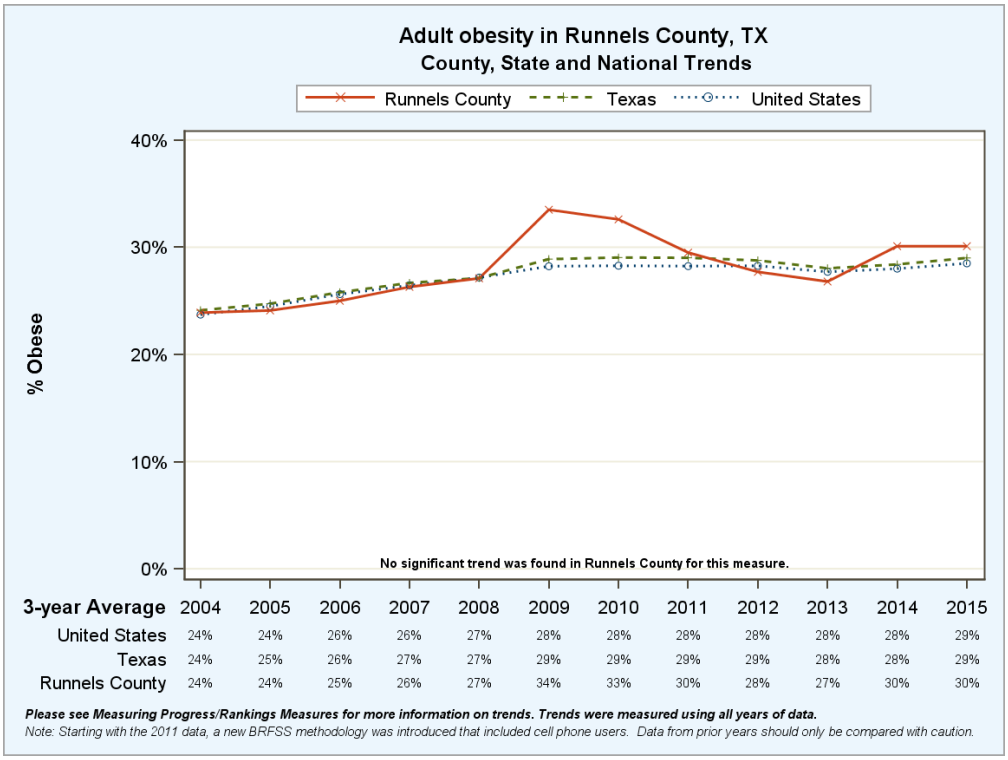
Runnells County: 10.9%
Texas: 8.9%

Adult obesity rate:

Runnells County: 30%
Texas: 29%
US: 14%

Low-income preschool obesity rate:

Runnells County: 11.4%
Texas: 15.7%



Obesity among every age demographic is a significant problem for Runnels County, the state, and the nation. Health systems will continue to see the accompanying health issues.

The County rates for Adult Diabetes, Adult Obesity Rate, and Low-income pre-school obesity rate are comparable to other rural communities throughout Texas, if not higher. These three issues contribute significantly to the cost of health care and the overall health of the community. All three were brought up in the Focus Groups as participants discussed major health issues in the community. Exercise and education are being utilized in many areas to address this issue, both for adults and children. There has to be a willingness on the part of the community to address obesity and diabetes in order for the health providers to have an impact. The following are national statistics:

- Obesity correlates to level of education. Adults without a high school degree or equivalent had the highest self-reported obesity (35.6%), followed by high school graduates (32.9%), adults with some college (31.9%) and college graduates (22.7%).
- Young adults were half as likely to have obesity as middle-aged adults. Adults aged 18-24 years had the lowest self-reported obesity (16.5%) compared to adults aged 45-54 years who had the highest prevalence (35.8%).[18]

Mental Health	*Runnels County*	*Texas*	*Top U.S.*
Poor or Fair Health Days (%)	19%	18%	12%
Poor Physical Health Days/Month	3.8	3.5	3.0
Poor Mental Health Days/Month	3.6	3.4	3.1
Health Behaviors	Runnels County	Texas	*Top U.S.*
Physical Inactivity	25%	23%	20%
Access to Exercise	47%	81%	91%
Adult Smoking	15%	14%	14%
Sexual Health	*Runnels County*	*Texas*	*Top U.S.*
Teen Births (per 1,000 females)	38	41	15
Sexually Transmitted Infections (per 1,000)	199	520.4	152.8

High teen birth rates reflect a need for better sex education *before* and *during* sexual maturation. There is no easy answer to this issue and no single entity responsible. Partnerships with schools and health organizations are encouraged.

Clinical Care	*Runnels County*	*Texas*	*Top U.S.*
Patients per Primary Care Physicians	1,490.1	1,660:1	1,050:1
Mental Health Providers	3,420:1	1,260.1	1,260.1
Preventable Hospital Stays (per 1,000 Medicare enrollees)	56.97	49.66	27.6
Mammography Screening	30%	58%	71%
Flu Vaccinations	30%	43%	52%

The low rate of mammography screening reflects the types of services that often get neglected in rural communities. A recent paper published by the Texas Department of State Health Services indicates the rural-urban disparity concerning older, overweight cancer survivors, with rural communities seeing poorer health outcomes often due to limited transportation, education, income, and healthcare access.[7]

Most common underlying causes of death in Runnels County, Texas in 1999 - 2014[9]:

- Atherosclerotic heart disease (216 compared to the state rate of 170.7))
- Cancer (All types: County 184 with State at 151)

The remainder were all less than 10

- Bronchus or lung, unspecified - Malignant neoplasms
- Chronic obstructive pulmonary disease, unspecified
- Stroke, not specified as hemorrhage or infarction
- Unspecified dementia
- Congestive heart failure
- Unspecified diabetes mellitus, without complications
- Septicemia, unspecified
- Pneumonia, unspecified

HEALTH STATUS OF THE RURAL COMMUNITY

A National Overview of Our Problems [19]

An Economy Based on Self-Employment and Small Businesses

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

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

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

ultimately similar to those of the uninsured.

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

In many rural communities across Texas the health care delivery systems are on life-support or nonexistent leaving too many Texans vulnerable with limited or no access to care. Currently, 170 of the 254 counties in Texas are rural with nearly 20% of the state's population – or more than 3 million people – still residing in what can be considered "rural" areas. Statistically, rural Texans tend to be older, poorer, and less healthy than their urban and suburban counterparts, according to a report, "What's Next? Practical Suggestions for Rural Communities," conducted by the Texas A&M Rural and Community Health Institute (ARCHI) and the Episcopal Health Foundation.

The report is instructive in detailing health care challenges in rural communities. Consider that:

- 35 counties have no physician.
- 80 counties have five or fewer physicians.
- 58 Texas counties are without a general surgeon.
- 147 Texas counties have no obstetrician/gynecologist.
- 185 Texas counties have no psychiatrist.

Exacerbating the issue, more than 20 hospitals in Texas' rural areas have closed in recent years, while 60% of the 164 remaining hospitals are at-risk of closing, according to ARCHI. Financial issues, a lack of patients and a lack of leadership are noted in the report as factors leading to the demise of these hospitals. Since June 2019, three Texas Hospitals have closed in Hamlin, Grand Saline and Chillicothe, Texas. Texas leads all other states in rural hospital closures.

A Modern Healthcare investigation [20] also found that some rural hospitals were closed due to fraudulently "billing insurers for extremely high volumes of lab tests that may not have been performed for their patients or even in their facilities." A Texas hospital cited in the probe reported "extremely high outpatient lab charges in 2015 and 2016: $213.6 million and $372.2 million, respectively. Outpatient labs accounted for 62% of the hospital's total charges in 2015 and 86% in 2016." However, lack of experienced CEO's and experienced/educated governing boards add to this risk. Other factors include inappropriate program spending, lack of an adequate taxing base, excessive use of operating expenses and declining use of hospital services.

A Stressed Health Care Delivery System

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

reimbursements from public programs.

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

Health Care Provider and Workforce Shortage

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

An Aging Rural Population

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

A Sicker, More At-risk Population

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

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

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

Need for Preventive Care, Health and Wellness Resources

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

Increasing Dependence on Technology

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

changes from the State Pharmacy Board and legislative changes, rural hospitals averaging a certain in-patient census may be utilizing the use of tele-pharmacy more frequently with pharmacy drug orders by providers.

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

Effective Emergency Medical Services

Emergency medical services (EMS) are often the first-line medical and health care providers in rural areas. For many of the demographic and health care system issues outlined here, EMS have had placed on them growing demands and health care responsibilities. At the same time, many rural EMS providers are underfunded and face workforce and volunteer shortages. Billing and collections pose significant barriers plus new EMS mandates by Medicaid and other insurance carriers.

The National Conference of State Legislatures has outlined other issues facing EMS. Many EMS providers have inadequate communications infrastructure and are thus often isolated from the rest of the health care delivery. A major example is the lack of access EMS providers has to medical records and medical history, something health information could potentially resolve if EMS providers were able to obtain the resource to connect with other rural providers. Major health facilities owning their own EMS services are now equipping ambulances with EMR units for medical record synchronization of the ambulance and the Emergency Department.

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

A successful model of a hospital based EMS system is what is called EMS Home Care which works in collaboration with the Hospital Home Agency for follow-up Emergency Room visits, hospital patient dismissals and at-risk patients with frequent re-admits to the hospital who may not qualify for home health care. The EMS personnel responds to the home to monitor oxygen

levels, blood pressure, wound dressings and/or simply to “put eyes on the patient” to determine the next appropriate care level or intervention (if any).

How Does North Runnels Hospital Stand Among The Others?

We must think beyond asking “how do we save the local hospital?” or “how do we translocate urban health care solutions to rural Texas?” Each of the facts facing rural communities poses ongoing threats to healthcare in Winters, Texas. The direction and stability of a local hospital district board is a key factor in minimizing failure risks. Key factors involving years of experience, stability and consistency in governing leadership is critical. One of the top long-term success indicators for rural hospital survivals is board governance with capable and engaged board members. Boards whose members or new candidates for board members who strive to “fix things or make things right” many times have personal agendas that risk the overall success of the hospital. No personal agendas can exist in todays board rooms due to the fragility of small rural hospitals.

Rural hospitals must re-imagine their roles within the community. For too many years, the local rural hospital was “just the place at the edge of town where old people go when they get sick and if you are really sick you need to just keep on going.” Hospitals had little concept of connecting with community leaders and area health systems and working as a community team in finding solutions to local health concerns. In far too many Texas hospitals is the absence of sound and analytic data with seasoned leadership to help direct sound decisions, and it just may be that too many small hospitals were built in the 1950’s where every small town had a town “doc” and small hospital. The positive note is that North Runnels Hospital District remains the financially “stable hospital” in the county and area. The biggest threat will always remain the outmigration of services to larger regional tertiary facilities. It is less desirable to travel for a growing elderly and low-income population due to the financial hardships, availability of affordable lodging and weather. Strong and smart-thinking board members without personal agendas will be the goal for North Runnels Hospital District. The District has a strong physician champion and seasoned Chief Executive Officer.

Winters Health Status

This section of the assessment reviews the health status of Winters/Runnels County residents. As in the previous sections, comparisons are provided with the State of Texas, Abilene and San Angelo are the most immediate threats. In both cases, the outreach regional programs are nominal at best to help North Runnels Hospital except to “take the patients.” This assessment of health outcomes, health factors, and mental health indicators of the residents that make up the community will enable the hospital to identify priority health issues related to the health status of its residents. Good health can be defined as a state of physical, mental and social well-being, rather than the absence of disease or infirmity. According to Healthy People 2020, the national health objectives released by the U.S. Department of Health and Human Services, individual health is closely linked to community health. Community health, which includes both the physical and social environment in which individuals live, work, and play, is profoundly

affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community.

For a community the size of Winters, the issue of competing hospital & clinic services has to be examined as to function, need, and viability, not only for the immediate Winters community but the area. If other health services do choose to enter to the market and not utilize available hospital patient services such as Physical Therapy, Clinic System, Lab, Radiology, and in-patient admissions, the only conclusion that can be drawn is that the motive is not for the welfare of the community hospital. The same is true for supporting the local pharmacy and hospital home health services. Every patient not utilizing a local hospital service and instructed to obtain health services in other communities or otherwise is not only a disservice to that patient but one less dollar in the local hospital system. More will be addressed later in this document in "One Stop Shopping." The focus of the rural community is to always guard the continued existence of a local hospital because of the negative impacts for the overall community. That does mandate the local Hospital system be accountable for good care and service. There is no question with the instability of hospital services that it jeopardizes the utilization of all local threat of their community hospital.

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

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

We must think beyond asking "how do we save the local hospital" or "how do we translocate urban health care solutions to rural Texas?" Each of the facts facing rural communities poses ongoing threats to healthcare in Winters.

As a result of the Statistical Data, the following general conclusions can be made.

Identification and Prioritization of Health Needs

General Observations

(RED represents needs to be addressed by Hospital)
(GREEN to be addressed by Hospital and Community)

In reviewing the focus group responses, this report will comment on opportunities to refine action plans through an organization suggestion. A second set of Needs will be listed in the section “Community Health Focus Group”” stated later in the report. The following is recommended:

One of the historical paradigms of hospital health system management is that the hospital works independently from city/county government and non-profit agencies/programs until it needs a program or fulfills a need of the hospital through a program requirement. Until then the local agencies in the community and hospital continue to work in isolated “silos” of function. This can certainly include the medical staff working toward its own financial benefit in a clinic model without interest in hospital admissions where hospitalists and Emergency Department “docs for hire” are employed for that purpose. The end result is Physicians not being regarded as the “fuel” and “energy” of a successful healthcare system. The hospital is a vital ingredient of a successful community through its large employee base and the mere function of services.

However, hospital systems “rarely sit at the same table” in solving community health issues that underlie poor health habits or diseases such as: poverty, mental health, disease management, poor housing, obesity issues with adults/children, and high county statistics such as cancer, heart disease, diabetes and teen pregnancy. Hospitals view themselves as the “tail-end” of disease management in trying to “respond medically to a health issue” through Emergency Departments and Clinics. The community finds itself “circling” the same issues year after year, responding admirably but not dampening poor city and county health statistics.

Examples include:

Transportation: Indeed, this is a problem for patients being able to travel to physician appointments locally and regionally for care and treatment. This problem becomes exaggerated with senior and indigent populations with a private or transportation entity. Dealing with government funded programs such as Central Texas Rural Transit (CARR) is difficult at best due to available vehicles, patient appointment schedules, etc. There are limited alternatives due to the nature of the entity, area served and personalized service. The hospital could study the “clinic/ancillary cancelled services” and the impact on revenue for funding its own van. There are several examples across the state, such as Fisher County, where the clinic cancellations were excessive. With the purchase of a used van, clinic volumes increased significantly to offset any van expenses. Unfortunately, without the aid of senior citizen volunteers, church volunteers or retired citizens who could privately drive patients to San Angelo and Abilene, there are not positive alternatives that are consistent and reliable. The “philanthropic volunteerism” will eventually run a negative course.

Assistance/collaboration with the ministerial Alliance: A vital part of public and private communication avenues is a chaplaincy program at the hospital. This is easily accomplished with volunteer rotations for patients with churches or Emergency Department crisis.

Marketing: The strongest plan for marketing is "word of mouth" and public testimonies. However, a less expensive "marketing program" to be considered would be Direct Mail with some consideration of targeted home and business mailings to announce high importance news such as new physicians, clinics, etc. The hospital's home health agency and EMS services will remain the most visible "marketing program" for the hospital's first impression and care delivery.

Education: Most education would fall "on the backs" of the North Runnels Home Health Agency, EMS Service and assistance from hospital personnel. This is a rural issue with limited government or non-profit agency support for North Runnels Hospital District.

Financial Outreach programs: As noted above. Most patients are entering multiple agency services where approval into one program could gain access to other programs, saving multiple appointments by patients into various agencies. Transportation and childcare issues are always prevalent in the success of patient participation. Consider more home visits by key hospital and EMS staff (EMS Home Wellness visits) to gain more local support for local health services. In a hospital the size of NRHD/Clinic, billing should be efficient, clear and understandable. Consider home visitation visits from members of the Business Office to clarify bills, obtain billing information and ease the issues of billing and collecting.

Emergency Room: A consistent effort should be made while the clinic is open to transition any primary care to the clinic system for a provider relationship and decrease any unnecessary use of the Emergency Room by repeat offenders. National trends denote decreases in rural community emergency services with available Monday – Friday plus Saturday morning Clinic operating times. Clinic hours should always have a provider in "noon" slots.

One Stop Shopping: The hospital has a good opportunity to utilize a successful home health program to educate the public of services at the hospital.

Teen Pregnancy: The hospital and hospital clinic should place efforts toward educating the public regarding Teen Pregnancy. The school clinic should be its greatest weapon of education. The statistics regarding Runnels County (2017) teen births and unmarried mothers regarding poverty, finances, and income class are above state and national averages. This requires a multi-agency response through a Wellness Council model. Teen Birth Rates are as follows:

	Runnels County	Texas	Top U.S.
Teen Births (per 1,000 females)	38	37	14

Physician and Specialty Staff Recruitment: A well-defined plan should exist to utilize Dr. McKinnon as the lead with the CEO to recruit and hire a new Family Practice physician. This should include visits to Texas Tech School of Medicine Residency program and others as defined. The hospital should play a supportive and administrative role to Dr. McKinnon for him

to continue to establish the medical culture going forward. This will be one of the most critical aspects of the CHNA plan being implemented.

In many communities there is a recommendation to develop a city-wide Wellness Council that responds to the Community Health Needs Assessment. Even though the CHNA is a mandated report by the hospital every three years, the report must include hospital programs and its response to community health needs through new programs, facility, clinic, physicians, personnel, and so forth. However, most hospital CHNAs do not respond to the health needs of the community in a collaborative way to decrease such issues as teen pregnancy, alcohol and drug abuse, mental health, hunger, obesity, and disease management such as heart disease, cancer, etc.

In this size community and the lack of in-town support agencies, these responsibilities would fall to the Home Health program at North Runnels Hospital but include the Nursing Home, the School District, city and county representatives, health department to the county, ministerial alliance, and so forth who can represent a core response to community health needs. This provides a process to guarantee the public that sound medical and healthcare principles and plans are within current medical practice standards and a coordinated plan is being implemented to address growing disease mortality and morbidity. This group could easily form a Community Wellness Council with powerful implications of success due to its size and ability to evade “multiple agency red-tape” issues.

Demographic Trend Data: Demographic projections of population growth in Winters, Texas were reviewed. Growth trends for vulnerable population groups were included in the review. The population trend for this county will likely continue to stagnate/decrease without any industry locating to this immediate area. The need for more industry is a stated concern from all community focus group participants. The need for a viable Nursing Home and Assisted Living become key factors in the community remaining stable without a downhill spiral as with communities with vacant nursing home buildings. Representing one of the top employers in the community, and because of the business questions regarding healthcare services and the importance of healthcare for any significant business, it was noted that the hospital CEO should be included in any possibilities to recruit small or large businesses to the community/area.

Other Healthcare Resources: Data and information on the supply of hospital professionals, home health agencies, pharmacy, and dental services, and mental health services were reviewed. As with many Texas rural communities, the supply of qualified healthcare and community health officials is in crisis. This could be primarily a result of the close proximity of healthcare programs in larger communities such as Abilene and San Angelo. There is a trend for older health care professionals to slow down in a more relaxed area with close access to an urban center for entertainment, transportation, shopping, and a less hectic lifestyle. The attraction of young professionals will be a challenge due to the lack of jobs for the other non-healthcare spouse. Even though the hospital must recruit one Family Practice physician and one PA and/or Nurse Practitioner, it is healthy to re-state that a community must help choose their physicians in the selection process. This need requires a concentrated effort of community leaders, pastors, and school officials to work in harmony to attract health professionals to the community. Hospitals have a long history of “selecting physicians and announcing to the

community hoping the community will like them and spend thousands of dollars in marketing if clinic visits are not positive because of the lack of acceptance either by others in the medical staff or community."

Survey of the Poor and Extremely Poor: It is important to assert the community-wide health needs of vulnerable populations in Winters. With this perspective at the forefront, the needs assessment has made every effort to use data to identify needs of community-level importance which, in many instances, can only be addressed through cooperative, collective community action including senior citizens, churches, and school. It was noted that the rates of uninsured and children in poverty are higher than state and national averages. This is an alarming statistic. This population group remains the #1 target for healthcare providers due to the lack of compliance usually due to lack of funds, educational resources, and transportation. The hospital should consider a partnership with the school in establishing a school clinic to ensure all Medicaid children are captured at such events as school registration and school clinic visits. A Medicaid screener could be present at school registration meetings to register any possible Medicaid qualifying student or upon registration at any new clinic visits. Every opportunity to capture Medicaid patients should be a priority.

Analysis of the data leads to the following summary list of identified needs for Winters. These listed are not only hospital needs but community health needs. These needs represent the analysis of the health data and not the focus groups.

1. **Needs of children and seniors**. Increase capacity to address health needs of children and seniors through physical activity, sex education programs, and nutritional support relating to the poverty levels. Such proactive ideas could include afternoon school programs for kids. The city has an excellent park with swimming, walking, running and sports. A specific opportunity relating to low income children with high obesity rates should be directed to assisting low-income family children to participate in sports by "adopting" kids to pay for scholarships for registration costs and uniform costs. Typically, this high risk disease group cannot afford team sports outside of the school system. This could be a goal for churches, social clubs, businesses, hospital, foundations, and so forth to fund a "kid who wants to play" but family funds are not available.

2. **Recruit and Retain Core Health Professionals**. Continue to maintain a healthy way to retain and recruit core health professionals. Consider a means to minimize competition or duplication of other local/regional health providers not associated with North Runnels Hospital to utilize or consolidate into the hospital network. The community should be guarded to "outside" companies or agencies that locate or set up referral patterns with Winters Medical Staff in exchange of medical director fees and erode the present hospital financial and clinic foundations. The hospital should always consider a scholarship program to return "home grown students" back to the community.

3. **Community Health Programs and Emphasis of Hospital Clinical Services:**

   • Heart disease, cancer, mental health, and cerebral-vascular disease screening programs should be strengthened through community-wide, multiple-agency approach through the Annual Wellness Programs and Clinic Electronic Medical Record templates.

   • Cancer detection screening programs through dermatology, mammography, PAP and PSA screening clinics should be held on some regular basis such as quarterly or bi-annually in coordination with the Clinic and Hospital. Mammography Screening remains below average to state and national averages.

   • COPD programs and screening should be conducted yearly through area annual clinic patient visits to meet quality care mandates. Portable Pulmonary Function Screening Programs can be done in any business center to identify base-line pulmonary disease such as asthma or chronic obstructive pulmonary disease. In lieu of a department, the hospital could co-sponsor these with an Abilene/San Angelo hospital partner.

   • Complications arising from diabetes. Area clinic patients should be screened at least annually (quarterly is better) with focused diabetic lab tests (A1C) as well as a scheduled bi-annual diabetic screening clinic along with foot wound evaluations in the Clinic. This was the most common comment made by participants.

   • Influenza and pneumonia immunization/vaccination programs should be a part of the quality measures of the Clinic Electronic Medical record systems with emphasis on school registration events and anticipated flu seasons. This should be coordinated with the health department representative, schools, senior citizen organizations, and any social and civic clubs. The health clinic and pharmacy in the city should collaborate to minimize the incidence of flu, Respiratory Syncytial Virus (RSV) and pneumonia. The School Clinic remains a viable vehicle available for the community.

4. **Develop capacity and access to quality behavioral health services:**

   • A local mental health initiative appears absent (e.g. classes and instructor development). A local task force of law enforcement, school, and health professionals (Emergency Department Staff/EMS) should be considered to collaborate with the regional Network of Care for Mental Health Services to manage the network of care between communities. This should continue to be a major emphasis going forward for the community health planning, as should reducing cost and other barriers to quality behavioral health services through prevention and treatment with depression screens. This topic was never mentioned in any conversation with staff or community members to the total lack of awareness to programs or state-wide epidemic of mental health disease. Mental Health First Aid for Students and Adults should be a major task force initiative for the Justice System, School, and Hospital.

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

   • Reducing cost and other barriers to quality behavioral health services through prevention and treatment with depression screens in clinic(s) and through the Electronic Medical Records for quality care management.

- Continuing to provide smoking and tobacco cessation classes as it ranks #3 of top causes of death. This could be in coordination with the hospital with portable pulmonary function screening in the community.

- Continuing to provide prevention and treatment of alcohol and drug abuse classes with the area Veterans programs and working with school programs to extend student classes to include parents.

6. **Preventative outreach to the poor and extremely poor**. Increase community capacity to reach the poor, extremely poor, and other vulnerable groups with preventative actions to:
   - Reduce obesity through community classes as Runnels County obesity rate (30.%) exceeds the state rate (26.6%).
   - Reduce cost and other barriers to medical care and treatment through cash or discounted programs and sliding scales.
   - Improve case management and routine preventative screenings in a clinic or Emergency Room Setting (Current Emergency Room and Clinic volume indicates time to accomplish screens)
   - Continue to provide educational classes to promote healthy living and wellness as noted with the high level of poverty with children with the school and hospital home health agency. This could be a collaborative effort with the regional Texas A&M Agri-Life Center.

7. **Food, housing, and neighborhood security**. Increase the security of poor and extremely poor individuals and households by:
   - Increasing access to nutritious foods through WIC, Summer Meal Programs for Children and the Supplemental Nutrition Assistance Program, etc. A program should specifically feed seniors on the weekends where food programs are not available. This should be a coordinated event with the senior citizens organization. The Meals on Wheels should be a "community program" cooking meals locally and qualifying as many vulnerable seniors as possible to guarantee every senior citizen is having a meal for the day. The current Meals on Wheels program is not provided locally. The hospital should consider absorbing such a community program with new home delivery teams in the community.

8. **Conduct community health classes (drug, alcohol, diabetes, obesity, heart)** with high risk groups with a Mid-level provider, RN and participating Pharmacist if possible. It was suggested that any health fairs and other educational or screening services should be off-site, in order to draw more people into the activities. It was suggested that businesses or community meeting places would be appropriate locations to reach many of the residents. As to be noted, the hospital of today needs to be "out there" and instead of demanding all services to be held at the hospital. To only focus services at a local Senior Citizens Center is not effective.

Nursing Home Care/Assisted Living Services were noted throughout the two days with mixed reactions that seem to primarily be directed at non-care issues such as the current corporate ownership of the programs. In noting public state report cards for State Nursing Homes, the home remains in a positive state. There are many pros and cons of a hospital affiliated nursing home. In this case, there probably remains more in the positive column than the negative with the relationship with the hospital and medical staff. Additionally, there are negative impacts to the community and region of a closure. Hospital ownership could avoid a major health entity(s) closing in the community while giving the hospital a needed "boost." A few key notes are listed:

- Increased volume to hospital departments such as home health, rural health Medicare, Medicaid visits, Swing bed utilization, various therapies and medical staff involvement of the physician and mid-level providers.
- Significant economic impact of the home not closing (same as with Assisted Living).
- Increased occupancy of Winters patients remaining in the community.
- Bases on recent Life Safety State Reports, minor repairs, paint, minor remodeling and face-lift, it can experience a better community response.

COMMUNITY HEALTHCARE NEEDS FOCUS GROUP

This Section addresses the comments of the Focus Groups.

The purpose of the Community Healthcare Needs Assessment is to identify the healthcare needs of the community, regardless of the ability of the hospital (NRHD in this case) to meet these needs. Information about the primary needs of community healthcare needs for Winters, Texas (which will have an over-all positive effect on Runnels County) was obtained through interviews in organized focus groups. These participants represented an excellent cross culture of this rural community in the coastal area. Individuals in Focus Groups consisted of members of various, races, income levels, education levels, government, schools, banking, churches, law enforcement services, healthcare and general businesses with varying household statuses.

Participants of the five focus groups and individualized meetings included the following participants:

- Community citizens
- Retired Business /Farm, Ranch Owner
- Business Owner
- Retired Volunteer
- Retired Hospital personnel
- Physicians Education
- County Representative
- School Superintendent and Administrative Faculty
- Hospital Board Members
- Key Hospital Leadership
- Nursing Home Administrator

Priorities Identified in Interviews

Much of the information presented from the Focus Groups is based on perceptions of the members of the community, most of whom have significant involvement in the community and have had some experience with North Runnels Hospital & Clinic and its services and staff. Even if a comment made was only perception and not based on actual experience, perception is reality to those individuals and needs to be considered.

Additionally, information shared in Focus Groups or direct conversations is often what gets repeated within the community and therefore becomes the basis for what people believe about the community & Hospital/Clinics. When all participants were asked to grade the hospital on a scale of 1-10 (5 being average and 10 being the best), the average personal rating was 6-8. When asked how they sense the community grades the hospital, the rating was 5. When asked to rate the physicians, the average personal rating was 8.

In addressing the CHNA, it is to be noted the hospital was the entity requesting the CHNA. This issue is noted because in many cases the public's perception is that the "*hospital is the health system*" and is solely responsible for addressing all health needs. This is false. The hospital is one component responsible for community health services. There is no question that hospitals play a major role in the delivery of healthcare in any community, but the responsibility of community health services is shared by multiple agencies, non-profits, state health departments, churches, and social health programs.

It is also to be noted in this public document that the hospital and community have much work to be done in improving the health outcomes in the County.

As a review:

Texas Health Ranking[12]

Runnels County ranks well (#90) in comparison to the 254 counties in Texas. A higher rating represents a poorer rating. Ten Texas counties have no data.

Other Health Outcomes rankings:

- Length of Life: #88 of 244
- Quality of Life: #115 of 244
- Health Behaviors: #108 of 244
- Clinical Care: #124 of 244
- Social and Economic Factors: #110 of 244
- Physical Environment: #88 of 244

The following topics were most often repeated by a significant number of participants and are listed as priorities for the Hospital Board and Administration to consider as future planning is being developed. Most of these issues are not particular to Winters, Texas, North Runnels Hospital District or surrounding health entities. In fact, most of these issues are endemic to American communities. The Hospital Board and Administration should look outside of its borders to discover effective models from which to build action plans.

Lack of Usable Insurance for Low Income Households

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

The current US administration is in the process of either discontinuing or reorganizing the entire plan or major parts of this plan and penalties imposed by the IRS. However, it still does nothing to address the overall issues with premiums, available plans, deductibles, physician availability, etc. In addition, the retired school teachers of Texas now have a low reimbursement insurance product and a supplemental Medicare Advantage Plan which is a direct threat for reimbursement of Critical Access Hospitals and Provider Based Rural Health Clinics. *The current biggest financial threat to rural hospitals in Texas* is Blue Cross/Blue Shield products with poor hospital reimbursement fees.

Almost every member of low income households who did not qualify for Medicaid, charity care, or indigent programs prior to 2016 and who purchased health insurance in 2014 to comply with the PPACA found they could not afford the monthly insurance premiums even when purchasing insurance through the Marketplace. In addition, they stated while they had the health insurance

coverage, either the deductibles or co-pays were so high they could not take advantage of the insurance, i.e. they did not seek medical treatment.

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

A review of health coverage in Runnels County:

The Percentage of People Who Had Some Form of Health Care Insurance Coverage in the Area

Runnels County shows it has 83% health insurance coverage which is the 5th in health insurance coverage out of 10 total in the area. The county with the highest health insurance coverage in the area is Taylor County with an insured rate of 84%, only slightly larger.

Percent of People with Health Insurance Coverage	
Runnels County	82.6%
Coleman County	75.6%
Texas	80.7%
United States	88.3%

Detailed Types of Health Insurance Coverage in Runnels County, TX

Types of Health Insurance Coverage					
	Employer Based	Direct Purchase Insurance	Medicare	Medicaid or Public	None
Runnels County	51%	18%	29%	10%	20%
Coleman County	43%	14%	32%	11%	28%
Texas	53%	12%	17%	9%	22%
United States	56%	15%	21%	13%	14%

The Percentage of Men and Women with Coverage

82% of men have health care insurance coverage which is the sixth highest of all other places in the area. Concho County has the highest number of men with health care insurance coverage in the area with coverage of 85%. 81% of women in Runnels County have health care insurance coverage. Taylor County leads coverage of women at 100%. Overall, Runnels County, like other rural counties across the country, has health insurance coverage below national rates.

Percentage of Men and Women with Coverage		
	Men	**Women**
Runnels County	82%	84%
Coleman County	76%	76%
Texas	80%	82%
United States	87%	89%

The Percentage of People Who Do Not Have Health Insurance

By income, the highest percentage of people who do not have health insurance are those earning under $25K. Insurance coverage between 2015-2016 declined for all of those making below $75,000.

Percent of People with No Health Insurance by Income					
	Under $25k	$25k - $50k	$50k - $75k	$75k - $100k	Over $100k
Runnels County	32%	17%	15%	9%	9%
Coleman County	32%	30%	21%	13%	8%

People in the Area Who Do Not Have Health Insurance by Race/Children

When combined with demographic racial data the overall rates of uninsured Minorities are higher overall than that of White residents, even though the percentage number may be higher. For example, though 51% of uninsured residents are White that represents a smaller proportion of White residents who are without health insurance than Black residents.

Not seen below but of interest is that Ganado has the highest rate of children without health insurance at 17%. This county and the state of Texas have poor rates of insured children.

People Without Health Insurance by Race					
	Black	**Hispanic**	**White**	**Native American**	**Asian**
Runnels County	1%	31%	64%	1%	3%
Coleman County	1%	22%	76%	0%	1%
Texas	7%	41%	50%	0%	2%
United States	12%	29%	54%	1%	4%

Children Without Health Insurance Coverage	
Runnels County	9%
Coleman County	13%
Texas	10.9%
United States	5.9%

The insurance market remains a significant threat to the future of local rural hospitals and Winters, Texas is not an exception. This represents a National Health Crisis for Texans and this community. At the same time, hospitals are incurring declining reimbursement rates, resistant health insurance partners, lack of state participation with national programs, complicated billing and collecting systems and lack of experienced hospital personnel in rural areas. From conversations with the hospital leadership, every possible avenue is being investigated to continue to offer cash discounts, sliding scales and even offer boutique payment plans to offer citizens every possible alternative for payment of hospital services. Additionally, the hospital is making every effort to provide the public processes to better understand the patient billings and navigate through the mirage of insurance billing language.

Other Health Insurance Issues

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

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

Chronic Diseases and Healthy Living

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

- Diabetes (child and adult) as the number 1 noted health concern
- Obesity (child and adult)
- Hypertension
- Cardiovascular disease and stroke
- Cancer
- Kidney disease
- Arthritis
- Allergies
- Dementia

Many individuals suffer from more than one of these diseases. A Community Wellness Council model (detailed below) will need to continue to offer several health fairs and health screenings throughout the year as well as education presentations through the Wellness Initiative. A good working model exists in Palacios, Texas to examine. Most people interviewed said they were unaware of health fairs, screenings, and educational presentations by the hospital. When discussing this item, many acknowledged that time is an issue, many seniors did not have transportation, or they did not feel they would benefit. Many expressed a desire to see more education presentations, and in contrast, there were also those residents who might not attend health screenings or education or were not interested in hearing more about health education.

As with every community, some participants do not seek care for illnesses or chronic diseases until hospitalization is required. The reasons for not seeking care include the inability to afford routine healthcare visits or medications, the inability to take time off from work, and the lack of transportation. One of the greatest challenges for health providers is to provide incentives for participation other than “it will help your overall health and risks.” Even though this seems to be overall American laziness to attend free and educational seminars or screens, it is not until a crisis evolves that people change personal behavior patterns. Large business avenues such as the local grocery store, senior citizens and public programs (such as athletic events or church events) represent “out of the box” thinking for health screening and educational programs. As a note, all this contributes to re-hospitalizations and costs to the health system and continued

crisis with issues such as diabetes, obesity, cancer and heart disease. The latest available statistics demonstrate NRHD Preventable Hospital Stays:

Clinical Care	Runnels County	Texas	Top U.S.
Preventable Hospital Stays (per 1,000 Medicare enrollees)	56.9	49.6	27.6

The "One Stop Shopping" Bias

North Runnels Hospital District has met major obstacles in its history to warrant community reluctancy to "go to San Angelo and Abilene" for services. NRHD has made considerable strides in combating this situation but it still persisted in focus groups. The successful implementation of a new replacement facility might be a historical turn of events of public perception of its hospital.

If a patient needs a particular medical service not available in Winters they travel to San Angelo or Abilene for that service. Once they leave the area they tend not to come back for other healthcare services at NRHD. This includes routine medical services, skilled nursing/rehabilitation, surgery, diagnostic, and imaging services. Many reasons exist for this bias. Some feel it is easier to have all of the healthcare needs met in one general location. Others felt if healthcare services in Runnels County could not meet one particular need, they would receive better overall healthcare for all needs in the cities offering more services. Several stated they would feel more comfortable going to Abilene or San Angelo because they perceived those doctors had more experience in treating certain conditions than providers in Runnels County. All participants expressed a desire to stay home for healthcare needs because of convenience as well as the support of family, friends, and church.

The hospital administrative and professional staff noted that they do lose a certain amount of the local patient population to the larger tertiary healthcare systems in the San Angelo and Abilene Medical Systems most commonly discussed. This transition of patients to some of the larger healthcare systems may be due to the "one-stop shopping" bias. It may even potentially result from marketing and professional staff communication between the respective healthcare system practitioners and patients while receiving care at those system facilities. It is also likely that some transition of patients to the larger healthcare systems is due to patients from the local communities being unaware that NRHD offers many of the same Laboratory, Radiology, Therapy, Wound Care, and Swing Bed services as the larger healthcare systems. The hospital and the community should continue its efforts to provide this insight to the local patient population. NRHD can serve many needs of patients in primary care, and it can also serve as high-quality post-tertiary care during the transition stages of recovery in areas of swing bed and therapy services. The lack of direct and focused specific marketing was expressed in all groups. The participants suggested themes such as "This Is MY Hospital" testimonies from local and respected citizens or "NRHD Saved My Life." All focus group participants commented they were unaware of specific programs provided by the hospital nor knew names of staff because most staffed lived outside Winters.

Working Effectively Across Organizations and Sectors

The current leadership of NRHD should continue collaborative efforts and networking across tertiary hospital system in larger cities. Turf and competition often take a front seat when it relates to cooperation to solve specific problems. Here and across the country many practitioners and policymakers are coming to the conclusion that collaboration as it usually looks *is not sufficient*. Again, there is no magic bullet. Unfortunately, without a robust evidence base like that for many clinical interventions, "best practices" is too often code for "things other communities are doing that are getting good press." This being stated, certain principles and practices do appear to make a real difference. Several of these principles have been bundled and adopted in communities across the country as a "collective impact approach" to solving complex, adaptive problems that do not have a clear and straightforward technical solution. Whether or not collective impact as a "branded" approach is of interest, its core principles are all worth a serious look. Some of these principles are being incorporated with intentionality into Community Health Improvement Plans and processes.

Mental Health Needs

"Complex Problems Requiring Complex Solutions: Mental Illness and Substance Use."

Few focus group participants focused on the issues of mental health within the community. This represents a major community "disconnect" of one of the national and state healthcare needs and mandates. As with the public discussion of how mental health affects individuals and families, this issue was not a widely discussed item due to the seeming lack of emphasis placed on mental health in this community.

We know in healthcare this is a major health issue facing all communities and currently being discussed as the Top #1 Health Issue among Texans. When we effectively attack mental health issues, we attack a wide variety of health concerns. This set of interrelated issues includes mild to severe mental illness including depression and post-traumatic stress disorder (PTSD), problem drinking, and problem drug use including prescribed medications. These issues present the health system with vast and unresolved problems and are tied to the following: **1)** Physical activity is a lever of some kind – a contributor to or an effective intervention for – a number of other important health issues like depression, overweight and obesity, and chronic physical illness and disability; **2)** Unhealthy eating contributes in different ways to a number of health issues, notably overweight and obesity, diabetes, heart disease, and stroke. Hunger is one of the single greatest threats to the well-being of low-income seniors. Hunger remains a serious problem for children as well, particularly during summer and winter breaks when food is not available through school breakfasts, lunches, and after-school programs. Better marketing of summer food programs, particularly through social media, would help connect more families to existing and underutilized programs serving children. The senior population is growing disproportionately quickly compared to other age groups and will place increasingly significant demands on local health care and social service systems. The local response must go beyond "do a lot more of what we're doing now." A completely different approach to senior well-being is needed if this large segment of the county population is to thrive with a high quality of life and not simply survive until an advanced age; **3)** While an unplanned pregnancy – extremely common in all counties – is quite often a wanted pregnancy, it is rarely a well-prepared-for

pregnancy. This issue is not nearly so high-profile as is teen pregnancy. But reducing unplanned pregnancy yields improvements in birth outcomes, maternal health and well-being, the prevalence of adverse childhood experiences, and a host of other health and social issues; **4)** Child abuse, family violence, and street violence are too common in Runnels County and do serious harm to health and well-being. That remains the case whether one is the direct victim of violence or is only exposed to it in the home or the neighborhood, and the harm may begin immediately and continue until death.

This issue is of high importance to health service education and programs as hunger, obesity, physical exercise, drug overuse, senior care and family violence all become county health priorities affecting multiple agencies and disease management. These programs should be provided to school officials, churches, emergency department and law enforcement to train First Responders (Law enforcement & EMS) in Adult and Youth Mental Health First Aid courses as minimum education requirements. As noted in many law enforcement agencies across the state Law enforcement should be trained in mental health first aid.

Noted was the absence of any questions related to local counseling services and the development and promotion of local counseling services. It is a need within the community at least a full day per week.

Male and Female Health Needs

When questioned about the above average comparisons with state, national and county statistics regarding overall health and opportunities to improve family health, several discussion points were prevalent among all focus groups. The points of discussion revolved around the lack of health services for men and women. It was determined in all groups that the availability of PAP screens, Mammography, and HPV testing/vaccination would be beneficial to improve female health risks. Likewise in men PSA, dermatology skin cancer screening, as well as comprehensive yearly physicals would be helpful. Weight loss programs were discussed but not viewed as a realm of service provided by the hospital. It was discussed that supervised physician weight programs address the obesity issues facing Runnels County and are considered cash-only boutique hospital programs.

Alcohol and Substance Abuse

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

Focus groups mentioned the need for education about alcohol and drug abuse. The Drug Abuse School Programs address the issue of how students are educated to alcohol and drug abuse, but rarely did programs educate parents or seniors in the community. There was a consensus

that the school and hospital should work closely on drug abuse especially with the opioid epidemic. This this should be a community-wide response especially since the hospital is not involved in any alcohol-drug programs. These are typically located in the metropolitan areas.

Pregnant Women/Abusive Relationships/Home Environment

There was little discussion with the need of a "safety net" for pregnant women suffering from abusive relationships, broken homes, or parental (usually father) abandonment. Regional resources most well-known are located in Abilene and San Angelo.

However, to the focus group participants remains the question for Winters teens and women. Although this report is not meant to provide solutions but ideas to consider, a community wide response should include this topic and should involve area pastors, counselors, school officials, health department and clinic providers. In all these areas abusive relationships can be identified and must be reported. The School, Pastors and Hospital could include Instructor Training for Fathers from the National Center for Fathering (see fathers.com or fatherscry.org) for fathers to understand their roles as fathers as well as parenting classes for young couples. There are established parenting classes for secular and non-secular populations.

School Programs and Hospital Partnership

A positive and smart-thinking program noted by focus group participants was the Hospital/Clinic relationship with the School District through the establishment of a School Clinic with a hospital Nurse Practitioner. This represents "forward thinking" of two of the largest employers and organizations in the county solving mutual issues. Verification of health and school data was reviewed regarding teen pregnancy, narcotics, marijuana, opioid, sex education, and overall drug awareness with a spirited desire to improve mental health, primary care and a collaborative relationship with the hospital.

A teen clinic was specifically discussed with some focus group members to better provide targeted care and education particularly to young teen girls. A very positive project is a dedicated Women's Clinic for teachers and flexible schedules for teachers to access primary and specialty care. This is a major opportunity for the hospital to partner with the school system with education, professional/student mentorships, drug and sex education, as well as immunizations and vaccination clinics, school physicals, and significant dollars saved for the school system and community health. HPV is the leading cause of cervical cancer in women, and it is the duty of the community to educate and provide HPV vaccinations, especially to young women who, possibly through poor decisions early in life, will battle a now-preventable disease that has enormous impacts on individuals, families, and communities. This should be an on-going relationship building discussion to keep as money women in the community and meet the female health issues of the community.

Communications

The majority of focus participants and participating hospital employees felt the hospital could do a better job of being "one" with the community and viewed as a more positive provider. The lack of television and public communications avenues were limited except through Facebook.

Representatives of various churches recommended using churches to better inform as well as to improve relations with the Ministerial Alliance. The most popular idea was using very directed and focused messages in direct mail pieces on a quarterly basis, highlighting core services, changes in services (like Clinic changes), new technology, and a campaign along the lines of "This Is MY Hospital." In challenging community leaders attending the focus groups if they were willing to stand publicly and declare "This Is MY Hospital", the idea was overwhelming popular and well received. The hospital has recognized this need to improve in its planning.

Home Health Care

Considerable time was spent with the Home Health Agency leadership discussing the overall direction, goals, services, service area, and the new changes slated for January 2021.

This is an unusual agency for a community and hospital of its size. It is obvious through the meetings that it is one "not in the current box thinking" with an active wound care service (which is very marketable and viable) due to the absence of certified wound care specialists in this field of service. It does set this agency apart. In reviewing the agency patient volumes and referral points, the majority of services are in the Abilene metroplex due to the high referrals in wound care. This is a viable attribute. Winters has approximately 25 continuous referrals while the Abilene market yields approximately 400 continuous referrals that cycle on and off. A typical diabetic referral will cycle on and off three to four times before death. In reviewing the statistics from May – September of 65 total referrals, 7 were from the clinic (5 MD, 2 NP which were only at patient request, 4 Swing Bed and the remainder from Abilene).

The key to evaluate is the lack of referrals from all NRHD referring sources, primarily the mid-level provider in the clinic. The advantage of the wound care program is multi-fold with referrals in and out of the Swing Bed program and therapy programs. The primary source of patients is the key podiatrists in Abilene. Texas. Increased nursing home and clinic referrals from all three providers will see the volume increase locally. As with a typical home health without a specialty as wound care, it would be at risk for survival due to the new changes including:

- Pre-claim review,
- PDGM (a thirty-day billing cycle)
- Blood pressure and cardiac referrals are falling which are not typically profitable

This agency is the only consistent service in and out of homes in the Winters community that can address housing, nutrition, senior abuse, etc. This agency, due to the lack of local agencies, becomes the center of the Wellness response for the Community Health Assessment Needs. These services could possibly be considered the "flagship" of services for this rural hospital and community. I believe the leadership is willing to assume further challenges. The perhaps negative aspect of this service is its location. It once was downtown and is now located to the back of the clinic without any signage. Strategically, this might require further space management and public image than presently.

Community Partnerships

Emergency Department/Hospital Navigator

An Emergency Department/hospital case manager (Navigator) has been a popular model throughout the state to assure patients dismissed from the Emergency Department have a follow-up call to determine if patient compliance has occurred such as pharmacy pick-up, referrals visits occurring, clinic appointments, etc. However, the spike in Emergency Department visits seem to occur in the lunch hour when the clinic is closed for lunch. When 3+ providers (at present) an alternating clinic schedule should be considered to keep the clinic open for those businesses that need to spend their lunch hour at the clinic.

Community Wellness Pathway

There are two models to review: Clinical Navigation Pathway and a Community Wellness Pathway. The need for the hospital to take a role in this project regarding the clinical pathway navigator and wellness model should be studied by the hospital. Additionally, the Wellness Model will need to assure that community education (along with any education agency) meets usual and accepted medical practice standards. All these members would participate in the Community Wellness to ensure communication and a healthy collaboration. Since there are few collaborative services in Winters, the Home Health Agency becomes a positive Wellness Model program to adopt along with EMS. A hospital component will need to be added such as the Chief Nursing Officer and/or COO.

As a note, this model of a Community Wellness Council is rare and remarkable. It is a model to follow across rural Texas in providing community collaboration in meeting healthcare needs as noted in a Community Health Needs Assessment as a map. This is a refreshing model for rural Texas. It becomes the “response vehicle” for the community to resolve community health issues.

Wellness Council Model

In rural counties where healthcare services are provided, there is usually a lack of a coordinated effort to identify and respond to issues affecting health for all the population. In most rural communities, the default falls to the local community hospital to “respond and fix anything health related” which is neither within their obligations nor capabilities. Not through a lack of effort, in most cases they do their best with the limited resources, but the county health demographics usually remain unchanged. A Wellness Council Model can be incorporated into several avenues:

- Home Health Agency/Hospital representatives ***along with:***
- School, pastors, health department, Meal on Wheels, Senior Citizens, Nursing Home
- State agencies that have direct influence over disease and inter-agency collaboration and networking.

In larger urban areas the effort to collaborate or network healthcare services is usually competitive, political, and self-serving due to competing non-profit organizations, physician or clinic practices, hospital systems, home-health agencies, etc. More often than not these gatherings are politically motivated (someone running for office), self-motivated (the effort to

"control" a given product line), or institutionally motivated (goals intermingled into the goals of a community effort), undermining the original purpose. In short, it is seldom that we can accomplish community health goals with demonstrable outcomes with numerous agendas "overriding" the local health needs and required solutions.

In most cases Texas has a poor system for state agencies, local healthcare agencies, community volunteers, and hospitals to "sit at one table. Unfortunately, the isolation of Winters and the lack of local resources allows a limited model. The hospital has a very active and forward-thinking home health agency that, on questioning in an extended focus group meeting, understood and embraced such a model. In effect, the home health agency is already functioning in this model. The goal in a community the size of Winters is to have further compliance in businesses, schools, churches, and retirees to gain as much participation and allow as many volunteers to work within their area of gifts/assets to achieve the plan's objective such as mental health first aid, community CPR, diabetic management, hunger, community health garden, exercise programs, etc. It is appropriate that the Home Health agency partners with the primary provider of health and medical services in the community not only because it is the "right thing to do" but to offer what no other Home Health agency provides (perhaps in Texas). By default, the majority of the Community Needs Assessment will rest in the hands of the hospital and Home Health agency to meet the health needs of the community. This is not necessarily a bad thing in that it is as good as a "marketing campaign" as one could devise. Suddenly, the community and hospital district agendas are the same.

A critical component in addressing the CHNA would be to maintain "outcome of programs" at the forefront for the successful award of grants for exercise programs, community food garden, etc., and net community progress that might be afforded through any available school, city, county or hospital grant opportunities.

A forward and comprehensive community response is required in addressing the issues in the report in a more definitive outcome methodology. It is important to determine a means of outcome. For example: Of the entire Law Enforcement Agencies in Runnels County (at least Winters), 100% of personnel could complete the Mental Health First Aid program, as could the WISD, NRHD Emergency Department and EMS. Other such groups could include Clinic Personnel, Ministerial Alliance, Educators, etc. If there are community programs being conducted, the questions can be asked, "What is the outcome of such courses?" "Is it to improve the overall mental health status of the community?" The mere fact that "x" number of classes have been conducted for Mental Health First Aid misses the mark. The question must always be asked *"Did we change anything?"*

As a reference, refer to the Texas County Health Rankings on pages 19-21 of this report. Most small communities lack a process to comprehensively respond to community health issues which affect the overall county rankings. A Council model might investigate means to evaluate community health outcomes: https://www.ruralhealthinfo.org/toolkits/community-health-workers. This is fairly typical analysis the Home Health agency would be accustomed with in their standards of care.

The Wellness Council model should consider a means to quantify outcomes of their programs and the effect on community health. This would be beneficial for more competitive grant awards through a qualified foundation. Successful grant requests today rely heavily on outcomes. Again, this falls within an outcome of health model already conducted by the Home Health agency.

Additional to the community health awareness block is the actual improvement of patient outcomes. For example in a very similar rural community, Carrizo Springs, Texas, there was a lack of community education in any organized and responsible manner, except the hospital would do a local health fair for seniors. However, agency directors who helped manage the WIC, food stamps, dental care, clinic care, pharmacy, high school truancy program, school pregnancy (Medicaid), 211 program director, senior citizen director, hospital representative and Wesley Nurse programs met as needed to help coordinate care to the most vulnerable in the health system. The rationale is that similar patients frequented the same organizations seeking help. The process generally begins in the local Emergency Department or clinic with patients who are in crisis and need agency referral. These are often the “frequent fliers” of a crisis unit such as the Emergency Room. Therefore, a hospital/clinic directs and summons the appropriate agency to help as needed/required to follow patient outcomes. This becomes a collaborative effort within the community for health outcomes. At the end of the day, there is a process to monitor diabetic care for “Mr. Infected Foot” when normally the system loses this patient among agencies because of a lack of follow-through. Additionally, this patient might be proactively asked to come to the clinic each week for monitoring and care even in the face of no reimbursement to the clinic. It outweighs frequent unpaid emergency room fees. In terms of focus group members, “there should be someone that can help us get into the right agency, doctor or clinic.” This is a commendable avenue to improve patient outcomes.

As a note, this model of a Wellness Council is rare and remarkable. It is a model to follow across rural Texas that provides community collaboration to meet healthcare needs, using a Community Health Needs Assessment as a map. A model continuing to be matured and which should be studied is the Palacios Community Wellness Council. To date, mental health training, a community garden concept, after school exercise program and parenting classes are ongoing with collaborative agencies and health department members. Since there is a lack of state agencies in Winters and due to its isolation, the Home Health Agency becomes an even more model for isolated rural hospitals.

Other Comments by Focus Group Participants

(Generalized Comments Provided Less than Half of the Groups)

- NRHD provided a full range of health services and the most notable was counseling services but understaffed and overwhelmed. The consensus was negative.
- A need for a Free Community Garden asset to the community for healthy food alternative. This could be a project of the school and retired citizens with donated land.
- Hospital Hospice Room was a very positive effort by the hospital to provide for the hospice experience and easily converted.
- Any type of specialty clinic would be important to minimize out of town referrals where travel is even more difficult.
- One of the biggest needs was “assuring Dr. McKinnon remained healthy and had the necessary medical team to assist him” in the community.
- Hospital needed to win back the “faith of the community.” Few knew the staff of the hospital when in the past, much of the staffing was from Winters not adjoining communities.
- The Humana Health School Retirement is viewed as a negative. At least for the hospital, any Medicare advantage plan represents a negative reimbursement for a Critical Access Hospital and Rural Health Clinic. As a point of education, these plans are viewed as a “commercial insurance product” not a Medicare plan which is of benefit to the hospital. For every Medicare patient with a Medicare Advantage plan is a “take-away of reimbursement for the hospital/clinic).
- Wound Care being a part of Home Health has been a viable success factor for this agency due to high referrals in Abilene. As a note, focus group members noted that the local Nurse Practitioner/Physician Assist did not refer to the hospital’s agency.
- A need for the Board to conduct “Board Education”.
- The hospital staff suffered from “Battle Fatigue” with the changes occurring at the District.

SUMMARY AND RECOMMENDATIONS

In summary, the feedback from the various participants can be very beneficial to the community and hospital as the future needs of the Hospital are considered. The level of services currently being provided can perhaps best described as a health “reboot” freshly looking at services and opportunities.

The recommendations gathered from the statistical data and those of the Focus Group participants should provide a roadmap of plan implementation strategies. I would like to commend the hospital for their hard work, commitment to the community, and “making a difference”, especially as many rural Texas communities of similar and larger size fight closures and financial insolvency. The hospital appears to be in a positive position to help navigate these community issues that directly affect the hospital/clinic. With the adoption of a more community-wide response to Community Health Needs, the hospital takes the lead in Runnels County in resolving ongoing and chronic needs that require a community response instead of a one-entity approach. It is obvious new hospital leadership with fresh vision is timely.

This report is not addressing the “elephant in the room.” The hospital is aged, lacks space and is not strategically in alignment for a facility that will survive the future. Space allocation to respond to any new hospital services is limited. The District purchased a downtown bank which will require significant renovations to make it viable for any healthcare service. One focus group suggestion was to discuss how government offices could be located to one central office. Other than that, and due to the size of Winters, the adoption of new healthcare services might be an “over-stretch” at best. This will require thorough study in order to concentrate future funding in the “best strategic programs and services as possible” going forward.

Unlike many rural hospitals in Texas, this District is in better financial condition than the majority. However, it is at risk with low census and the out-migration of patients to San Angelo and Abilene. In no focus groups meetings did Ballinger or Coleman pose any threat to the hospital, and this has to be viewed as a positive for Winters.

The Community Health Needs Assessment does not require the North Runnels Hospital Board of Directors to approve the plan but adopt its findings since it involves multi-agencies. A Plan of Action will need to accommodate this report, perhaps with the formation of topic-focused committees or Wellness Council model with professionals related to the assessment needs.
It is suggested that Focus Group Participants are invited to a presentation of this report.

End of Report

Appendix

Focus Group Questions

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

IV. What is healthy & unhealthy about Runnels County?

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

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

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