Graham Regional Medical Center

COMMUNITY HEALTH NEEDS ASSESSMENT
September 24 – 25, 2019

Prepared by:
Dave Clark

TORCH MANAGEMENT SERVICES, INC.

TORCH Management Services, Inc. (“TORCH”) appreciates Shane Kernell, Chief Executive Officer, of Graham Regional Medical Center (“GRMC” or the “Hospital”) 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 of Tammy Whittenburg organizing the focus group participants, physicians and staff to provide their thoughts and insights concerning the health needs of Graham, Texas and surrounding region.

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Conducted: September 24 - 25, 2019
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GENERAL OVERVIEW

A Community Health Needs Assessment ("CHNA") was conducted for Graham Regional Medical Center on September 24 – 25, 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 your physicians, local agencies, and community members 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 Young County: (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, nine 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. Additionally, Graham city employees filled out a questionnaire regarding Hospital services. Additionally, there were several one on one meetings 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 county health statistics. It is noted that the reports chosen were most applicable to community interest and not necessarily Hospital statistical operations.

A HISTORY LESSON [1,2]

Where Texas Comes Home…To Live

Graham can be best described as a community to be a great place to raise a family. Citizens state the school district is excellent and is ranked in the top ten of the Lone Star Cup competition which combines excellence in academics, sports and other extracurricular activities into a ranking among all the schools in the state of Texas. Graham's community facilities and community organizations rate as good or better than those found in cities much larger.

Those interested in relocating or retiring in Graham will find a tightly knit community that offers security, affordability, and a lot of Texas charm. Housing in Graham is diverse with new construction to beautifully restored homes from the 1800s. Graham's cost of living index is 20 percent below the national average with median home costs of $72,000.

Land is plentiful and the sprawling ranches and small farms surrounding Graham offer rural living at its best. With Lakes Graham and Eddleman three miles north and Possum Kingdom Lake 20 minutes south of town, there are many attractive places to live or retire.

History

The site was first settled in 1871 by brothers Gustavus A. and Edwin S. Graham, primary shareholders in the Texas Emigration and Land Company of Louisville, Kentucky. The brothers moved to Texas after the Civil War, and after buying 125,000 acres in then-vast Young County, helped to revitalize the area, the population of which had become badly depleted during the war. During that same year as Graham

was settled, the Warren Wagon Train Raid occurred about 12 miles north of the city. In 1872 the Graham brothers purchased a local saltworks and established the town of Graham and set up the Graham Land Office. The saltworks was not a profitable venture as the salt was too expensive to ship and was closed in a few years.

New families started to arrive, and the brothers began promoting the sale of homesites and doing civic improvements. A post office opened in 1873, and after Young County reorganized the following year, Graham became the county seat. The town's newspaper, known as the *Leader* and still in existence today, was first printed in 1876, the same year that the first temporary courthouse was built. Other businesses from these early years included a gristmill, sawmill, cotton gin, a brick kiln, two hotels, and several stores.

On February 15, 1877 the city was the site of the organizational meeting of the group that became the Texas and Southwestern Cattle Raisers Association, created to police ranching and put a stop to cattle rustling. A three-story limestone courthouse was built in 1884. It was replaced by a new courthouse in the early 1930s. The 1884 structure's east door still stands on the courthouse square. From 1879-1896, Graham was the seat of a Federal District Court overseen by Judge A.P. McCormick; his jurisdiction extended over all of Texas north and west to New Mexico.

Edwin Graham had married Addie Mary Kintner in 1865. They had five children. Throughout the 1870s they divided their time between Texas and their families back north, but in 1879, with the town flourishing, they moved their wives and children to Graham permanently. Edwin and Addie lived there until 1891, then moved to Spokane, Washington, where Edwin died on May 7, 1899. His body was brought back to Graham for burial. Addie moved back to Graham and became a leading civic booster and philanthropist. In 1921, with her son Malcolm, she set up the Graham Foundation as a continuing fund for the city's growth and improvement. Addie died in 1929 and was responsible for the establishment of the Eden Home for the aged.

Public Square 1915-1920

By 1900, Graham had incorporated as a town, and railroad service began in 1903, through the Chicago, Rock Island & Texas Railroad, part of the Chicago, Rock Island & Pacific system. In 1921 the Wichita Falls and Southern Railroad, one of the Frank Kell and Joseph A. Kemp properties extended its line into Graham from Newcastle. The WF&S was abandoned in 1954 and the Rock Island sold its line to the Texas Export Railroad in 1972 but was abandoned just two years later.

The population of Graham grew slowly until 1917, when oil was discovered nearby; the population tripled from 878 in 1900 to 2,544 in 1920. By 1966, Graham had seventeen churches, seven schools, a hospital, a radio station, two libraries, three parks, and two newspapers. The population peaked at 9,170 in 1980 and has since gradually declined; it was 8,716 at the 2000 census and 8,518 by the July 2007 estimate. The population is presently approximately 8,694.

Geography

Graham, the County seat of Young County, Texas is located in the southeast portion of the county and has an area of 5.592 square miles. Geographically, Graham is located in the Western Cross Timbers area of North Texas. Locally this is known as the western portion of the Palo Pinto Mountains.

An impoundment in Flatrock Creek, Young County

Creeks drain the area generally into the Brazos River, Dry Creek on the east side of town flows into Salt Creek towards the south and into the Brazos. Flatrock Creek drains the rural areas to the southeast and also flows into the Brazos just below where Salt Creek enters.

Small impoundments are located along Flatrock Creek that are used for stock tanks and fishponds. Lake Graham is located on the Salt Creek in Young County, five miles north of Graham on US 380.

Predominant Fish Species

- Largemouth bass
- White & hybrid striped bass
- Channel catfish
- White crappie

Aquatic Vegetation:

- Bulrushes, lily pads, smartweed, pondweed

There are three public boat ramps, one fishing pier, a picnic area, and sites for primitive and improved camping. There are no boat rentals, no marina, and no handicap fishing access. A bait shop is located about two miles south of the reservoir on US 380. Shore fishing is limited to the area around the boat ramp on the Eddleman portion of the reservoir and along the US 380 causeways.

Graham Industrial Association (GIA)

The Graham Industrial Association was founded in 1956. For over 50 years, the Association has been the leading proponent for economic growth in Graham. It has played a major part in creating over 1,000 jobs and has seen the development of over 1 million sq. ft of industrial buildings. Companies that have relocated through the Industrial Association have annualized payrolls in excess of 10 million dollars. Some of the businesses relocated by GIA to Graham include Hexcel, Graham Magnetics, Texas Recreation, Cavalier Homes, and Remington Tie Company. In the early 1960's the GIA also provided office space for new doctors as they located to Graham.

The Graham Industrial Association has buildings and land available for businesses wishing to relocate to Graham or expand their current Graham businesses. The buildings range in size from 16,000 sq. ft to 122,000 sq. ft. Land is available in the Industrial Park and along Hwy 380.

City Government

The City of Graham is not only governed by the City Council but also has many Council appointed boards which direct the individual departments. Board members are appointed by the City Council and have terms of two years. There are 11 different City of Graham boards which include the Airport Board, Arena

Board, Auditorium Board, Board of Adjustments and Appeals, Cemetery Board, Convention and Visitors Bureau Board, Graham Economic Improvement Corporation Board, Library Board, Parks and Recreation Board, and the Planning and Zoning Board.

Education

Public schools in the City of Graham are managed by the Graham Independent School District and home to the Graham High School Steers.

In 2010, North Central Texas College established a learning base in Graham. The campus offers a wide range of academic transfer courses, vocational nursing (LVN), Oil & Gas production technology, allied health certificate programs, and continuing education programs. Graham ISD and NCTC also have a partnership offering dual credit courses to high school juniors and seniors.

Notable people

- Rex Brown, former bassist for the heavy metal band Pantera
- Bob Estes, golfer, four-time winner on the PGA Tour
- Bob Lilly, NFL Hall of Fame football player
- William D. McFarlane, U.S. Congressman from 1933–1939
- Robert McFarlane, National Security Adviser to President Ronald Reagan
- Dean Smith, 1952 Olympic gold medalist
- "Big Ed" Wilkes (1931–1998), radio broadcaster, taught school at Graham in the early 1950s
- Owen J. Baggett, the WWII B-24 Liberator crew member who on March 31, 1943 killed a Japanese pilot in his Zero aircraft while dangling from a parachute, using a .45-caliber M1911 pistol.

HOSPITAL BIOGRAPHY[3]

Mission: The best place for patients to receive care, employees to work and physicians to practice medicine.

Vision: To lead our region as the Medical Center of choice providing essential health care and diagnostic services by a modern professional team that exceeds customer expectations for quality and service.

In 1924, the founding members of the city of Graham and local physicians realized the importance of having a modern hospital in the city. This hospital was a benevolent foundation to be turned over to the city of Graham after 25 years. M.K. Graham not only donated the land to build the hospital but offered $20,000 if the citizens would match this amount. Within three days of the challenge, 75% of the money had been raised, and thus Graham General Hospital was begun and remained on Cherry Street until 1957.

In 1956, under the Hill-Burton Act, Graham General Hospital was constructed on its current location and was officially opened in 1957. Since that time, expansions and improvements to the hospital have been made through the generosity and support of this community.

In 1997, a Graham Hospital Foundation was formed, and a new $6.2 million expansion of the hospital was started. A $1.4 million challenge grant was issued by local benefactors of Graham to match these funds for the new facility. One year after the project was started, 99% of the money pledged had been collected.

This expansion increased the emergency room to more than 3,600 square feet and included a designated trauma room, cardiac room, 3-bed general room, OB, and pediatric room. A new outpatient surgery area was also added that included operating rooms with state-of-the-art equipment. In addition to that expansion, the hospital was redesigned to include a 3,500 square foot clinic complete with its own patient waiting area for the various specialists who come to Graham on a weekly basis. Specialists utilizing this clinic are gastroenterologists, neurologists, urologists, orthopedics, oncologists, cardiologists,

pulmonologists, ENTs, and podiatrists. In 2019, plans continue to meet the growing needs of the community.

Foundation

The Graham Hospital Foundation was created in 1997 to perform charitable activities for the exclusive use, benefit and support of Graham Regional Medical Center. Since its inception, this foundation has raised millions of dollars to improve the facility of Graham Regional Medical Center.

Graham Medical Association

GMA HEALTH

GMA Health is a full-service independent family clinic with eleven providers that offers a wide variety of services and specialty clinics utilizing a wide variety of technology. The clinic offers standardized weekday office hours with Saturday clinic open 8am - 8pm with Sunday afternoon clinic from 12 noon to 5 pm. These are very aggressive hours for a community the size of Graham and are commendable to minimize outside free-standing Urgent Care Centers or competitors into the community. The clinic offers a wide variety of services which many rural hospitals would view as threats to the financial welfare of the Hospital. The goals for both the physician group and Hospital are to assure viability for both players in a small rural community in view of the Hospital providing hospitalists and Emergency Department coverage. This will require open lines of communication and working relationships where both maintain a win-win relationship.

Services Include:

- Full Spectrum Family Medicine: Pediatrics, general medicine, and geriatrics
- Walk-In Clinic with convenient hours
- Wellness Examinations (with female providers available)
- Well Child Check-Ups
- Allergy Testing and Immunotherapy
- SmartBeat Cardiovascular Screening
- Echocardiography and Vascular Ultrasound
- Treadmill and Nuclear Stress Testing
- Bone Density Testing
- BioFire Infectious Disease Testing
- Full-Service Laboratory and X-Ray Imaging
- Dermatologic Procedures: Cryotherapy, Biopsies, Excisions
- Sports Medicine including casting and splinting
- Online Patient Result & Appointment Portal
- BioTE Bioidentical Hormone Replacement Therapy
- Sphenocath Procedure for migraine relief
- Vasectomy

Specialty Clinics

- Cardiology
- Human/Oncology
- General Surgery
- Pulmonology
- Podiatry
- Nephrology
- Neurology
- Physical Medicine & Rehabilitation (PM&R)
- Ear, Nose, & Throat (ENT)
- Obstetrics & Gynecology (OB/Gyn)

Young County Family Clinic: Sports Clinic/Coverage

Established in 2003, Young County Family Clinic is a certified Rural Health Center located in a rural designated shortage area.

Resident Providers

- Pete Brown, M.D.
- Cathy Gresham, F.N.P.
- Cat Feist, F.N.P.
- Becky Bell, L.P.C.

Graham Regional Medical Center's General Surgery Clinic

This clinic is open and accepting new patients under the direction of Dr. Steven G. Vaughan, Graham Regional's general surgery clinic offers general and laparoscopic surgery. Dr. Vaughan also specializes in breast and colorectal surgery.

Regional Hospital Out-Migration Patterns

- Wichita Falls Hospitals
  - United Regional Hospital: Full Acute Care Hospital Services
  - Kell West Regional Hospital LLC
  - Numerous Long-term and rehabilitation hospital services

Area Hospital Experience

The following charts are based on a national survey of patient experience in hospitals.[4,5]

Patients Room and Bathroom Always clean	%
Graham Regional Medical Center	63
Palo Pinto General	68
Stephens Memorial	74
Seymour Hospital	75
Hamilton Hospital	78
Faith Community Hospital	78
Kell West Regional	81

Patients Room Always Quiet at Night	%
Palo Pinto General	60
Hamilton Hospital	68
Stephens Memorial	71
Graham Regional Medical Center	73
Faith Community Hospital	74
Seymour Hospital	76
Kell West Regional	77

Patients Always Received Help When Needed	%
Hamilton Hospital	72
Palo Pinto General	74
Seymour Hospital	77
Kell West Regional	77
Faith Community Hospital	80
Graham Regional Medical Center	81
Stephens Memorial	82

Patients Pain Always Well Controlled	%
Hamilton Hospital	67
Stephens Memorial	73
Palo Pinto General	73
Kell West Regional	73
Faith Community Hospital	75
Seymour Hospital	79
Graham Regional Medical Center	81

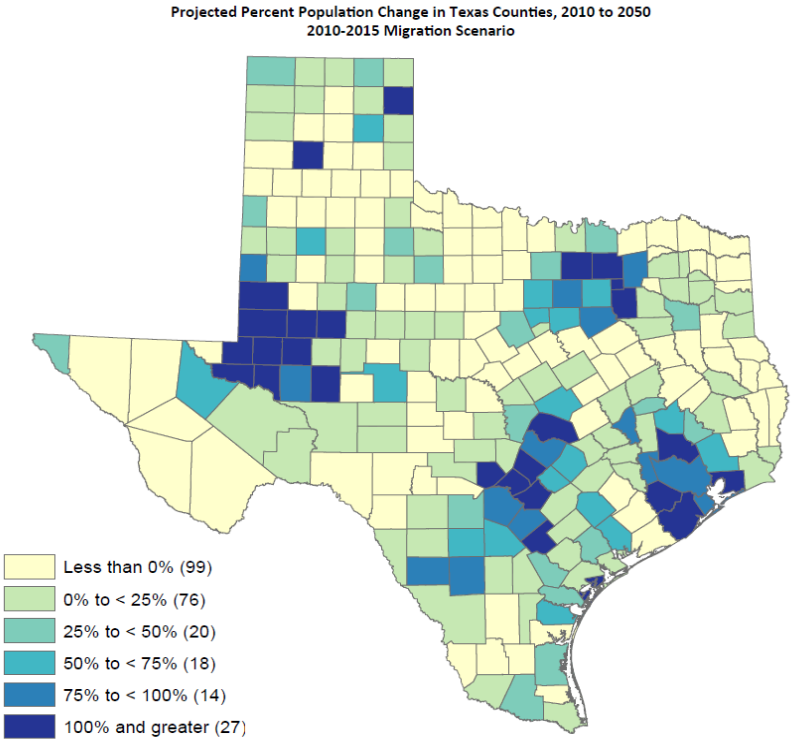
Nurses Always Communicated Well	%
Palo Pinto General	79
Hamilton Hospital	80
Faith Community Hospital	82
Graham Regional Medical Center	83
Stephens Memorial	83
Kell West Regional	83
Seymour Hospital	84

Doctors Always Communicated Well	%
Palo Pinto General	82
Stephens Memorial	84
Kell West Regional	84
Graham Regional Medical Center	91
Faith Community Hospital	91
Seymour Hospital	91
Hamilton Hospital	95

Overall Hospital Rating of 9 or 10 by Patients	%
Faith Community Hospital	66
Palo Pinto General	68
Hamilton Hospital	71
Stephens Memorial	71
Graham Regional Medical Center	75
Seymour Hospital	77
Kell West Regional	80

YOUNG COUNTY PROFILE[6]

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



COUNTY POPULATION (Census Bureau, 2010)

County Population	
Estimate 2018:	18,045
Estimate 2017:	17,978
Estimate 2016:	18,105
Estimate 2015:	18,165
Estimate 2014:	18,278
Estimate 2013:	18,358
Estimate 2012:	18,278
Estimate 2011:	18,353
Census 2010:	18,550
Census 2000:	17,943
Population of Places in Young County	
Graham:	8,694
Newcastle:	569
Olney:	3,111

GENERAL INFORMATION

County Size in Square Miles (Census Bureau and EPA)	

Land Area:	914.5
Water Area:	16.4
Total Area:	930.9
Population Density Per Square Mile	
2010:	20.28
Urban and Rural Population of the County, 2010 (Census Bureau)	
Percent Urban:	66.43
Percent Rural:	33.57
DEMOGRAPHICS	
Ethnicity - 2017 (Census Bureau)	
Percent Hispanic:	19.1%
Race - 2017 (Census Bureau)	
Percent White Alone:	94.7%
Percent African American Alone:	1.6%
Percent American Indian and Alaska Native Alone:	1.3%
Percent Asian Alone:	0.9%
Percent Native Hawaiian and Other Pacific Islander Alone:	0.1%
Percent Multi-Racial:	1.5%
Race and Ethnicity - 2017 (Census Bureau)	
Percent Not Hispanic White Alone:	77.3%
Percent Not Hispanic Black Alone:	1.2%
Age - 2017 (Census Bureau)	
17 and Under:	24.0%
65 and Older:	20.3%
85 and Older:	2.6%
Median Age:	41.3
Income	
Per Capita Income - 2017 (BEA):	$45,405
Total Personal Income - 2017 (BEA):	$816,339,000
Median Household Income - 2017 (Census Bureau):	$44,909
Poverty - 2017 (Census Bureau)	
Percent of Population in Poverty:	15.8%
Percent of Population under 18 in Poverty:	24.5%
Educational Attainment (Census Bureau, 2012-2016 American Community Survey 5-Year Estimate)	
Percent high school graduate and higher:	82.6%
Percent bachelor's degree or higher:	19.6%
Pay (BLS)	
Average Annual Pay - 2017:	$42,430
Average Annual Pay - 2016:	$42,283
Average Annual Pay - 2015:	$39,887
Average Annual Pay - 2014:	$39,959
Average Annual Pay - 2013:	$40,737
Annual Unemployment Rate, Not Adjusted (Texas Workforce Commission)	
Unemployment Rate - 2018:	3.2
Unemployment Rate - 2017:	3.8
Unemployment Rate - 2016:	4.4
Unemployment Rate - 2015:	4.3
Unemployment Rate - 2014:	4.1

COUNTY FINANCES (Texas Comptroller of Public Accounts)

Property Taxes - 2017	
Total County Tax Rate:	$0.758613
Total Market Value:	$1,995,597,201
Total Appraised Value Available for County Taxation:	$1,104,278,131
Total Actual Levy:	$8,377,197

Graham, TX Economic and Demographic Data[7]

Population (2018 Est.)	**8,982**
Population in Households	8,840
Population in Families	7,385
Population in Group Quarters	142
Population Density (pop. per square mile)	1,608
Diversity Index[a]	52
Median Household Income	$47,207
Average Household Income	$67,595
Per Capita Income	$25,653
Total Housing Units	3,960 (100%)
Owner Occupied HU	2,677 (67.6%)
Renter Occupied HU	735 (18.6%)
Vacant Housing Units	548 (13.8%)
Median Home Value	$92,864
Housing Affordability Index[b]	234
Total Households	3,412
Average Household Size	2.59
Family Households	2,374
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.

Graham, TX Population[8]

According to the most recent demographics data available from the Census Bureau released in December of 2018, Graham has an estimated population of 8,774. From 2010 to 2017 the population is estimated to have decreased by 1.4%. The median age is 38.6. Comparing the median age of men versus women we find a sizeable gap, with the median age of men at 34.6 and that of women at 41.5. The overall population consists of 48% men and 52% women. Breaking down by age, 29% of Graham residents are under 20 years old, while 24% are over 60.

Family Size, Makeup, and Births

The average family size in Graham is 3.1 people, and 72% of people in Graham are in a family compared to the national average of 66% and the state average of 70%. 71% of families in Graham are led by a husband and wife. 20% of families are led by a female alone, while 9% are led by a man alone. The state and national rates of husband and wife families are 73%.

The Graham birthrate of 7% (over a 12 month period) is consistent with the state average of 6%. The teen birthrate is very high. The 2018 American Community Survey shows the percentage of women aged 15-19 who gave birth in a 12 month period as 41%. The national average is 5%.

Single People by Never Married, Divorced, and Widowed

30% of people in Graham have never been married, 10% have been widowed and 12% have been divorced. This divorce rate is fairly equal to the rest of Texas. 32% of Texans have never been married. 47% of Graham residents are classified as single.

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.

Graham, TX Citizenship

96% of Graham residents are citizens. Of the 4% who are non-citizens, 9% are under the age of 18, with the median non-citizen age at 39.2. Almost half naturalized citizens became citizens between 1990-1999. 82% of foreign-born people are from elsewhere in the Americas, while almost 15% come from Asia. A small percentage come from South Africa and England.

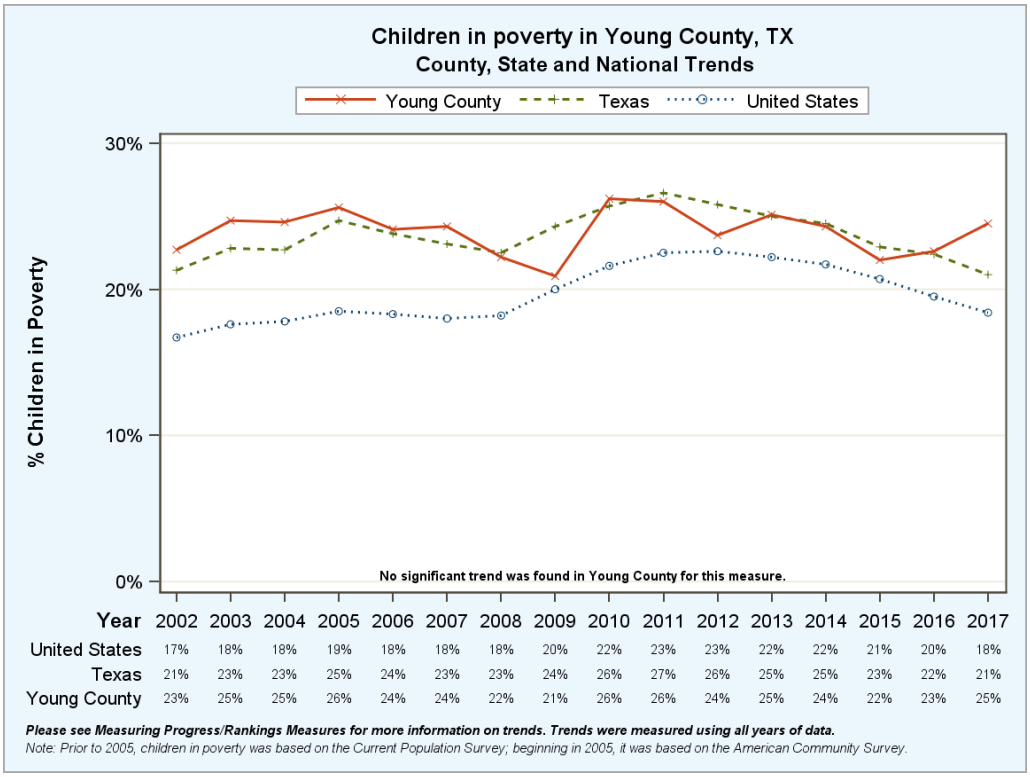
Comparisons

Estimated median household income (2016):
Graham: $41,613
Young County: $50,822
Texas: $56,565

2019 estimated unemployment [11; see note]*:*
Graham: 3.4%
Young County: 3.0%
Texas: 4.4%

Children in Poverty[12]
Young County: 25%
Texas: 21%
Top US counties: 11%

Children in Single Parent Households
Young County: 39%
Texas: 33%
Top US counties: 20%



Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
United States	17%	18%	18%	19%	18%	18%	18%	20%	22%	23%	23%	22%	22%	21%	20%	18%
Texas	21%	23%	23%	25%	24%	23%	23%	24%	26%	27%	26%	25%	25%	23%	22%	21%
Young County	23%	25%	25%	26%	24%	24%	22%	21%	26%	26%	24%	25%	24%	22%	23%	25%

Please see Measuring Progress/Rankings Measures for more information on trends. Trends were measured using all years of data.
Note: Prior to 2005, children in poverty was based on the Current Population Survey; beginning in 2005, it was based on the American Community Survey.

Most Common Occupations in Graham (2016)[9]

Males

- Other production occupations, including supervisors (7.4%)
- Driver/sales workers and truck drivers (5.5%)
- Construction traders workers except carpenters, electricians, painters, plumbers, and construction laborers (5.2%)
- Metal workers and plastic workers (5.0%)
- Vehicle and mobile equipment mechanics, installers, and repairers (5.0%)
- Other sales and related occupations, including supervisors (4.6%)
- Other management occupations, except farmers and farm managers (4.3%)

Females

- Preschool, kindergarten, elementary, and middle school teachers (8.2%)
- Secretaries and administrative assistants (5.5%)
- Other office and administrative support workers, including supervisors (5.2%)
- Bookkeeping, accounting, and auditing clerks (5.1%)
- Child care workers (4.4%)
- Building and grounds cleaning and maintenance occupations (4.2%)
- Other production occupations, including supervisors (3.9%)

Crime[10]

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

- There is an average of about 2 crimes a week in Graham.
- The overall crime rate in Graham is 46% lower than the national average of 27 crimes per 1,000 people.
- Graham is safer than 55% of cities in the United States.
- In Graham you have a 1 in 69 chance of becoming a victim of any crime.
- The number of total year over year crimes in Graham has decreased by 31%.

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

- High school/GED or higher: 79.3%
- Bachelors degree or higher: 18.8%

Young 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]

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

Young County shows it has 78.8% health insurance coverage which is the 5th in health insurance coverage out of 10 total in the area (other counties include Stephens, Palo Pinto, Jack, Baylor, Throckmorton, and Archer). The county with the highest health insurance coverage in the area is Archer County with an insured rate of 87.5%, a sizeable difference.

Percent of People with Health Insurance Coverage	
Young County	78.8%
Texas	80.7%
United States	88.3%

The Percentage of Men and Women with Coverage

Looking at men and women separately, the percentage of men and women with health coverage is both 79%. Palo Pinto County has the lowest male coverage in the area at 78%, while Stephens County as the lowest female coverage at 76%. These are all well below national levels. Archer is the only county in the area at national levels of health insurance coverage.

Percentage of Men and Women with Coverage

	Men	Women
Young County	79%	79%
Texas	80%	82%
United States	87%	89%

Detailed Types of Health Insurance Coverage in Young County, TX

Types of Health Insurance Coverage

	Employer Based	Direct Purchase Insurance	Medicare	Medicaid or Public	None
Young County	48%	16%	27%	7%	22%
Texas	53%	12%	17%	9%	22%
United States	56%	15%	21%	13%	14%

The Percentage of People Who Do Not Have Health Insurance By Income

By income, the highest percentage of people who do not have health insurance are those earning under $50K.

Percent of People with No Health Insurance by Income

	Under $25k	$25k - $50k	$50k - $75k	$75k - $100k	Over $100k
Young County	29%	30%	12%	23%	11%

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

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 72% of uninsured residents are White, that represents a smaller proportion of White residents who are without health insurance than Hispanic residents.

People Without Health Insurance by Race

	Black	Hispanic	White	Native American	Asian
Young County	0%	26%	72%	1%	1%
Texas	7%	41%	50%	0%	2%
United States	12%	29%	54%	1%	4%

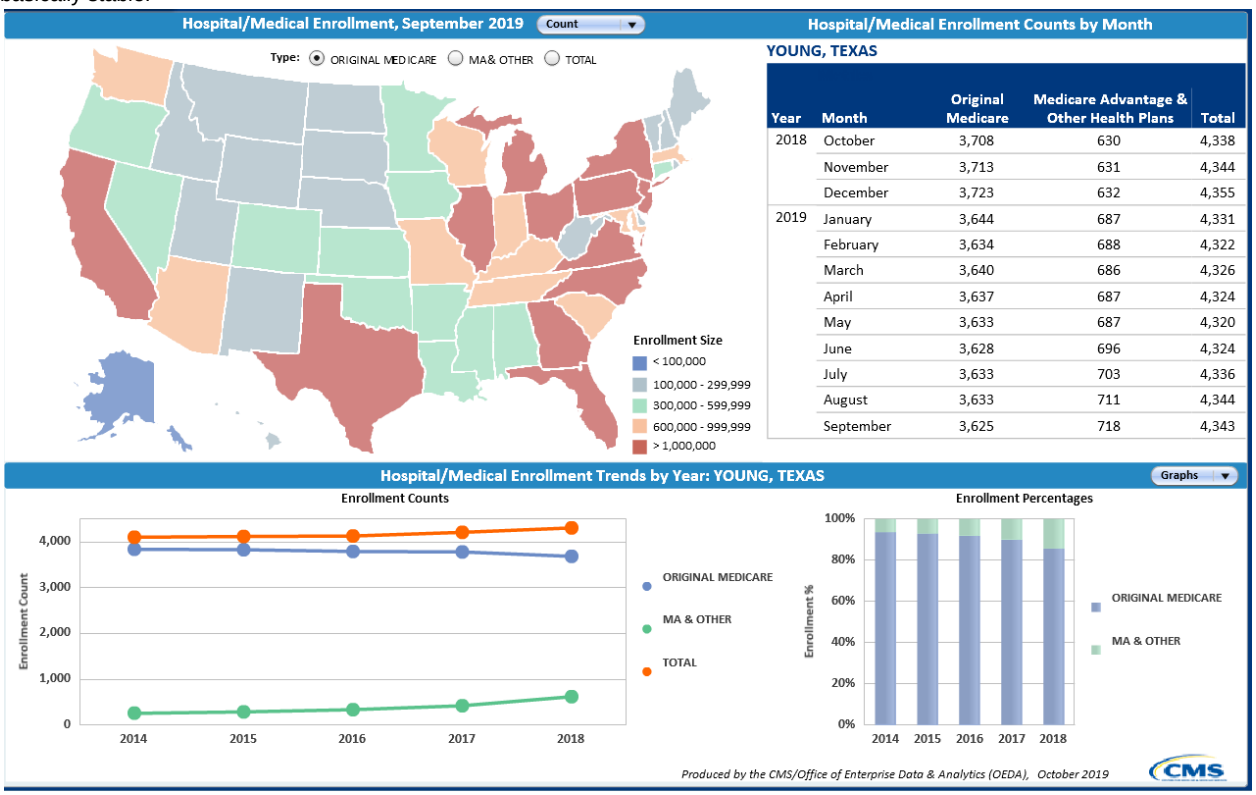
Medicare/Medicaid in Young County

Medicaid

7% of Young County residents are covered by Medicaid or public assistance. 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

27% of Graham 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]



County Health Rankings

Texas Health Ranking[12]

Young County: #114 (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:

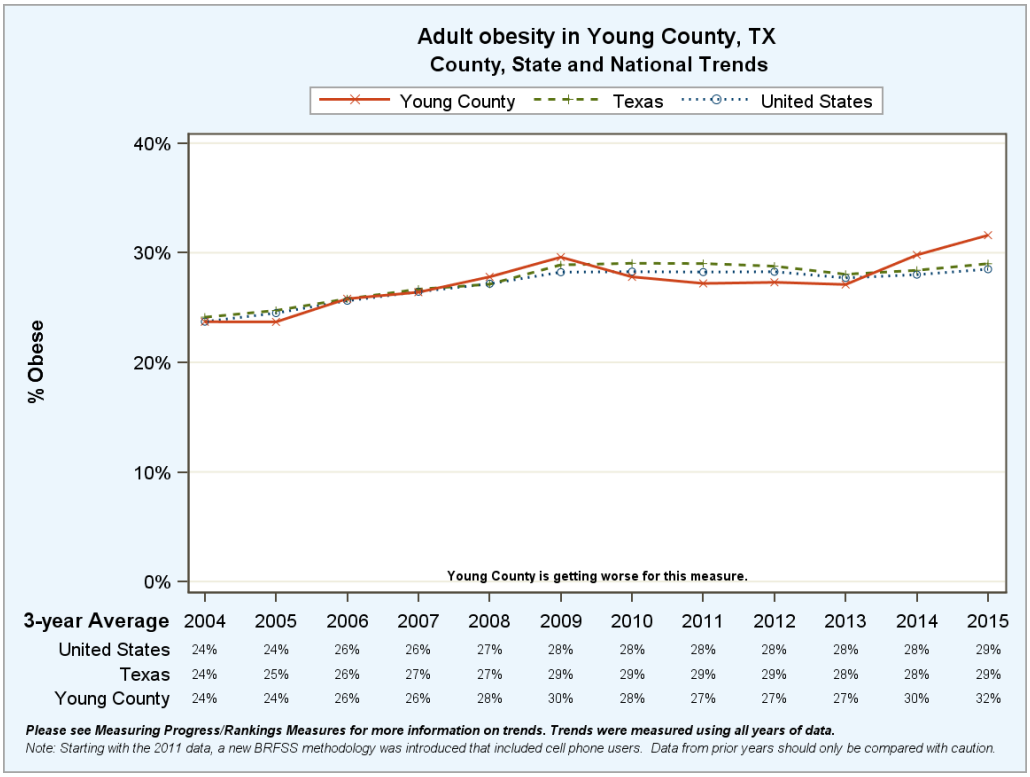
- Length of Life: #207 of 244
- Quality of Life: #15 of 244
- Health Behaviors: #114 of 244
- Clinical Care: #121 of 244
- Social and Economic Factors: #95 of 244
- Physical Environment: #37 of 244

Food Environment[9]

Adult diabetes rate:
Young County: 10.5%
Texas: 8.9%

Adult obesity rate:
Young County: 32%
Texas: 29%
US: 14%

Low-income preschool obesity rate:
Young County: 13.7%
Texas: 15.7%



3-year Average	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
United States	24%	24%	26%	26%	27%	28%	28%	28%	28%	28%	28%	29%
Texas	24%	25%	26%	27%	27%	29%	29%	29%	29%	28%	28%	29%
Young County	24%	24%	26%	26%	28%	30%	28%	27%	27%	27%	30%	32%

Please see Measuring Progress/Rankings Measures for more information on trends. Trends were measured using all years of data.
Note: Starting with the 2011 data, a new BRFSS methodology was introduced that included cell phone users. Data from prior years should only be compared with caution.

Obesity among every age demographic is a significant problem for Young 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 and, in some cases, 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	*Young County*	*Texas*	*Top U.S.*
Poor or Fair Health Days (%)	16%	18%	12%
Poor Physical Health Days/Month	3.6	3.5	3.0
Poor Mental Health Days/Month	3.7	3.4	3.1
Health Behaviors			
Physical Inactivity	27%	23%	20%
Access to Exercise	70%	81%	91%
Adult Smoking	15%	14%	14%
Sexual Health			
Teen Births (per 1,000 females)	50	41	15
Sexually Transmitted Infections (per 1,000)	268.2	520.4	152.8

High rates of Teen Births and Sexually Transmitted Infections 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	*Young County*	*Texas*	*Top U.S.*
Patients per Primary Care Physicians	1,510:1	1,660:1	1,050:1
Mental Health Providers	2,000:1	1,260.1	1,260.1
Preventable Hospital Stays (per 1,000 Medicare enrollees)	57.41	49.66	27.6
Mammography Screening	27%	58%	71%
Flu Vaccinations	36%	43%	52%

The increasingly low rate of mammography screening (down from a 2014 high of 37%) 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.[19]

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

- Acute myocardial infarction, unspecified (372)
- Atherosclerotic heart disease (277)
- Bronchus or lung, unspecified - Malignant neoplasms (263)
- Chronic obstructive pulmonary disease, unspecified (243)
- Alzheimer's disease, unspecified (207)
- Congestive heart failure (189)
- Pneumonia, unspecified (122)
- Unspecified dementia (90)
- Stroke, not specified as hemorrhage or infarction (89)
- Sudden cardiac death, so described (86)

Health *Status of the Rural Community*

A National Overview of Our Problems [20]

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 [21] 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 (Young County) and nearly 82% of rural counties are classified as Medically Underserved Areas (Young 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 referred as EMS Home Care which works in collaboration with the Rural Health Clinic, Surgical Clinic, 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 Graham Regional Medical Center Stand Among 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 Graham, Texas. The direction and stability of a local hospital board and senior leadership team 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 survival is board governance with capable and engaged board members.

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 Graham Regional Medical Center remains the financially “stable hospital” in the area. The biggest threat will always remain the outmigration of services to larger regional tertiary facilities. GRMC has minimized this threat by a solid core of physicians and specialists. 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. A continued strong and smart-thinking board and hospital leadership team agenda will be the goal for GRMC. GRMC has strong physician champions and seasoned Chief Executive Officer and leadership team. This Hospital system sits in a strong and positive position to weather the financial storms facing hospital systems. Its goal will continue to be interfacing community and hospital systems to be one community health system.

Graham Health Status

This section of the assessment reviews the health status of Graham/Young County residents. The report will compare statistics with the State of Texas, US, Wichita Falls and other regional hospitals as the most immediate threats. 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 Graham, the issue of competing Hospital & clinic services must be examined as to function, need, and viability, not only for the immediate Graham 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. 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 that the instability of a hospital service jeopardizes the utilization of all strategic services and poses a 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 Graham.

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

Identification and Prioritization of Health Needs

Based on Demographics and Health Data

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 organization suggestions. A second set of Needs will be listed in the section “Community Health Focus Group”” stated later in the report. The following is recommended for consideration by the Graham leaders:

One of the historical paradigms of hospital health system management is that the hospital works independently from city/county government, non-profit agencies/programs, and/or the faith community until it needs a program or when those entities fulfill 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 a community medical staff working toward its own financial benefit in a privately-owned clinic model without interest in hospital admissions where hospitalists and Emergency Department “docs for hire” are employed for that purpose. The result becomes 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.

Thus, community 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, adult/child obesity issues, 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 the elderly and medically indigent populations with a private transportation entity. To deal with government funded programs such as Sharp Lines Rural Public Transportation 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 might consider a study of the “clinic/ancillary cancelled appointments” and the impact on revenue for funding its own van. With the primary clinic in the community privately owned, it would appear the Hospital and clinic may have less of a problem than Graham Medical Association. There are several examples across the state, such as Fisher County, where the Rural Health Clinics appointment cancellations were excessive. With the purchase of a used

van, all 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 Wichita Falls, there are not positive alternatives that are consistent and reliable. The “philanthropic volunteerism” will eventually run a negative course. This could be reviewed for action or discarded as an item requiring action.

Marketing: The strongest and cheapest plan for marketing is “word of mouth” and public testimonies. However, an affordable “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 implementation of an EMS Home Care Program goes a long way in “one patient at a time success.” The Hospital Facebook page is very positive and informative of the numerous programs the Hospital is providing. An opportunity to review is key Hospital senior leadership members attend or become members (at Hospital sponsorship) to key community service organizations, community event fundraisers, speakers, and Champions for the Hospital. EMS and the Hospital home health agency is always “critical” with patients, family and neighbors in crisis and how their opinions of the Hospital are quickly formed.

Education: Education is always held out first in all conversations to educate our public about disease. However, hospitals tend to believe a program/in-service “here or there” hits the mark of disease issues, but it only amounts to a minimum response with little effect or impact on community disease issues. Most “acute” education tends to fall on the backs of the Home Health Agency and EMS Service with assistance from hospital personnel. This is a strategic vantage for a hospital in minimizing re-admissions and avoiding a more serious issue with “eyes on patients” on a more frequent basis. A community wellness council could be considered to determine the area of disease issues (derived from this report) to which the community agencies can respond. Studies have demonstrated that a hospital health fair at the senior citizen organization once a month has little impact on disease.

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 GRMC/Clinics/EMS, billing should be efficient, clear, and understandable. Consider a simple card of the explanation of the bill, home visitation visits from members of the Business Office to clarify bills, obtain billing information and ease the issues of billing and collecting. This singular change in how we conduct billing will “win” disgruntled patients back into our system simply because of a poor understanding of a hospital billing system, Medicare, Medicaid, and commercial insurance programs. It becomes one of the most intimidating services a hospital provides. A patient could receive great care, have wonderful satisfaction of services with a desire to return, and recommend the hospital. Yet the final closure of our patient experience is billing trauma and anger. The program *MD Save* is a forward thinking program for the public to view the costs, financing and comparison.

Emergency Room: A consistent effort should be made during clinic hours 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 clinic hours Monday – Friday (no closure for lunch) plus Saturday morning Clinic operating times. The private-owned clinic has admirably responded to these needs of the community. Clinic hours should always have a provider in "noon" slots. The posting of anticipated costs, waiting times, and follow-up home experience calls will do more to sooth unhappy experiences in the Emergency Department (which where all listed as Focus Group concerns). It was noted that new staff leaders and culture was beginning to generate a new attitude of the Emergency Department and networking with local health agencies. An effort either through marketing and/or patient calls of patients the past two years utilizing services asking for their experience and recommendation would be a worthy consideration. There was a consistent opinion by focus groups and the new Emergency Department leadership team that "some catching up" needed to be done to restore a lack of public trust with this department. The poor public perception of Emergency Services is a state and national issue. The public lacks a general understanding of Clinic and Emergency Department disease management roles, but the Emergency Department will always lose that battle with public perception and processes must be in place to respond to better services, faster services, and directing patients to the correct avenue of care. This is an easier problem to solve in a rural area than the larger urban community.

One Stop Shopping: The Hospital has a good opportunity to utilize a successful home health program and EMS service to educate the public of services at the Hospital. This assessment will address this more fully in another section.

Teen Births or Pregnancy: The Teen Birth Rate is extraordinarily high (29%) compared to the state average of 6% and the US rate of 4%. The community, schools, local agencies, churches and Hospital should create a round-table discussion to combat this trend. A school clinic with a Hospital nurse practitioner and school nurse is a front line defense in education and female teen health. The statistics regarding Young County (2017) teen births and unmarried mothers regarding poverty, finances, and income class are above all state and national averages. This requires a multi-agency response through a Wellness Council model.

Physician and Specialty Staff Recruitment: The Hospital seems to have a well-defined plan along with the private physician group to meet the local demands of the community based on present physician services. No member of any Focus Group noted a problem in getting an appointment with any physician organization in the county. All Physicians were highly regarded.

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 not a mandated report by GRMC, the Hospital is wise and strategic to request a thorough community report to determine community health needs and its response to these needs either through new programs, facility, clinic, physicians, personnel, new community collaborations, and so forth. The Hospital must envision itself as a catalyst "at the community health forum" in responding 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 with the lack of in-town support agencies, many of these responsibilities would fall to the Hospital to include key nursing homes, the school district, city and county representatives, health department to the county, Texas A&M AgriLife Extension, 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 Graham, Texas were reviewed. Growth trends for vulnerable population groups were included in the review. The population trend for this county will likely continue to decrease without any new industry locating to this immediate area. The need for more industry is a stated concern from all community focus group participants. Because of the business questions regarding healthcare services and the importance of healthcare for any significant business venture, it was noted that the Hospital CEO, representing one of the top employers in the community, should be included with any economic development 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 along with mental health services were reviewed. As with many Texas rural communities, the supply of qualified healthcare and community health officials are in crisis. This could be primarily a result of the proximity of healthcare programs in larger communities such as Wichita Falls, Decatur, and the Metroplex. There is a trend for older health care professionals who are slowing in their professional careers are more prone to locate to 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. However, Graham has been successful in providing above average medical-dental professionals. The area has done a good job of marketing the benefits of living in Graham, "Where Texas Comes Home….to live."

Survey of the Poor and Extremely Poor: It is important to assert the community-wide health needs of vulnerable populations in Graham. 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 district. 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 solidify 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 Graham. 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 recreational facilities with swimming, boating, fishing, 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 Graham Regional Medical Center 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 Graham 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. The model program of over 25 years is Childress Regional Medical Center.

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 compared to state and national averages. Programs with the biggest success in tele-health remains psychiatry and dermatology.

   - 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.

- 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 listed in the top five most common comments 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 pharmacies 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. Lack of flu vaccinations for Young County (36%) were significantly below the state (43%) and national averages (52%).

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. The community has a significantly higher than average rural counseling services by private practitioners. However, nationally, private professional counseling services play a smaller role in public awareness of behavioral health issues such as Mental Health First Aid classes.

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 Young County obesity rate (30%) exceeds the state rate (26.6%).

- Continue to investigate means to reduce cost and other barriers to medical care and treatment through cash or discounted programs and sliding scales.

- 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.

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 and every senior is having a meal for the day.

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 from the Hospital, 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 at 7:00 pm with poor attendance and interest. To only focus services at a local Senior Citizens Center is not effective.

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 a hospital (GRMC in this case) to meet these needs. Information about the primary needs of community healthcare needs for Graham, Texas/Young County was obtained through interviews in organized focus groups. These participants represented an excellent cross culture of this rural community. 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 focus groups included the following participants:

- Community citizens
- Retired Business/Farm/Ranch Owner
- Business Owner
- Retired Volunteer
- Retired Hospital personnel
- Physicians
- Education
- County Commissioner
- Economic Development Director
- Chamber of Commerce Representative
- Methodist Church Representative
- City Mayor
- City employees via questionnaire
- Retired Banker
- Retired Optometrist
- Retired Optician
- School Superintendent and Administrative Faculty
- Hospital Board Members
- Justice of the Peace
- Key Hospital Leadership
- Catholic Charities Representative
- Highway Contractor
- Retired Military
- Sheriff
- Virginia's House Representative
- Affirming Texas Families Representative

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 Graham Regional Medical Center & Clinics 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 and national health departments, churches, and social health programs.

It is also to be noted in this public document that the Hospital and community have challenges in improving the health outcomes in the County.

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 Graham, Texas, 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. State and national recommendations will be volunteered in this report.

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 the Blue Cross/Blue Shield products with poor hospital reimbursement fees*.

Almost every member of low income households who did not qualify for Medicaid, charity care, or indigent programs prior to 2016 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.

The insurance market remains a significant threat to the future of local rural hospitals and Graham, Texas is not an exception. From conversations with the Hospital leadership, every possible avenue is being investigated as to plans to continue to offer cash discounts, sliding scales, and even offer boutique payment plans to offer citizens every possible alternative for payment of Hospital service. 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. 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, a lack of state participation with national programs, complicated billing and collecting systems, and lack of experienced hospital personnel in rural areas.

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 GRMC offered a cash discount to all patients. Every effort should be made to help educate the public regarding "good insurance products" and "bad products" not only for them but the Hospital. The Hospital needs to take an active role in combating bad TV information for the consumer either in public forums, social clubs speakers bureau, newspaper and radio.

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 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 with the community and hospital 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 issues of time, transportation for

seniors, or the general consensus that “they did not feel they would benefit”. Many expressed a desire to see more education presentations presented in locations and at times more accessible to the public. The general consensus is “we are not going to the hospital for a class.”

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 GRMC Preventable Hospital Stays:

Clinical Care	Young County	Texas	Top U.S.
Preventable Hospital Stays (per 1,000 Medicare enrollees)	57.41	49.6	27.6

The “One Stop Shopping” Bias

Graham Regional Medical Center has done a remarkable job in providing local health services to minimize citizens traveling to regional hospitals for services. The Hospital has been successful in converting space and plant improvements to provide a remarkable positive Hospital environment.

If a patient needs a particular medical service not available in Graham, Texas they travel to Wichita Falls, Decatur, or the Metroplex for more advanced surgery as well as complicated disease management such as cancer, heart disease or major surgical procedures. Once they leave the area they tend not to come back for other healthcare services at their local hospital. Some feel it is easier to have all the healthcare needs met in one general location. Others felt if healthcare services in Young 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 Wichita Falls because they perceived those doctors had more experience in treating certain conditions than providers in Young 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. Graham Regional Medical Center has responded to these needs in a positive manner but it goes without saying its focus remains on general surgical and primary care needs.

The Hospital administrative and professional staff has noted that they do lose a certain amount of the local patient population to the larger tertiary healthcare systems in Wichita Falls as the 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 GRMC 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. GRMC 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 “GRMC Saved My Life.” All focus group participants commented they were unaware of specific programs provided by the Hospital, and the Hospital could be better in “being a part of community health issues.”

Working Effectively Across Organizations and Sectors

The current leadership of GRMC 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 common in Young 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, elderly 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. Law enforcement should be trained in mental health first aid responders as noted in many law enforcement agencies across the state.

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 seemingly 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 (HPV screening for men does not currently exist). Weight loss programs were discussed but not viewed as a realm of service provided by the Hospital, but this service is being provided by the clinic by a highly recognized hormone replacement program. It was obvious there was some confusion of what the Hospital provided verses the Graham Clinic. Regardless, it appears a better focus should be made to make the public more aware of male and female services being provided in the community.

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 of the need for a "safety net" for pregnant women suffering from abusive relationships, broken homes, or parental (usually father) abandonment. In meeting with local agencies, the area does have county representatives providing many of these services with perhaps poor public recognition of these existing resources.

However, to the point of the focus group participants remains the question for Young County 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) and the National Fatherhood Initiative for fathers to understand their roles as fathers as well as parenting classes for young couples. There are established parenting classes for the secular and non-secular populations. It was noted with the retirement of several key community leaders or "champions" in this area of interest, that an absence was created that has not been filled by others.

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. An issue noted was school insurance not being accepted for employees. However the Rural Health Clinic (RHC) is a viable model for the kids.

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 women in the community and meet the female health issues of the community, plus seeing kids in the RHC.

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. There was a renewed effort by the Emergency Department and Hospital to network better with local/regional agencies in the total management of patients in and out of the Hospital realm of services. 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", was overwhelming popular and well received. The Hospital has recognized this need to improve in its planning.

Community Partnerships

Emergency Department/Hospital Navigator

An Emergency Department/Hospital case management (Navigator) has been a popular model throughout the state in assuring 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. It appears with the new leadership changes in this area of care were fresh and newer concepts of patient care (Pre-Hospital and Post-discharge follow-up care). The idea "we take care of Trauma patients and you must wait your turn" is usually invalid with the volume of ED cases in a rural community. The majority of patients remain primary care interventions not Trauma or cardiac emergencies or what is referred to as a Code 3 patient (critical). As a note, this same follow-up model should be considered for all Hospital dismissals and high risk RHC patients

Community Wellness Model

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. It was noted that there were few collaborative health services in Young County. However, there was a positive desire by participants for the Hospital to assume community leadership in community disease and wellness 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. A Wellness Council Model can be incorporated into several avenues:

- Home Health Agency/Hospital representatives knowledgeable of community agency services/population health ***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 rural Texas has a poor system for state agencies, local healthcare agencies, community volunteers, and hospitals to "sit at one table". Fortunately, the isolation of Graham and its success with Hospital, clinics, and medical staff, plus willing and interested local non-profit and state agencies, allows a working model for the community. The Hospital has a very active and forward-thinking leadership team that, on questioning in an extended focus group meeting, understood and embraced such a model. In effect, the new leadership of the Emergency Department is striving for more community networking in its continuum of care model. The goal in a community the size of Graham 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. By default, the majority of the Community Needs Assessment will rest in the hands of the Hospital leadership to meet the health needs of the community because of its overall mission and vision of care. This can be viewed as a good thing in that it is as good as

a “marketing campaign” as one could devise. Suddenly, the community and Hospital 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 Young County, 100% of personnel could complete the Mental Health First Aid program as well as the GISD, GRMC Emergency Department, and EMS. Other such groups could include Clinic Personnel, Ministerial Alliance, Educators, Hospital Chaplains, 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?”

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 Quality Improvement Department would be accustomed to in their standards of care.

This 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.

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 outcome. 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.

A model continuing to be matured 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. As a note, this model of a Wellness Council is rare and remarkable. It is a refreshing model to follow across rural Texas in providing a community collaborative in meeting healthcare needs as noted in a Community Health Needs Assessment as a map.

Other Comments by Focus Group Participants

(Generalized Comments Provided Less than Half of the Groups)

- MHMR services and staff in Graham were viewed as entirely negative.
- To study if the existing Community Garden asset provided by the Methodist Church could be expanded to respond to a growing number of single parent households for healthy food alternatives. In many communities, the local medical clinics are high referral sources for the use of fresh vegetables for the diet. Year round provision of food can be accommodated with vegetable shelters through public fundraisers or grants emphasizing “hunger zones” in rural Texas.
- Hospital needed to win back the “faith of the community.”
- The School Health benefits are viewed as a negative (as it is statewide in the rural areas). 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.
- Maternity services were ranked as the highest priority for City employees.
- ED physicians with out-of-network health plans was a significant negative.
- Billing issues of the past were a negative with incorrect bills.
- Hospital chaplains were viewed as a very positive service.
- Hospice care was viewed as a very positive service.
- Front desk hospitality was very friendly and welcoming.
- MRI/CT scans and laboratory tests were higher than other regional hospitals.
- Lack of community programs for school kids.
- Homeless Men services lacking in the community.
- Fitness Center was viewed as a “huge plus”.

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 drawn 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” unlike many Texas rural communities of similar and larger size that are fighting 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 the region in resolving ongoing and chronic needs that require a community response instead of a one-entity approach. It is obvious Hospital leadership has a positive vision and desire to improve community health services.

Unlike many rural hospitals in Texas, this Hospital is in better financial condition than the majority. It should be commended for its present financial condition and forward thinking. The Hospital feels, acts, and presents itself well with friendly staff with eagerness and community spirit. This community should be impressed and proud of its medical staff, clinics, Hospital, and leadership team.

The Community Health Needs Assessment does not require the GRMC 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 the report by the Hospital. Although this assessment is not a required mandate for this Hospital, placing the report and action plan on the Hospital web site is a normal requirement for those hospitals mandated to perform a CHNA. It is not required but recommended as a means to improve communication.

Congratulations to a well operated and successful program. The findings in this report only serve as a means for hospitals to improve care, consider solutions to improving community health needs within a community, and reduce obstacles for better community health.

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 Young 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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