LILLIAN M. HUDSPETH MEMORIAL HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT
March 21 – 22, 2019

Prepared by:
Dave Clark

TORCH MANAGEMENT SERVICES, INC.

TORCH Management Services, Inc. (“TORCH”) appreciates Roger Masse, Interim Chief Executive Officer, of Lillian M. Hudspeth Memorial Hospital (“LMH” or the “Hospital”) for giving TORCH the opportunity to conduct, and for providing assistance throughout, the compilation of the Community Health Needs Assessment. I would like to extend special appreciation to Joe Marshall of the hospital for assistance in scheduling the participants for the focus groups and his warm hospitality to all the participants. TORCH also appreciates the time and effort the Focus Group Participants made to provide their thoughts and insights concerning the health needs of Sutton County and the secondary market, including the counties of Schleicher, Edwards, and Crockett.

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Conducted: March 21 – 22, 2019
Dave Clark, TORCH Management Services, Inc.

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GENERAL OVERVIEW

A Community Health Needs Assessment ("CHNA") was conducted for Lillian M. Hudspeth Memorial Hospital on March 21 – 22 2019. The value of the Assessment is that it allows healthcare organizations to better understand the needs of the communities they serve, with the ultimate goal of improving the overall health of the local citizens. Whether or not an organization is required to conduct a Community Health Needs Assessment, it is an extremely valuable tool for fulfilling its role in the community. An old adage goes, "You can't provide the right kind of services when you haven't asked the customers you serve what they like or not." By listening to members of the community and reviewing demographic data, the Hospital can gain information on health status and where gaps in healthcare delivery currently exist. Further, it solidifies the Hospital's role in the community as a partner in improving overall health status, as well as in areas beyond health, such as education and economic development.

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

ABOUT THIS ASSESSMENT

INTRODUCTION

Community Health 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 Sutton County: (1) the community health survey [primary quantitative data]; (2) existing data [secondary quantitative data]; and (3) focus group data [primary qualitative data]. References are being made to the February 2016 TORCH CHNA by Dick Sweeden.

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

A HISTORY LESSON [1]

History of Sutton County

SUTTON COUNTY

Sutton County is in west central Texas. Its geographic center is at 30°31' north latitude and 100°38' west longitude, 135 miles northwest of San Antonio and seventy miles south of San Angelo. Sutton County covers 1,455 square miles on the western edge of the Edwards Plateau; elevations range from 1,900 to 2,300 feet. The most important of the county's natural resources are moderate-sized oil and gas reserves, which came into significant production in the late 1960s and 1970s. Though range grasses constitute the most common form of vegetation, the area is distinguished from true grassland by the existence of isolated stands of shin oak, juniper, and mesquite. The region was originally home to a wide variety of game animals and predators, most significantly deer, quail, dove, wild turkey, plover, coyotes, timber wolves, and bobcats. Periodically herds of antelope and buffalo wandered onto the Edwards Plateau, though they were not native to the region. The single most significant factor in the development of Sutton County has been the scarcity of water. Precipitation averages just twenty inches annually, and severe droughts occur regularly. Meager rainfall is further depleted by rapid evaporation due to the plateau's constant, dry winds. Consequently, the county is completely dependent for its water supply upon deep wells that tap the Edwards Trinity Aquifer. Sutton County's climate is that of a subtropical steppe, characterized by wide daily temperature fluctuations. The January average low is 32° F, and the July average high is 96°. The growing season is 235 days long. Generally, the county receives about two inches of snow each year.

Human beings have inhabited the southern Great Plains and Edwards Plateau for at least 10,000 years. Archeological digs indicate that Paleo-Indians ranged across the area from about 9500 B.C. until around 5000 B.C. One significant archeological discovery is the Next Week Site, just south of Interstate Highway 10 in the eastern part

of the county. The site, discovered and excavated in early 1975, is a burned-rock midden containing evidence of mortars and pestles, as well as other tools connected with the processing of plant foods. Europeans first contacted Indians of the southern plains in the sixteenth century. At that time the groups who roamed the Edwards Plateau were known collectively as the Tonkawa's. In the seventeenth century, the Lipan Apaches moved into the region and quickly forced the Tonkawa's to restrict their hunting and gathering activities to Central Texas. The period of Lipan supremacy was brief, however. By the mid-nineteenth century competition for resources again heated up as the Comanches migrated southward onto the Texas plains. They subdued the Lipan Apaches and within a generation had all but sealed off the bison-rich Llano Estacado. The Lipans, forced to restrict their activities to the Edwards Plateau, which was meager in plant resources and nearly devoid of bison, attempted to supplement their diet by raiding local herds of domesticated cattle. The Texas government, in accordance with its general Indian policy, responded by trying to drive the Lipans from the state. To this end, the state built a series of forts across the Edwards Plateau, including Fort Terrett in the eastern part of what was to become Sutton County. This policy, combined with declining animal herds, disease, and Comanche aggression, drove the Lipans from Texas by the end of the Civil War. By the time white ranchers discovered the potential of the Edwards Plateau as a grazing area, it was virtually uninhabited.

In 1887 the Texas legislature established Sutton County, which was carved out of eastern Crockett County and named after Confederate officer John S. Sutton. The establishment of Sutton County set off a new round of competition between the interests at Winkler's Well, now called Wentworth, and Sonora, over the location of the county seat. Initially Wentworth had the advantage, but in 1889 Charles Adams was successful in drilling a well on the Sonora courthouse property. With its water supply assured, Sonora proceeded to entice settlers with land grants. This program proved decisive, for by the time of the 1890 election Sonora had a large enough population to assure that it, not Wentworth, would be the county seat. By 1900 Wentworth had ceased to exist.

The first three decades of the twentieth century saw the end of the leased range, its replacement by privately owned ranches, and a dramatic growth in the size of herds. The greater availability of water, the movement to fence off landholdings, and the low price of land stimulated the growth. In 1900, for example, state school land sold for a dollar an acre, roughly the price of eight pounds of wool. Land purchases were made even more feasible by the introduction of 3 percent forty-year loans. Consequently, large ranchers were able to purchase virtually all of Sutton County's lands. By the early 1920s 58 percent of the county's ninety-seven ranches were larger than eight sections. Of those, ten ranchers controlled lands in excess of thirty-two sections each, some 672 sections altogether, over one-third of the county's land area. As holdings grew larger, so also did herds.

Sonora traditionally has been an important population center as well as the locus of social, economic, and political activity. After a disastrous fire in 1902, the town enjoyed

a quarter century of growth, from just over 700 to nearly 1,800 residents. By 1930 Sonora had taken on a distinctly urban look, with stone buildings, a modern water-supply system, a number of churches, a new school building, two newspapers, a well-established bank, and several prosperous mercantile establishments.

It was the onset of the Great Depression that finally put a halt to Sutton County's rapid growth. In areas that depended upon production of food and animal products for livelihood, the contraction of the money supply after the stock market crash was compounded by disastrously low commodity prices. Even with the nearly full recovery that followed World War II, the livestock industry in Sutton County never again approached its pre-depression rate of growth. In Sonora the impact of the depression was less severe. City population remained steady, and relatively few businesses failed. To some extent Sonora's continuing economic strength resulted from the establishment of the Sonora Wool and Mohair Company in 1930. This enterprise, a cooperative venture among county livestock managers, helped to stabilize commodity prices while providing Sonora with a viable economic base. The Sonora Wool and Mohair Company continues to handle most of the region's production of animal fibers and sponsors a variety of community events. Sonora also benefited from federally sponsored relief programs. Work Projects Administration endeavors included the construction of a fire station and city hall and modifications to the municipal waterworks and light plant. In 1936 the city was able to complete the L. W. Elliot School.

After World War II the county entered a new era of economic growth. This prosperity was especially pronounced in Sonora, which between 1955 and 1961 constructed a hospital, a municipal airport, and a flood-control project consisting of thirteen dams. At the same time the county's oil and gas industry began a period of steady growth that peaked in the mid-1970s. At that time the Arab oil embargo and the previous undervaluation of oil lands stimulated an explosion of oil and gas exploration in Sutton County. As oil firms moved to Sonora and drilling rigs sprang up across the county, the economy underwent a drastic expansion. Whereas receipts from mineral (mainly natural gas) extraction totaled roughly $3.2 million in 1972, by 1975 this figure had jumped to nearly $41 million. At the same time over 400 miles of pipelines were constructed. Production peaked in 1977, when revenue topped $63.3 million. Subsequently, as price controls and market saturation rendered exploration relatively unprofitable, Sutton County's petroleum industry entered a period of decline. The oil boom did have lasting consequences, however. Most significantly, the favorable economic conditions attracted large numbers of people, especially to Sonora. From 1970 to 1977 the city's population grew from 2,600 to an estimated 6,000. The city was confronted with a severe housing shortage, and many oil-industry laborers were forced to live in mobile homes. The oil boom also enabled Sonora to upgrade its city utility system and schools.

Perhaps the most important development in Sutton County in the post-depression era, however, has been a gradual change in land use. In 1946 the state established the Edwards Plateau Soil Conservation District, which was composed of all of Sutton and part of Edwards County. The movement toward protecting and reinvigorating Sutton County's natural landscape was paralleled by efforts to reintroduce wildlife. In 1938 ranchers formed the Edwards Plateau Game and Wildlife Management Association. This organization, like the Soil Conservation District, sponsored educational programs to promote game conservation and worked to secure legislation that would encourage efforts at restoring the region's ecological balance. So successful was this program that by 1950, with a deer population estimated at seventeen per square mile, hunting was reintroduced. Since then the deer population has continued to grow, and hunting has become a major source of income for Sutton County.

Despite the importance of hunting and the brief period of petroleum prosperity, however, the Sutton County economy continues to be based on sheep and goat products. Agriculture is relatively unimportant to the local economy. Aridity and shallow, stony soils make farming so difficult, expensive, and harmful to the environment that as of 1982 less than one percent of the county's land was under cultivation. Crops produced are limited to small quantities of cereal grains, mainly wheat and sorghums, and pecans. On several occasions in the twentieth century attempts have been made to grow cotton, but all have ended in failure. Also unsuccessful have been attempts to cultivate grapes and several types of fruit trees.

Ethnically, most of Sutton County's residents are of Mexican or Anglo-American stock. From 1890 through 1940 Mexicans were by far the largest group of immigrants entering Sutton County from outside the United States. By 1980, 2,071 of the county's total population of 5,130 claimed Mexican ancestry. In 2014 the population was 3,972. About 37.8 percent were Anglo, 0.9 percent African American, and 61.1 percent Hispanic. Until after World War II the county vote was solidly Democratic in national elections, aside from supporting Herbert Hoover in 1928. In 1952, however, the county went for Dwight D. Eisenhower, and since then only in 1960 and 1964 have Democrats carried Sutton County. Sonora continues to be the center of community activity. Just outside of town are the Caverns of Sonora, some seven miles of caves with exotic limestone formations, which are visited by more than 7,500 persons annually. The caverns and hunting account for most of the county's tourist traffic.

HOSPITAL BIOGRAPHY[2]

Lillian M. Hudspeth Memorial Hospital History

Originally compiled by Patricia Craig Johnson

Mission Statement

To provide quality health care and services which are responsive to the needs of our community in the spirit of our founders.

Vision Statement

To commit our compassion to significantly improving every dimension of healthcare in the community we serve.

The idea for the Lillian M. Hudspeth Memorial Hospital was conceived in the mind of Roy H. Hudspeth, Sutton County rancher, as a tribute to his wife, Lillian Maddox Hudspeth, who had died in 1946. In 1947, he offered to supply half the funds for a hospital, if the citizens of Sutton County would contribute the other half. The community had long felt the need for a hospital and eagerly accepted his offer. Plans got under way for what would turn out to be a $500,000 facility.

Roy Hudspeth died in 1948, after the hospital was incorporated, but before construction had begun. In addition to his initial donation, in his will he left a 20 section ranch as an endowment for the hospital. On July 1, 1951, the two-story LILLIAN M. HUDSPETH MEMORIAL HOSPITAL opened its doors.

Over the years, the hospital served the community well. In September of 1970, a one story 39 bed Nursing Home was added to the original building. An active Women's Auxiliary furnished many amenities for hospital patients and nursing home residents.

But times changed. After the deaths of the two family doctors who had presided over the hospital for so many years, it became almost impossible to recruit young physicians to this rural area. When they did come, they did not want to deliver babies. For financial and medical-legal reasons it was impractical for surgeons and anesthesiologists to continue to come from San Angelo to perform operations in the Hudspeth surgery. The production of oral anti-biotics did away with the necessity of hospitalization for round-the- clock injections, and government regulations mandated the length of time a patient could stay in the hospital. The patient count dwindled to almost nothing.

Hudspeth Hospital, never a for-profit institution, had been able to survive with the

income from the ranch, but over the years a deficit accumulated.

In 1986, the hospital was $650,000 in debt and the ranch had exhausted its borrowing power. Some action had to be taken. There were two options; close the hospital, or create a Hospital District, which would have the power to tax. A number of persons clamored for a third option; sell the ranch.

This, however, was never really an option because it would only postpone the inevitable. The sale of the ranch would pay off the current debt and provide operating capital for a few years. When that money was exhausted, the original two options would again have to be faced.

Most of the population was opposed to having taxes raised, but neither did they want Sutton County left without primary care. At the polls they voted overwhelmingly for a Hospital District which added 10 cents per $100 evaluation to their taxes. Since 1986, the board of the Hospital District has returned twice to the Texas Legislature to increase the tax cap, which now stands at 75 cents per $100.

The board of directors of the newly created Sutton County Hospital District took over the management of Hudspeth Hospital. The trustees of the original Hudspeth Hospital Corporation, known as the Corporate Board, who had previously operated the hospital, no longer had a hospital to operate. These trustees then petitioned the Attorney General of the State of Texas to make a ruling as to the disposition of the trust's assets, i.e., the ranch. By agreement between the Attorney General and the Corporate Board, a declaratory judgment was rendered by the District Court. In essence, the judgment allowed the Corporate Board to retain the ranch, with all income, other than that necessary to maintain the ranch, to be applied against the debt. After the debt was retired, the income was to be used for capital improvements to the hospital and necessary, unexpected expenses.

In 2001, faced with a aging physical plant, the Board of Directors began to develop the plans to replace the hospital with a new state-of-the-art hospital.

Plans were to complete the construction of the facilities without increasing taxes or incurring debt. In early 2004 through operational capital, grant funds and assistance from the Hudspeth Ranch. Construction began on the new 5.2 million dollar acute hospital and wellness center.

Construction was complete in summer of 2005 and patients and staff moved into the new facility with amenities and technology never before available in Sonora. The new

facility included complete digital imaging, multi-slice helical scanner, ultrasound and PACS. The laboratory was tripled in size and included state-of-the-science analyzers. The Emergency Department has five beds with bed-side monitoring connected through a wireless telemetry system that also monitors the twelve private acute-care beds. In addition to the acute hospital, The Health and Wellness Center opened. The Health and Wellness Center includes fitness facilities, in-door swimming pool, aerobic facilities and member showers and locker facilities. In addition to the fitness areas, the Center includes a physical therapy department with dedicated wound care and a cardiac and pulmonary rehab department.

Hudspeth Hospital continues to serve the community after six decades and continues to advance the mission and vision by installing complete electronic health records in 2006 and completed three residential properties for professional recruitment and purchasing eight apartments in 2008 and 2009. These properties bring the total housing opportunity for recruiting to thirteen.

Construction of a 6.2 million dollar 8200 sq/ft facility to house MRI, GI lab/procedure space and mammogram was completed in October 2010. The Diagnostic Center provides for specialty clinics including cardiology, neurosurgical, nephrology and orthopedics. The facility includes women's imaging and a GI suite. Women's imaging suites includes digital mammography, ultrasound and breast capable MRI.

October 1, 2010 the hospital implemented Specialist on Call (SOC). SOC provides tele-neurology services to support Sonora attending physicians in treating patients with stroke. This service coupled with the 64 slice helical CT scanner allows for early intervention and the use of clot buster drugs in reversing or limiting the effects of stroke.

In August 2011 the Sutton County EMS transitioned from a mostly volunteer service to a full time advanced life support service. The partnership between Sutton County and The Hospital District allows for this leap in EMS service. The operations will be managed by the Hospital District and both 911 and non-emergency transportation is available.

In 2012 two new programs were added to our every growing service line. In April Sports Medicine was added to our rehabilitation services. Two athletic trainers provide care and prevention to the Sonora ISD and surrounding county schools. This program integrates the local medical staff, visiting orthopedic surgeons, Wellness Center and the physical therapy staff to reduce and minimize athletic injuries. In addition to school activities the staff are available for consultation to weekend warriors as well.

On August 1, 2012, the Sutton County EMS, Hospital and Sonora Medical Clinic began offering services through the Community Paramedic Program. The Community Paramedic Programs offers services to our patient in their home that range from safety and preventive services to health monitoring and medication reconciliation. These services are provided free to the community and utilize the EMS personnel through a multi-disciplinary quality program. The goal of the program is to improve compliance with health issues like diabetes and heart disease and to prevent falls, unnecessary emergency visits and readmissions.

Administration and staff continue to plan the future by providing the latest medical technology to the citizens and travelers in this region of Texas.

Additional hospital notations:

- The hospital has been aggressively changing to a "Patient First" culture; transforming from a physician centric culture.
- The hospital has experienced internal challenges with physician contracts, CEO turn-over, physician departures, new physician hire and board election controversies of a former doctor being elected to the board. All these challenges were communicated by 4 of 5 Focus Group Participants.
- Sutton County is a small and limited market.
- The hospital is capturing 40% of the local market share; remaining patients go elsewhere as noted by the Focus Group Participants. There is a positive attitude that Dr. Will Griffin will help turn the medical community's attitude toward the hospital.

Sutton County is a Health Professional Shortage Area (HPSA) for Primary Care and Mental Health Providers, and a Medically Underserved Area (MSA), as designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration.

Available Hospital Services

Lillian M. Hudspeth Memorial Hospital provides general medical care for inpatient, outpatient, and emergency room patients, and participates in the Medicare and Medicaid programs.

Emergency room services are available on a 24-hour per day, seven-day per week basis. It is certified as a Level IV Trauma Center.

- Cardiac Rehabilitation
- Cardiovascular Services
- Emergency Medical Services
- Hospitalization Services
- Imaging
- Laboratory
- Physical Therapy
- Pulmonary Rehabilitation
- Sports Medicine
- Wellness Center: Public Exercise Programs

Additional Services

- Swing bed program
- Hospice program
- Chronic Care Management Program
- CCM 24/7 Nurse Triage Advice Line
- Observation Bed program
- Specialty clinics: Cardiology, Neurology, Orthopedics, Urology, Hearing
- Paramedic outreach

Sonora Medical Clinic

The Sonora Medical Clinic is a designated a CMS Rural Health Clinic (RHC). Rural Health Clinics are federally qualified health clinics certified to receive special Medicare and Medicaid reimbursement. CMS provides advantageous reimbursement as a strategy to increase rural Medicare and Medicaid patients' access to primary care services.

The Sonora Medical Clinic is a part of the Sutton County Hospital District and the Lillian M. Hudspeth Memorial Hospital. The clinic provides primary health care services and functions within the mission of the hospital district.

Hours of Operation: Monday through Friday 8:00am - 5:00pm

Pajestka Clinic

This clinic is owned and operated by a private physician.

Financial Services

The Patient Financial Services department of Lillian M. Hudspeth Memorial Hospital consists of the Business Office and Patient Counseling.

The Business Office functions including billing, collections and cashiering. The Patient Counseling performs financial and benefits counseling. All services are accessed through the Main Lobby registration desk.

Insurance Products

The hospital accepts all major health insurance products such a Blue Cross, Etna, and Cigna. (Patients with HMO and PPO coverage). If services are the result of a work-related injury, Hudspeth Memorial will bill the employer or employer's liability carrier.

Health insurance information in the event that Worker's Compensation denies the claim or does not cover all the charges is requested from the patient at the point of service. The hospital accepts Medicaid and Medicare, but neither the hospital nor its physicians accept Medicare Advantage Plans.

The hospital provides many cash options:

- 30% discount with no insurance
    - Elective Procedures:
        - Patient or Guarantor will receive a 30% discount for elective procedures if payment is received in full at the time services are rendered
    - Emergency Room, Observations, or Inpatient Admissions:
        - Patient or Guarantor will receive a 30% discount if paid in full within 30 days of receiving first billing statement

- 30% discount with insurance
    - All services:
        - Patient or Guarantor will receive a 30% discount for services rendered and are not paid in full by the insurance plan. This payment must be paid in full within 30 days of receiving the first billing statement.

Alternate payment options

- 3 or 6 Month Payment Plan – Balance less than $1,200. The 6 month plan must be approved by the Business Office Manager.
- 12 Month Payment Plan – Balance must be greater than $1,200 and less than $3,599.
- 24 Month Payment Plan – Balance must be greater than $3,600
- Longer Payment Plan – Requires approval by the Chief Executive Officer

HELP Patient Payment Plans

This program will be offered to accounts with balances greater than $300 and within 90 days of 1st statement. A 10% discount will be given at the time the contract is signed and is reversed if the patient defaults on the signed contract. Exception: Accounts associated with elective procedures are only offered this program with management approval.

Area Healthcare Services

In addition to Lillian M. Hudspeth Memorial Hospital, which operates 12 beds as a Critical Access Hospital, other hospitals in the area include:

Schleicher County Medical Center, El Dorado
- Hospital District (Managed by Preferred Management Corporation)
- 14 beds

Kimble Hospital, Junction
- Hospital District
- 15 beds

Shannon Medical Center, San Angelo
- Not-for-profit
- 401 beds

San Angelo Community Medical Center, San Angelo
- Investor owned
- 171 beds

Notations to Area Hospitals

- All Focus Group Participants noted they received adult primary care, pediatric care, OB-Gyn, and most specialty care at one of the major hospitals in San Angelo. All participants noted that the out-migration of local residents along with the instability of the board and senior leadership posed a significant threat to the viability to the hospital and less to the two clinics. It was noted that the El Dorado hospital, Schleicher County Medical Center, did not seem to present a threat. As a note: Preferred Management now provides ownership and management of rural hospitals and represents one of the premier rural hospital management companies in Texas. Sonora should not under-estimate this new hospital facility and management team.
- As a note: Schleicher County Medical Center (SCMC) was recognized in 2019 week with the 2018 TMF Gold Award for Hospital Quality Improvement. This regional award was given to only 51 of the 745 hospitals in Arkansas, Missouri, Oklahoma and Texas, that demonstrated improved performance on specific national quality measures.
- Shannon Hospital System was the first system noted by the majority of Focus Group Participants primarily due to name recognition and the noted availability to get an appointment. No participant complained about the Shannon Experience.

However, it is to be noted that all specialty clinics at the hospital/RHC is provided by San Angelo Community Hospital.

Behavioral Health Facilities (including MHMR): Many participants were aware of their facilities but not sure what services were provided while mental health issues and the need for counseling services was a prevalent addressed need.

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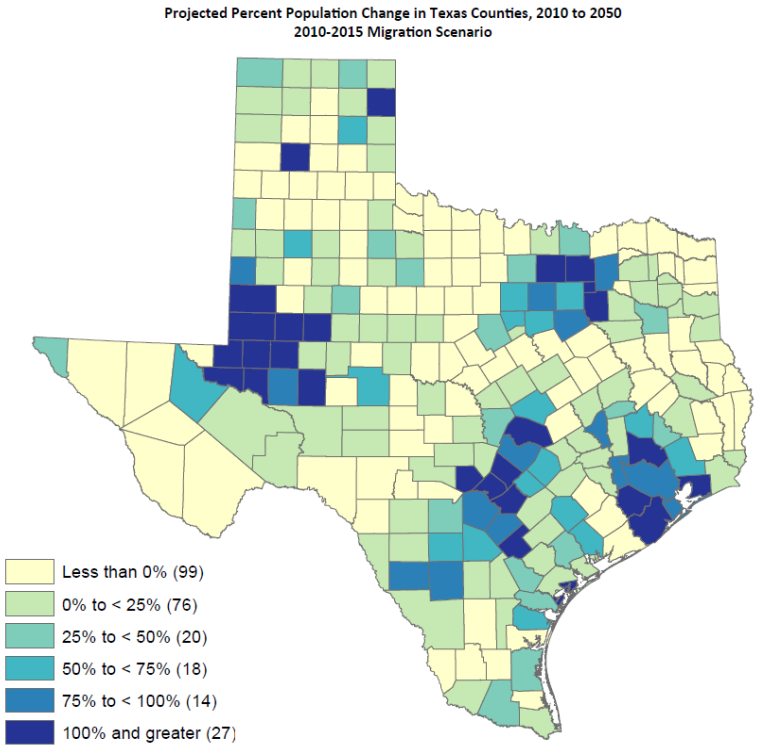
SUTTON COUNTY PROFILE [3]



POPULATION (Census Bureau, 2010)	
County Population	
Estimate 2018:	3,758
Estimate 2017:	3,798
Estimate 2016:	3,885
Estimate 2015:	3,916
Estimate 2014:	3,970
Estimate 2013:	3,983
Estimate 2012:	3,917
Estimate 2011:	3,988
Census 2010:	4,128
Census 2000:	4,077

Population of the County Seat (Sonora)	
Census 2010:	3,027
Census 2000:	2,924
GENERAL INFORMATION	
County Size in Square Miles (Census Bureau and EPA)	
Land Area:	1,453.9
Water Area:	0.5
Total Area:	1,454.4
Population Density Per Square Mile	
2010:	2.84
Urban and Rural Population of the County, 2010 (Census Bureau)	
Percent Urban:	81.20
Percent Rural:	18.80
DEMOGRAPHICS	
Ethnicity - 2017 (Census Bureau)	
Percent Hispanic:	62.6%
Race - 2017 (Census Bureau)	
Percent White Alone:	96.2%
Percent African American Alone:	1.2%
Percent American Indian and Alaska Native Alone:	1.1%
Percent Asian Alone:	0.6%
Percent Native Hawaiian and Other Pacific Islander Alone:	0.1%
Percent Multi-Racial:	0.9%
Race and Ethnicity - 2017 (Census Bureau)	
Percent Not Hispanic White Alone:	36.2%
Percent Not Hispanic Black Alone:	0.6%
Age - 2017 (Census Bureau)	
17 and Under:	24.4%
65 and Older:	17.7%
85 and Older:	2.3%

Median Age:	40.8
Income	
Per Capita Income - 2017 (BEA):	$58,599
Total Personal Income - 2017 (BEA):	$220,744,000
Median Household Income - 2017 (Census Bureau):	$57,986
Poverty - 2017 (Census Bureau)	
Percent of Population in Poverty:	14.3%
Percent of Population under 18 in Poverty:	23.6%
Educational Attainment (Census Bureau, 2012-2016 American Community Survey 5-Year	
Percent high school graduate and higher:	76.6%
Percent bachelor's degree or higher:	16.8%
Pay (BLS)	
Average Annual Pay - 2017:	$64,317
Average Annual Pay - 2016:	$59,040
Average Annual Pay - 2015:	$68,304
Average Annual Pay - 2014:	$80,971
Average Annual Pay - 2013:	$65,784
Annual Unemployment Rate, Not Adjusted (Texas Workforce Commission)	
Unemployment Rate - 2018:	3.8
Unemployment Rate - 2017:	5.1
Unemployment Rate - 2016:	8.0
Unemployment Rate - 2015:	6.0
Unemployment Rate - 2014:	3.6
COUNTY FINANCES (Texas Comptroller of Public Accounts)	
Property Taxes - 2017	
Total County Tax Rate:	$0.676819
Total Market Value:	$1,604,753,645
Total Appraised Value Available for County Taxation:	$579,770,881
Total Actual Levy:	$3,921,022

The data table fairly accurately reflects the projections given in the prior health report done by Angelo State for Sutton County. The upcoming 2020 Census will be an opportunity to solidify the numbers. Given the County's geography, growth will be limited, as urban centers such as San Antonio and Austin will experience higher birthrates and in-migration. To echo the previous report, growth in Sutton County will come from Hispanic residents. However, the total population is expected to remain fairly constant for the foreseeable future.

As the data below indicate, poverty remains a challenge, disproportionately among children. This, coupled with uninsurance and Medicare/Medicaid, present resource challenges for rural hospitals, including Sutton County. Texas is one of the states that have not expanded Medicaid, which means limited resources for rural hospitals to handle the County's at-risk population.

The prospect of a rapidly aging population seems to be less severe than prior projections. Instead of the projected 816 seniors in Sutton County, there are currently estimated 655 adults over 65. There is a higher ratio of men to women in the County, including among the elderly.[9]

ADDITIONAL DATA

Texas Health Ranking[4]

Sutton County: #99 (of 254 Texas Counties) which is indicative of length of life and quality of life. This is a decrease from the 2016 CHNA report of #41.

Other Health Outcomes rankings:

- Length of Life: #119 of 244
- Quality of Life: #81 of 244
- Health Factors: #28 of 244
- Clinical Care: #95 of 244
- Social and Economic Factors: #98 of 244
- Physical Environment: #32 of 244

Crime[10]

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

- The overall crime rate in Sonora is 59% lower than the national average.
- Sonora is safer than 72% of the cities in the United States.
- In Sonora you have a 1 in 88 chance of becoming a victim of any crime.
- The number of total year over year crimes in Sonora has decreased by 13%.

Food Environment[6]

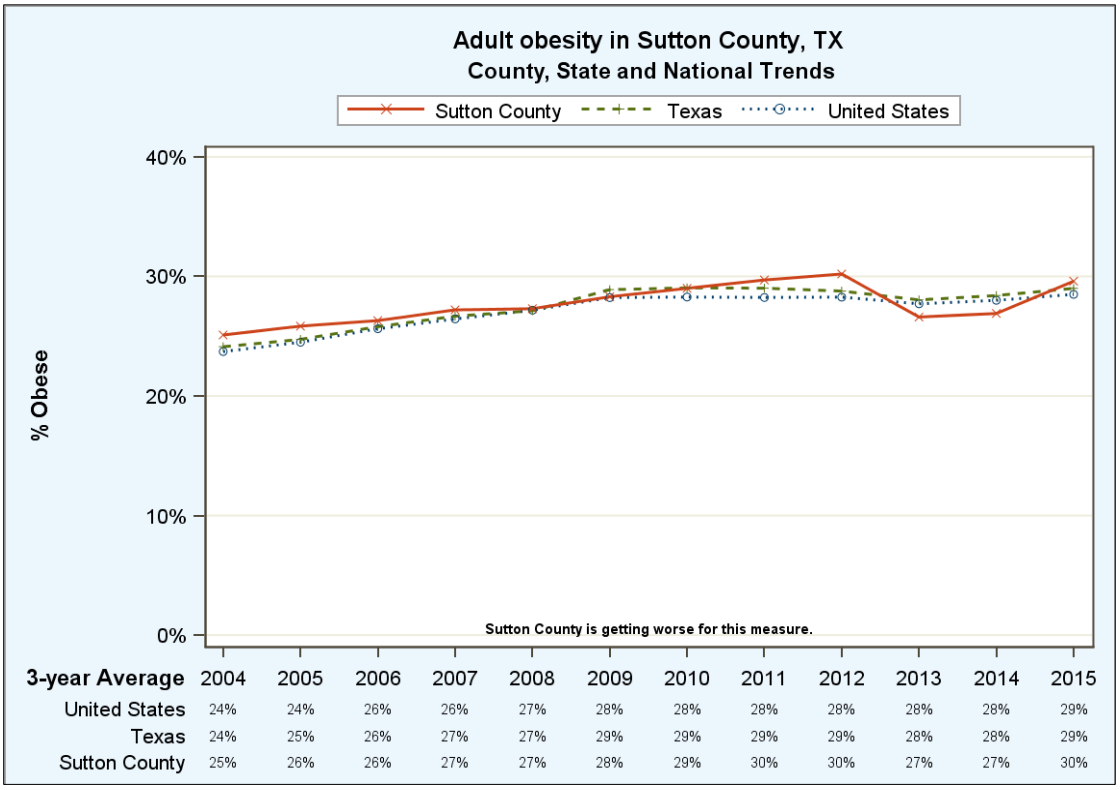
Number of grocery stores:
Sutton County: 1
Texas: 1.47 per 10,000 people

Number of convenience stores (with gas):
Sutton County: 7
Texas: 3.95 per 10,000 pop.

Adult diabetes rate:
Sutton County: 9.0%
Texas: 8.9%

Adult obesity rate:
Sutton County: 27.2%
State: 26.6%

Low-income preschool obesity rate:
Sutton County: 11.5%
State: 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%
Sutton County	25%	26%	26%	27%	27%	28%	29%	30%	30%	27%	27%	30%

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

The rates for Adult Diabetes, Adult Obesity Rate, and Low-income pre-school obesity rate are comparable to other rural communities throughout Texas. While the numbers are not particularly higher for Sonora and Sutton County, 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. Continuing to provide education through a community wide task force of health, education and home health leaders is critical. The fact that a very modern and economically affordable exercise facility is available is phenomenal.

Economic and Demographic Data[6][7]

Most Common Industries (2016)

- Educational services (11%)
- Health care and social assistance (10%)
- Retail trade (6%)
- Accommodation and food services (5%)
- Other services, except public administration (4%)
- Professional, scientific, and technical services (4%)
- Mining, quarrying, and oil and gas extraction (3%)

Most Common Occupations (2016)

- Construction and extraction occupations (21%)
- Transportation occupations (18%)
- Management occupations (13%)
- Installation, maintenance, and repair occupations (9%)
- Material moving occupations (7%)
- Production occupations (5%)
- Sales and related occupations (5%)

Median age:

Sutton County: 36.7
Texas: 34.7

Estimated median household income (2016):

Sutton County: $56,399
Texas: $56,565

2019 estimated unemployment:

Sutton County: 3.5%
Texas: 4.4%

Percentage of residents living in poverty in 2016:

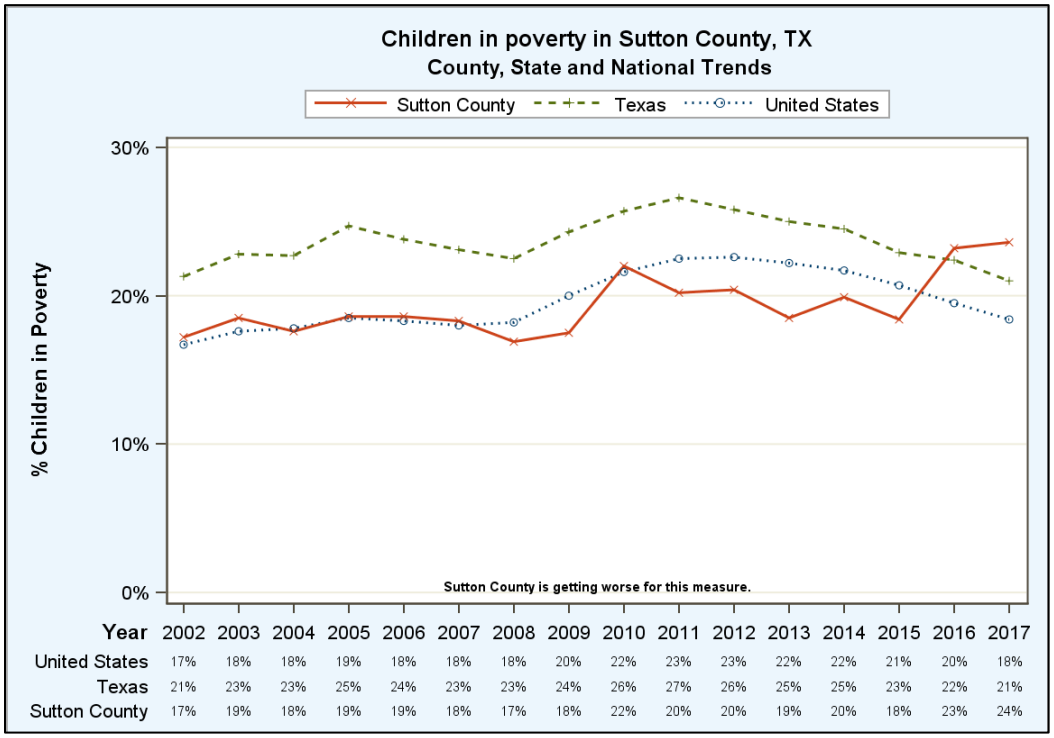
Sutton County: 8.6% (1.9% for White Non-Hispanic residents, 13.2% for Hispanic or Latino residents, 11.0% for other race residents)
Texas: 15.6%

Children in Poverty:

Sutton County: *24%*
Texas: 21%

Children in Single Parent Households:

Sutton County: *37%*
Texas: 33%



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%
Sutton County	17%	19%	18%	19%	19%	18%	17%	18%	22%	20%	20%	19%	20%	18%	23%	24%

Unemployment numbers remain fairly steady in the County. When compared with the poverty rate and the amount of children in single parent households, low unemployment may not equate to livable wages. In addition to this, the limited availability of employer-provided private insurance will limit rural hospital reimbursements.

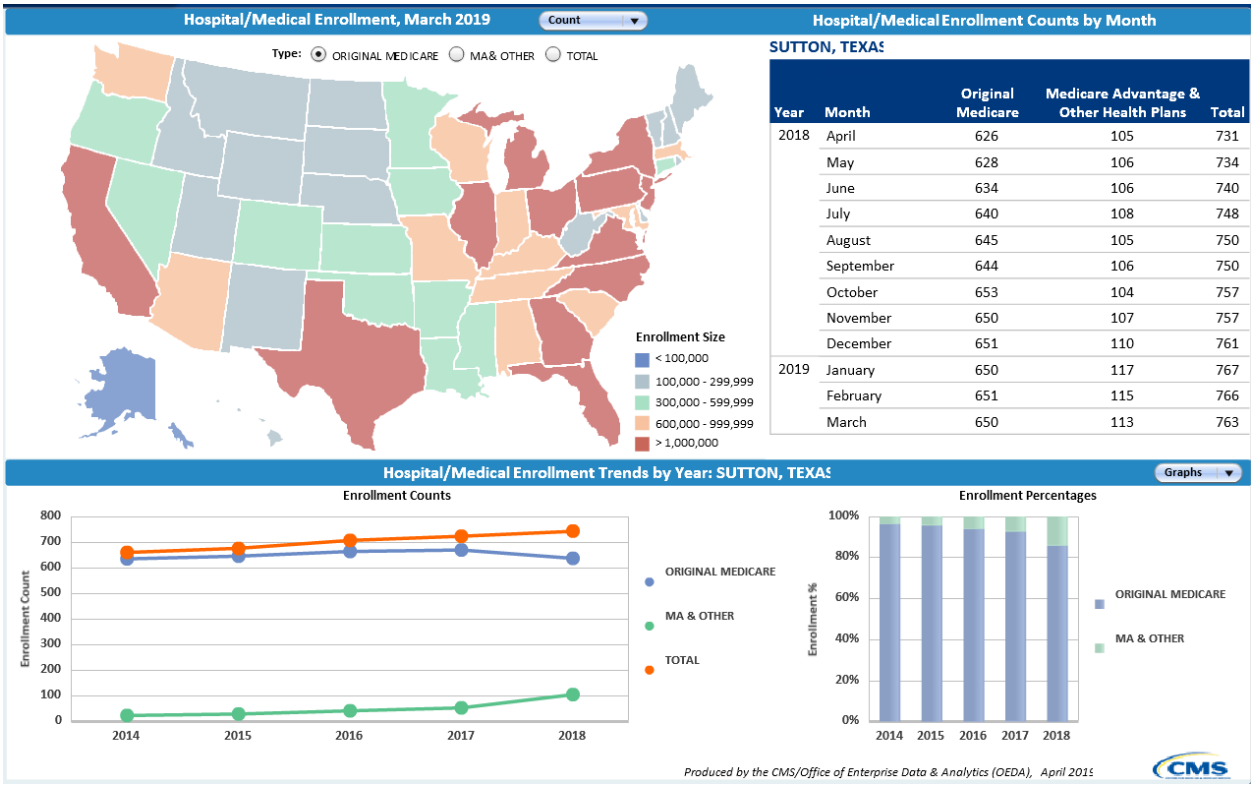
Adults without health insurance coverage:

Sutton County: 23.7%
Texas: 23%

Children without health insurance coverage:

Sutton County: 9%
Texas: 10%

Medicare in Sutton County



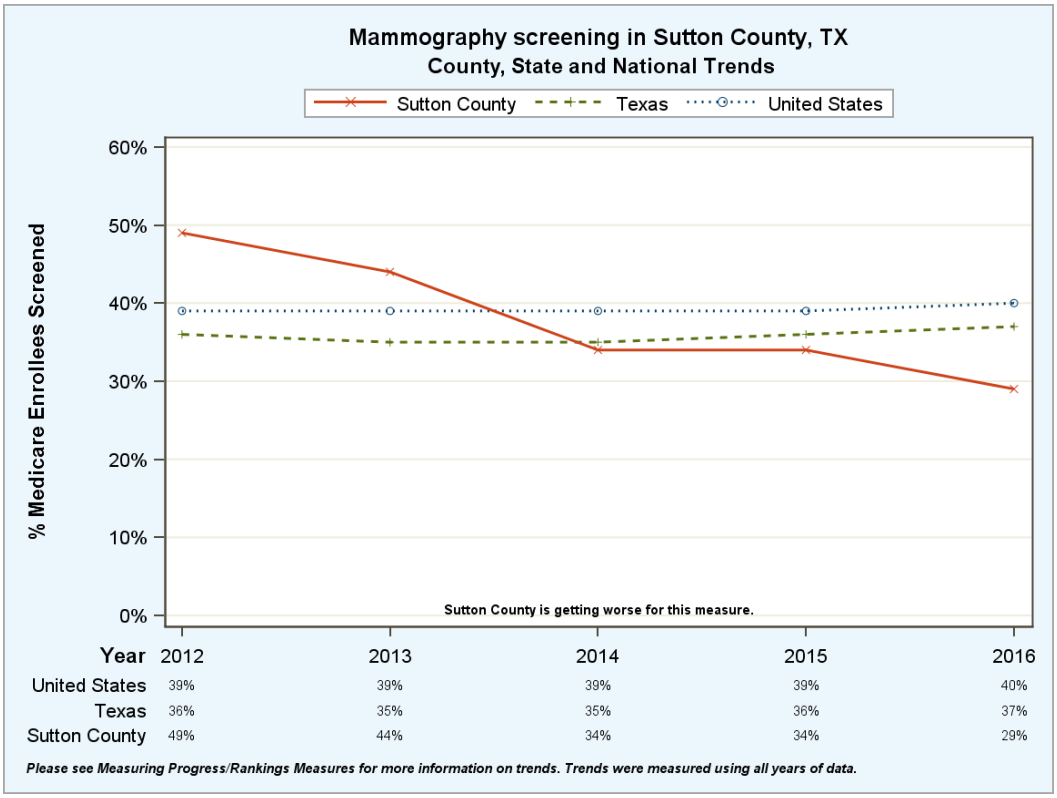
Year	Month	Original Medicare	Medicare Advantage & Other Health Plans	Total
2018	April	626	105	731
	May	628	106	734
	June	634	106	740
	July	640	108	748
	August	645	105	750
	September	644	106	750
	October	653	104	757
	November	650	107	757
	December	651	110	761
2019	January	650	117	767
	February	651	115	766
	March	650	113	763

Other Health Data [4]

Mental Health	*Sutton Co.*	*Texas*
Poor or Fair Health Days (%)	18%	18%
Poor Physical Health Days/Month	3.4	3.5
Poor Mental Health Days/Month	3.3	3.4
Health Behaviors	Sutton Co.	Texas
Physical Inactivity	12%	23%
Access to Exercise	83%	80%
Adult Smoking	16%	14%
Sexual Health	*Sutton Co.*	*Texas*
Teen Births (per 1,000 females)	54	37
Sexually Transmitted Infections (per 1,000)	15.3	52.0

Teen birth rates remain high especially in rural communities. STI rates have fluctuated over the past few years, likely indicating an outbreak.

Clinical Care	*Sutton Co.*	*Texas*
Patients per Primary Care Physicians	1,290:1	1,660:1
Flu Vaccinations	39%	43%
Preventable hospital stays (per 1,000 Medicare enrollees)	54.1	49.7
Mammography Screening	29%	37%



The declining rate of mammography screening reflects the types of services that often get neglected in rural communities. A recent paper published by the Texas Department of State Health Services indicates the rural-urban disparity concerning older, overweight cancer survivors, with rural communities seeing poorer health outcomes often due to limited transportation, education, income, and healthcare access.[11]

Health Status of the Rural Community

A National Overview of Our Problems [8]

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. In a state as resourceful as Texas, this is unacceptable. Currently, 170 of the 254 counties in Texas are rural with nearly 20 percent 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 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 percent 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.

A Modern Healthcare investigation 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 percent of the hospital's total charges in 2015 and 86 in 2016." [9]

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

An Aging Rural Population

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

A Sicker, More At-risk Population

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

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

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

Need for Preventive Care, Health and Wellness Resources

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

Increasing Dependence on Technology

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

State of Health Care in Rural Texas

Interesting Facts

- 15-20% of all jobs in rural communities are in a health care field
- Health Care Provider Shortages: 50% of future doctors who leave Texas to receive medical residency training never return to the Lone Star State
- $150,000 annual training cost per physician
- 80% of Texas is rural land
- Out of Texas' 254 counties, 1776 are rural
- 64 Texas counties do not have a hospital
- 35 miles between critical access hospitals
- 25 Texas counties do not have primary care physicians (PCP's)

Things to Know about Texas Rural Hospitals

- Texas leads the country in hospital closures.
- The driving force behind the closure of Texas Rural Hospitals is cuts and underpayments to rural hospitals by Medicare, Medicaid, Commercial Insurance Carriers (Blue Cross) totally an estimated $120 million a year.
- There are currently 163 rural hospitals in Texas out of approximately 550 acute care general hospitals.
- Texas rural hospitals provide access to emergency care and other care for 15% of the state's population but cover 85% of the state's geography.
- Only 70 of the 163 rural hospitals provide obstetrical care and deliver babies.
- 89 of Texas hospitals have 25 beds or less.
- 122 Texas rural hospitals have 25 or less beds.
- 45 rural hospitals are located in counties of less than 10,000 persons.
- 77 of 254 Texas counties do not have a hospital.
- Some parts of Texas are more than 75 miles away from the nearest hospital.
- Half of Texas rural hospitals rely on local tax support to remain open.
- Small, rural hospitals nationally have equal or better patient quality outcomes, and cost less per Medicare beneficiary than their urban counterparts.
- Rural hospitals have a narrower patient revenue margin than urban hospitals and do not provide more profitable advanced services and medical procedures.

How does Sutton County 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 does pose ongoing threats to Sutton County. Sutton County faces the challenge of stabilizing senior leadership through multiple resignations of the Chief Executive Officer. The community focus groups revealed a fractured culture within the Board of Directors and the general concerns expressed by focus group members of turmoil within the hospital board and the need to stabilize itself for the good of the community. This will pose a significant threat to the hospital among the more prevalent issues facing rural hospitals.

Rural hospitals must re-imagine their roles within the community. For too many years, the local rural hospital was “just the place at the edge of town where old people go when they get sick and if you are really sick you need to just keep on going.” If the local hospital administrator went to the local Lions Club meeting at the local café or went to the Baptist Church on Wednesday night and Sunday, he was done. 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.

Sutton County Health Needs

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

Healthy people are among a community’s most essential resources. Numerous factors have a significant impact on an individual’s health status: lifestyle and behavior, human biology, environmental and socioeconomic conditions, as well as access to adequate and appropriate health care and medical services. Studies by the American Society of

Internal Medicine conclude that up to 70 percent of an individual's health status is directly attributable to personal lifestyle decisions and attitudes. Persons who do not smoke, who drink in moderation (if at all), use automobile seat belts (car seats for infants and small children), maintain a nutritious low-fat, high-fiber diet, reduce excess stress in daily living and exercise regularly have a significantly greater potential of avoiding debilitating diseases, infirmities, and premature death. The interrelationship among lifestyle/behavior, personal health attitude, and poor health status is gaining recognition and acceptance by both the general public and health care providers. Some examples of lifestyle/behavior and related health care problems include the following:

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

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

Identification and Prioritization of Health Needs

The Following County, State and National data provide a foundation for identifying pertinent Community Health needs in Sutton County:

• Demographic Trend Data: Demographic projections of population growth in Sutton County were reviewed. Growth trends for vulnerable population groups were included in the review. The population trend for Sutton County will continue to fluctuate due to the absence of new industry and the transient outflow of families from the flood and decrease of oil and gas jobs.

• Other Health Care Resources: Data and information on the supply of health care professionals, community clinics, home health agencies, and mental health services were reviewed. The supply of qualified healthcare and community health officials do not seem in critical crisis as with most Texas rural communities. The challenge will be to maintain key positions from the threat of living in San Angelo with two major healthcare systems. The advantage of living in Sonora is the more relaxed rural setting with closer access to an urban center for entertainment, transportation and shopping. This trend can be attributed to the priority of a smaller school system with smaller teacher-student

ratios and a less hectic life style. Even though San Angelo is only an hour in distance, the topography has significant changes from West Texas mesquite to more a Hill County topography.

• Family and Maternal Health: Indicators of family composition, domestic abuse data, and maternal health were reviewed. This is trending downward across rural communities due to the high costs and risks associated with maternal child services and poor reimbursement. A system could be examined to care for pregnant mothers up to the third trimester with San Angelo OB-Gyn physicians for delivery with return of the mother and child back to Sonora for continued care to minimize the lost of the family health model to San Angelo due to the lack of birthing services.

• Survey of the Poor and Extremely Poor: Survey data to identify elevated health and behavioral health risks among the poor and extremely poor population of Sutton County. It is important to assert the community-wide health needs of vulnerable populations in Sutton County. With this perspective at the forefront, the needs assessment has made every effort to use data to identify needs of community-level importance which, in many instances, can only be addressed through cooperative, collective community action including senior citizens, churches, and school. It is noted that the rates of children to the state average of 21% is within this range with a slight increase.. This should be a frightening statistic for this county.

Analysis of the data leads to the following summary list of identified needs for Sutton County. These listed are not only hospital needs but community health needs. This will be discussed further in the report.

These needs represent the analysis of the health data and not the focus groups.

1. **Needs of Children and Seniors**. Increase capacity and a need to address health needs of growing numbers of children and seniors through physical activity programs and nutritional support. There is a lack of local support agencies and programs that are working hard to solve the local and regional issues affecting kids and seniors. There should be a consideration for all kids and seniors programs directors to meet at least at quarterly meetings (with the hospital as a partner) to address current, re-current issues regarding the needs of the seniors and kids when it relates to the issues of Children Living in Priority, single mother households, supplement food needs on weekends for Seniors. The school system should be a part of this task force. It was noted than many of the clients rotate between an agency and the Emergency Department. The Emergency Department should consider some role of a Nurse Navigator assuring that children and seniors were not “dropped” in the community once dismissed from the Emergency Department. This

navigator could work in conjunction with the clinics. Often, the follow-up of patients leaving a clinic and Emergency Department is lacking with obtaining prescribed pharmacy drugs or agency follow-ups. This task force would manage clients between agencies as a team not as individual cases where patients are managed singularly not collectively to meet and address entire needs.

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 the hospital to utilize or consolidate into the hospital network. The hospital should be guarded at "outside" companies or agencies that locate to Sutton County that can erode the present hospital financial and clinic foundations which are successful to date. All Focus Group Participants agreed that the hospital should take the leadership role in recruiting physicians and providers that help the over-all health system. It was noted that community leaders, school officials, church leadership, etc. should take an active role in recruiting key healthcare professionals.

3. **Access to Emergency Care**. A need was expressed to provide a nurse navigator to help coordinate patient dismissals of all hospital areas with regional agencies to elevate stop-gaps in services and assess state and national financial resources. This system would coordinate systems care for patients and minimize re-current emergency room admissions. Patients with high Emergency Room admission rates should proactively have appointments with the RHC to manage care, for example weekly clinic visits.

4. **Community Health Programs and Emphasis of Hospital Clinical Services**
   - Heart disease, cancer and cerebral-vascular disease screening programs should be strengthened through a consistent and community team. Presently, the *Sutton County Health Foundation* addresses the need of having a local healthcare system as a critical issue. The Foundation's sole purpose is to raise sufficient capital funds in an endowment program so that the interest generated will supplement expenses of Lillian M. Hudspeth Memorial Hospital and other healthcare resources in Sutton County. This will not only ensure continued healthcare the community, it will also reduce the tax burden on local citizens. The hospital foundation should consider an active community wide role in community health education along with the goals of fund-raising, educational scholarships and capital equipment.
   - 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. The Mammography Screening rate in Sutton County (29%) remained below the state average (37%).

- 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 local shopping center (grocery) to identify base-line pulmonary disease such as asthma or chronic obstructive pulmonary disease. Continuing to provide smoking and tobacco cessation classes as it ranks in top five of top causes of death
- Complications arising from diabetes. Area clinic patients should be screened at least annually with focused diabetic lab tests (A1C) as well as a scheduled bi-annual diabetic screening clinic along with foot wound evaluations. This need was the most common comment made by participants. The Chronic Care Management Program and Annual Wellness Exams in both clinics should be a minimum screen for patients. Annual wellness visits should be mandatory for all Medicare patients, and most commercial plans such as Humana incentivize physician practices. Diabetic monitoring for the state averages 37% compared to Sutton County at 29%.
- Influenza and pneumonia immunization/vaccination programs should be a part of the quality measures of physician clinic electronic medical record systems with emphasis with school registration events and anticipated flu seasons. This should be coordinated with the local health department, schools, and senior citizen organizations, social and civic clubs. Both clinics should collaborate to minimize the incidence of flu, Respiratory Syncytial Virus (RSV) and pneumonia. These should be provided at cost to community health care partners, schools and law citizens, school district, law enforcement, etc. The state average or immunizations is 43% while Sonora is at 39%.

5. **Develop Capacity and Access to Quality Behavioral Health Services.** Mentioned frequently in the focus groups was the un-spoken epidemic in the United States regarding mental health issues as noted earlier in the report. A county task force of law enforcement, school and health professionals should be considered to collaborate with MHMR for Concho Valley, Mental Health Services in San Angelo such as Shannon Behavioral Health and River Crest Hospital to manage the network of care between communities. The community should consider providing the Mental Aid First Aid course for community healthcare providers, law enforcement, schools, churches and the general community in cooperation with MHMR for Concho Valley. This should be a major emphasis going forward for the community health planning. The hospital should access the Methodist Healthcare Ministries of South Texas and the San Angelo Health Foundation who provided support for a Community Health

Needs Assessment for the people of Sutton County. A community “champion” for mental health should be considered through a Community Health Task Force.

- 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. The depression screens should be bi-annually in all practices and at the annual wellness visit.

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 cost and other barriers to medical care and treatment thru cash or discounted programs, sliding scales and hospital district charity. The need to have as many signs available for basic patient services was considered to be helpful.
   - Improve case management and routine preventative screenings in a clinic or Emergency Room Setting (Current volume indicates time to accomplish screens). The need for a Nurse Navigator/Social Worker to work with area community needs group was discussed by several groups.
   - Continue to provide educational classes to promote healthy living and wellness as noted with the high level of poverty with children and the need for parenting classes with the high incidence of single parent households for Sutton County (37compared to a state incidence of 33%. This could be accomplished with a Regional Educational Task Force.
   - It was noted that the Area Ministerial Alliance helped with drug prescriptions for those in distress and could not afford a prescription. There is the need for the local Pharmacy to be engaged in community needs. All Focus Group Participants complained about the current pharmacy ownership and service.

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. Discussion addressed the lack of food to seniors or Meals on Wheels participants on the weekends and holidays. Present Food provisions were at the Resource Center who serves over 1500 clients yearly.
   - Increasing affordable housing in safe neighborhood environments. It was noted that housing was an issue with the culture change in providing one bedroom homes from the larger 4 bedroom homes. There was a stated need for one-two bedroom homes to accommodate seniors and single parent homes. Several Focus Group Participants discussed the need for designated Senior Apartments

and the Disabled. It was noted that the Low Income Housing had been utilized for flood victims and people of all categories were utilizing housing not how it was designated. It is noted that over 300 families were affected with the flood severely affecting seniors living alone.

8. **Investment in Community Health Needs**. Develop collaborative community efforts to increase investment in community health needs. Consider solutions for expanding quality coverage of the uninsured, coordinated funding and development of proposals or campaigns, coordinated organizational and agency strategic planning, and other collaborative community capacity building approaches to the Prioritization of Community Health Needs. This can be accomplished with a task specific focus group with existing community providers to avoid duplication and establish community priority programs and monitoring.

9. **Conduct Community Health Classes (drug, alcohol, diabetes, obesity, heart)** with the high risk groups with a Mid-level provider and RN. It was suggested that health fairs and other educational or screening services should be off-site, in order to draw more people into the activities. It was suggested that businesses or community meeting places would be appropriate locations to reach many of the residents. As to be noted, the hospital of today needs to be “out there” and instead of demanding all in-services to be held at the hospital. The new Pharmacy provider was noted as the most negative health service in the community. The Pharmacy should be involved in identifying high pharmacy costs, lack of payment sources plus finding pro-active means to supply drugs to patients with little or no funding. Additionally, it should be working hand-in-hand with the RHC. Efforts to work together for 340-B program remain a viable source of income for serving low income populations. At this time the local Pharmacy it is not viewed as a partner of the hospital.

    - It is obvious that a yearly health fair or bi-annual booth at a local grocery is insufficient. Instead of this community health burden being solely on the hospital, a community health task force be established to address not only educational needs but community health needs.
    - Provide prevention and treatment of alcohol and drug abuse classes with the area Veterans programs. The care of the Veterans in the community was rarely discussed.

Community Healthcare Needs Focus Group

This section addresses the comments of five Focus Groups. These five groups were well attended, involved, educated to community needs and were very engaged in the process. There is some “overlay” of needs from the Data Base Analysis.

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

Participants of the five focus groups included the following participants:

- Retired citizens (seniors)
- Sonora Flood Relief Representative
- Funeral Home Director
- Pastor
- Sonora Bank Officer
- Retired teacher
- Bank and Trust VP
- County Sheriff
- Former Hospital District Board Member
- Two physicians
- Chamber of Commerce/District Regional Board
- Business Owners
- Hospital Board Members
- Newspaper editor
- Chief of Police
- Bus Owner
- Justice of the Peace
- City Council member
- Economic Development Member
- District Judge

Priorities Identified in Interviews

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

The hospital was successful in the hiring of a new RHC physician who has been received well. The RHC should continue to provide or emphasize primary care, consider a weight loss programs, DOT exams, work injury, immunizations, counseling, school

program partnership, and diverting patients from the Emergency Department with the help of a Nurse Navigator/Case manager/Social Worker to minimize repeated patient visits or abuse of the Emergency Department.

It was a general consensus that the hospital needed to be “out there” and not be the hospital at the edge of town. Upon further discussion, a possibility was the CEO could perform quarterly luncheons somewhat like the CHNA format to be in touch with the community and vice-versa. With the transition of a new CEO, participants felt it was a good opportunity to meet key leaders in the region.
In addressing the CHNA, it is to be noted the hospital was the entity requesting the CHNA by IRS mandates of a 501C3. This is being addressed because in many cases the public’s perception is that the “*hospital is the health system*” which is false. The hospital is one component of the responsibilities of community health services. There is no question that hospitals play a major role in the delivery of healthcare in any community but the responsibility of community health services is shared by multiple agencies, non-profits, state health department, churches and social health programs such as the heart association. It is also to be noted in this public document that the public community service organizations serving the poor, homeless, un-insured, pregnant, hungry and clothing needs of the community makes up the families of providers that impact healthcare. However, as positive as these representatives were in the focus groups, there lacked a comprehensive plan to work as a larger problem solving team and in the absence of any hospital representative where many clients “end up or begin with a clinic or Emergency Department admission. There will have to be a direct objective to bring in agencies that do not office in Sonora but must be involved in Sutton County health activities on an active basis.

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

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 no longer must pay a fee called the individual shared responsibility payment (January 2019). The Internal Revenue Service collected this fee when taxpayers file their annual tax return.

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

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

Furthermore, they could not find healthcare providers who accepted their insurance plan or found it extremely difficult to get pre-authorizations for services. In essence, they were forced either to buy insurance they essentially could not use or pay the individual shared responsibility payment fee for not having insurance.
Many residents stated they would have rather used the money they spent on the insurance or the fee for actual healthcare needs. All residents stated they could have used the money for basic living expenses. Of the individuals interviewed who could not afford insurance prior to the passage of PPACA, these individuals also did not purchase insurance in 2015 and they also had not enrolled in the available exchange programs during 2016. They said the individual shared responsibility payment fee was at least sixty percent less than the annual insurance premiums. They stated the same was true of their friends and family members as well. Based upon state statistics, the percentage of adult patients without insurance in Sutton County remain average within the state with 23% without health insurance while children are within the state average of 9%. However, it should be noted that the State of Texas has the highest percentage and number of people without health insurance in the United States, which could cause long-term damage to the state's economy, says a study released this week by the Texas Alliance for Health Care.
The insurance market remains a significant threat to the future of local rural hospitals and Sutton County is not an exception. From conversations with the hospital leadership, every possible avenue should be 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 should

consider all options to provide the public processes to better understand the patient billings and navigate through the mirage of insurance billing language. An insert of benefit payments should be considered by the hospital to increase the community's understanding of hospital billing.

Other Health Insurance Issues

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

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

Note: The hospital billing was noted in the majority of Focus Group meetings as unsatisfactory, confusing and inaccurate, but nursing care was noted as having improved.

Chronic Diseases and Healthy Living

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

- Diabetes (child and adult) as the #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. LMH will need to continue to offer several health fairs and health screenings throughout the year as well as

education presentations perhaps in a regional agency wide educational forum. Most people interviewed said they were aware of several fairs, screenings and educational presentations by area agencies and other non-profit agencies and clinics. When discussing this item, many acknowledged that time is an issue, would see that many seniors did not have transportation or did not feel they would benefit. Many expressed a desire to see more education presentations, and in contrast, there were also those residents who might not attend health screenings or education or were not interested in hearing more about health education.

As with every community, some participants do not seek care for illnesses or chronic diseases until hospitalization is required. The reasons for not seeking care included the inability to afford routine healthcare visits or medications, the inability to take time off from work, the lack of transportation and often times stated a week to two weeks to get a physician appointment. 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 an overall American laziness to attend free and educational seminars or screens, it is not until a crisis evolves to change personal behavior patterns. Large business avenues such as a grocery or 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 Hospital Wellness Center remains one of the most popular community health benefits with a $12.00 monthly charge. It serves as a real model for rural facilities with various exercise programs for all ages.

Additionally, the coordination of the Wesley Nurse program was considered essential in meeting community health needs and working in collaboration with this regional program. It was viewed as highly successful by many of the Focus Group Participants. The nurse is stationed out of Junction, Texas.

The "One Stop Shopping" Bias

If a patient needs a particular medical service not available in Sutton County, they travel to San Angelo for that service. Once they leave the Sutton County area, those that could afford it tend not to come back for other healthcare services at LMH. This includes routine medical, skilled nursing/rehabilitation, surgery, diagnostic and imaging services. Many reasons exist for this bias. Some feel it is easier to have all of the healthcare needs met in one general location. Others felt if healthcare services in Sutton County could not meet one particular need, they would receive overall better healthcare for all

needs in the cities offering more services. Several stated they would feel more comfortable going to San Angelo because they perceived those doctors had more experience overall in treating certain conditions than providers in Sutton County. All participants expressed a desire to stay home for healthcare needs because of convenience they receive by support of family, friends and church.
The hospital administrative and professional staff has noted that they do lose a certain amount of the local patient population to the larger tertiary healthcare systems in San Angelo with Shannon Health System most commonly discussed. This transition of patients to some of the larger healthcare systems may be due to the “One stop shopping bias” or may even potentially result from the marketing and professional staff communication between the respective healthcare system practitioners and patients, while the patient is receiving care at those system facilities. It is also likely that some transition of patients to the larger healthcare systems is that certain patients from the local communities may not be aware that LMH offers many of the services patients are seeking. The hospital plus the community as a whole may wish to focus efforts on providing insight to the patient population locally that the hospital can serve many needs of patients in primary care, but can also serve as high-quality post-tertiary care during the transition stages of recovery, in areas of swing-bed and therapy services. 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 “DRH saved my life.” All Focus Group Participants commented they were unaware of specific programs provided by the hospital. The hospital has to continually evaluate the financial benefit for offering less utilized services over highly specialized services in San Angelo. The hospital has done a remarkable job staying within its goals of services that make financial sense.

Working effectively across organizations and sectors

The leadership of LMH still needs to regain its reputation for being much more collaborative than most organizations and has to network across tertiary hospital system in larger cities, with turf and competition often taking front seat when it relates to cooperation to solve specific problems. Here and across the country, though, many practitioners and policymakers are coming to the conclusion that collaboration as it usually *looks is not sufficient*. Again, there is no magic bullet. And 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.” Having said that, 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 the 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, though, its core principles are all worth a serious look. Some of these principles are being incorporated with intentionality into Community

Health Improvement Plans and process. A designated “Nurse Navigator/Social Worker etc. would be the excellent liaison working effectively across organizations and sectors.

Mental Health Needs

Complex Problems Requiring Complex Solutions: mental illness and substance use

All Focus Group Participants “mentioned” the issues of mental health concerns within the community. As with the public discussion of how mental health affects individuals and families, this issue was a discussed item. However, 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. There was discussion by several participants relating to the older and younger categories of Veterans PTSD with general mental health issues involving alcohol abuse and prescribed medications habits (opioid) of the veteran community.

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 present the health system with vast and unresolved problems. These issues 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, and 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, 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 can only yield 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 and family violence as well as street violence do serious harm to health and well-being. That remains the case whether one is the direct victim of violence

or is only exposed to it in the home or the neighborhood, and the harm may begin immediately and continue until death.

This issue is of high importance to health service education and programs as hunger, obesity, physical exercise, drug overuse, senior care and family violence all become county health priorities affecting multiple agencies and disease management. The county should consider a Mental Health Task Force to consider offering such programs for schools, churches 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.

All these stated items were consistent mentioned issues for the region. Those noted specifically were issues with child mental health, anxiety and depression.

In December 2015, a Community Health Needs Assessment was performed for Health and Behavioral Health Needs for Sutton County by Community Development Initiatives, Angelo State University with the Principal Investigators:

Kenneth L. Stewart, Ph.D., Director, Community Development Initiatives
Susan McLane, Project Coordinator, Concho Valley Community Action Agency
Cera Cantu, Research Assistant, AmeriCorps VISTA

In discussion with the Focus Groups, Sutton County has 4 counselors through West Texas Counseling at the Food Pantry at 1 day every other week. The goal would be to provide counseling weekly at least three days per week.

Male, Female, and Teen Health Needs

When questioned about the above average comparisons with State, National and County statistics regarding overall health and opportunities to improve family health, several discussion points were prevalent among all focus groups. The points of discussion revolved around the lack of health services for men, women and teens (especially young girls). It was determined in all groups that the availability of PAP screens, Mammography, and HPV immunizations would be beneficial to improve both male and female health risks. Likewise in men were PSA, HPV immunizations and dermatology skin cancer screening would be helpful plus comprehensive yearly physicals. Weight loss programs were discussed but not viewed in the means of a service by the hospital. Despite the lack of physicians and cash revenues, the RHC would be a good medium for a weight loss program. Supervised physician/nurse practitioner weight programs are considered cash only boutique hospital programs. These programs could work in tandem with the public school staff and programs.

Additionally, the need for public CPR classes, Mental Health First Aid classes, Parenting classes, Fatherhood programs, Summer Drowning classes, home emergencies, etc could be coordinated by a community education forum instead for this burden placed only on the hospital and EMS systems. The size of the hospital and community would prohibit one agency caring more burden than the next but address it as a community based project with various agencies represented.

Alcohol and Substance Abuse

Participants of Sutton County felt that there exists an alcohol and substance abuse problem similar to other communities. The abuse of prescription medicines has become more common. Patients, particularly on pain medications, pressure their doctors to authorize refills on their medications even though their current medical condition does not warrant the use of prescription drugs. In addition, children often find it easier to take their relatives prescription drugs than to purchase illegal drugs. This presents a problem to both the children and the people for whom the drugs were prescribed. Focus groups mentioned the need for education about alcohol and drug abuse for adults and teens. The Drug Abuse School Programs are excellent in addressing the issue of how students are educated to alcohol and drug abuse curriculum but rarely did programs educate parents or seniors in the community. There was a consensus that the school and hospital should work closely on drug abuse especially with the opioid epidemic.

School Programs and Hospital Partnership

One area that did not respond to the assessment related to the relationship of schools and hospital services. Verification of health and school data was reviewed for the region regarding teen pregnancy, narcotics, marijuana, opioid, sex education and overall drug awareness. Across the state education geography is a spirited desire to improve mental health, primary care and a collaborative relationship with the school and hospital. It would be suggested that a study be considered with the school of a School Base Clinic with flexible hours as that based in other regional rural areas such as Crystal City. A teen clinic should be discussed to better provide care and education particularly to young teen girls. A school clinic could improve Women's Clinic for teachers, flexible schedules for teachers to access primary and specialty care. This 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 to reduce the school systems cost of the drugs and to promote STD and HPV vaccinations/treatment. The program could increase the health services to female and male teachers with student health. The school goal of minimizing out of school absences maintains improved fiscal

accountability for the school system. It was also discussed to develop a Certified Nursing Assistant for hospital/nursing home/clinic staff for the area.

Transportation Services

The government sponsored transport service was noted as ineffective in scheduling sicker patients or single moms with children where pick up times ranged from 5-6 am with arrivals back to Sonora at 7:00 pm with exhaustive and traumatic days for patients or family even when traveling to San Angelo for care.

Emergency Medical Services

All Focus Group Participants had a positive opinion regarding EMS services. The only suggestions related to a better public education on the use of AED's and re-investing time and energy to key businesses of First Response CPR training while emphasizing choking maneuvers, drowning and electrocutions. During seasonal times, flu and influenza could be provided at the Senior Citizens, shopping and grocery areas with education material available. The EMS services should play a viable arm in delivering health care other than EMS duties and responsibilities due to the call volume. The Paramedic home visitation services are key to minimizing recurrent Emergency Department visits but should be directed to clinic appointments.

Communications

The majority of focus participants felt the hospital reputation needed considerable attention from recent year board conflict. Representative of various churches recommended using churches to better inform and 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, new technology and a campaign along the line of "This is My Hospital." Due to the size and age of the community, the local radio and newspaper remain the most popular. In challenging community leaders attending the focus groups if they were willing to stand publicly and declare "This is My Hospital" was with mixed reactions of participants.

Physician Access & Hospital Bed Utilization

Participants in the interviews spoke very favorable of having Dr. Pajestka and Dr. Will Griffin in the community. Beyond that, several participants, especially in the senior group, would like to see the Hospital expand the number of Specialists beyond what is currently available. Specifically, the availability Ophthalmology and Dermatology in the

community was considered important. Several participants suggested the Hospital offer dialysis services. Others understood that the economics of a dialysis center is probably beyond the financial capabilities of the Hospital.

Re-establishing the Gastroenterology service was also mentioned by several, but no other specific specialties were suggested, leaving it to the Hospital and Medical Staff to determine the need. Several stated that they appreciate the increase in specialists the Hospital has achieved, and that they are glad to be able to stay in Sonora for those visits.

The current Primary Care Physicians and Physician Extenders are very well liked and appreciated, but a number spoke of having difficulty getting appointments at times, and are concerned that additional primary care options are needed. One Nurse Practitioner position was being vacated with a need to re-hire. The availability of Specialty Clinics is especially important to the senior population and to the poor, for whom travel is a challenge, so any additional Clinics will be well received. The most important reason to address Physician Access is, of course, to meet the needs of the community. Beyond that, supplementing the existing level of Primary Care with a good mix of Specialty Clinics is also important for the Hospital to be able to keep community members in Sonora. As the Hospital develops strategies for the future, a current Medical Staff Management Plan will be important to insure the right mix of Providers to support the needs of the community today and into the future.

The Physician Focus Group suggested the hospital examine Long Care Hospital/beds that could expand to 25 utilizing more Nurse Assistants and 2 RN's. With the closure of the Rock Springs clinic, the concern was raised of losing patients to Ozona, El Dorado and Junction. The fact there was an absence of a nursing home was viewed as a negative with family members and patients navigating to other towns providing similar or better services.

Community Exercise Events

In many Focus Groups, the question addressing community exercise benefits were discussed such as a Community Walking Path. Further, it was discussed this could be a viable community/local government project. Additionally, due to the location and terrain of the area would be running/walk/biking benefits for community projects.

Long Term Senior Care

Focus Group participants were challenged to the need for Long Term Nursing Care for seniors with responses that the local community's nursing home was closed due to the lack of population to serve a facility. Seniors requiring long term care travel to Junction, Eldorado, and San Angelo for these services.

The argument that we do not have available population for such a facility or service would be flawed in comparing to Schleicher County Medical Center with 34 beds. According to the latest Medicare.gov analysis, the center rates health inspection 3 of 5 stars, staff ratios 4 of 5 stars, and quality 1 of 5 stars. This facility has received no fines in the last two years. In comparing Hill Country Care Center in Junction, Texas, this 63 bed facility is rated "much below average" in all areas relating to health inspection, staffing and quality with a fine in 2018.

In evaluating area nursing home care and the absence of such care in Sutton County, it would be feasible for a community task force evaluate community opinions to provide services within Sutton County.

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 by the hospital can be described as above average for a rural hospital. Texas leads the United States in hospital closures with five hospitals closing in Texas the last year. The challenge of LMH is to better coordinate care of the private physician practices to decrease core diseases in the community.

Lillian M. Hudspeth Memorial Hospital is indeed a community-based entity, by virtue of the services it offers, and as shown in the Mission Statement. Building on what exists today, listening to the community and to the Staff, and seeking innovative ways to deliver care will benefit the community for years to come. The sharing of the findings from this report with members of the community is a very important step, as it shows not only that the Hospital sought out their input, but that it is listening and willing to address that input. The recommendations of the statistical data and those of the Focus Group Participants should provide a roadmap of plan implementation strategies.

In general, the major priorities identified in the 2016 Assessments are not significantly too different in some areas. This does not mean that there has not been progress made but simply shows the same issues are still considered to be important by the community, and the Hospital's focus should continue to be on those issues.

In the 2016 Assessment, the following priorities were listed with highlights regarding the comments in 2019:

Recommendations are as follows:

1. Maintain an ongoing Medical Staff Management Plan to insure continued access for patients, through the availability of Primary Care and Specialty Providers at the proper level and for the appropriate services.
2. Continue the efforts to address chronic diseases through staffing, equipment planning, education, and partnering with others in the community, to include the Sonora Independent School District and other organizations, such as Churches, the Ministerial Alliance, local agencies and governmental entities, and businesses.
    a. Develop programs/services to address the issues of obesity and diabetes from an education and a treatment approach.
    b. Develop programs/services that include education on other chronic diseases, healthy lifestyle, with focus on the needs of Senior Citizens as well as children.
    c. Develop programs to insure access to services for the poor, including focus on chronic disease issues.

3. Review the feasibility of expanding services in the Wellness Center, as addressed under Priorities Identified, page 11.
4. Implement an action plan to address the perceptions and the realities in the community regarding pricing, the issue of unauthorized sharing of personal health information, and methods to address the application of charity care.
5. Develop a program to address the concerns in the community regarding Hospital direction, communication, and morale.
    a. Develop internal programs to address customer service and team building.
    b. Communicate strategies for maintaining viability.
6. Continue marketing of service capabilities, availability of specialists.
    a. Continue use of community sources such as radio, newspaper, speaking engagements.
    b. As practical, utilize Medical Staff and other clinicians to assist.

The Community Health Needs Assessment and the Implementation Plan are to be shared with the Community, either by posting on the website and/or distributing by other means. A Plan of Action will need to accommodate this report perhaps with the formation of topic focused committees with professionals related to the assessment need.

It is obvious that hospitals have tended to “work in isolation” in meeting community health needs and this county is no different when it comes to decreasing community disease and education. The Health rankings for this community remain very positive. The hospital and community should consider more of a Team Approach to decreasing diseases and enhancing agency relationships with the hospital by forming a Community Health Task Force whose goals would be to better manage adult and child diseases and have more inter-agency collaboration or case management.

TORCH through Torch Management Services, Inc. appreciated the invitation from Roger Masse for us to assist in the development of the Community Health Needs Assessment. I want to thank the Senior Management team in scheduling the participants for the interviews. I also appreciate all the community members who took time to share their insights, opinions and personal stories.

Lillian M. Hudspeth Memorial Hospital is recognized as a vital part of the community, and shows a strong commitment to its' needs. It has been an honor for TORCH to serve your hospital and community.

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 Sutton 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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