CHI St. Luke's Health Brazosport

Lake Jackson, TX

Community Health Needs Assessment

CHI St. Luke's Health Brazosport

Adopted by Board Resolution June 29, 2018[1]

[1]Response to Schedule H (Form 990) Part V B 4

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EXECUTIVE SUMMARY

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CHI St. Luke's Health Brazosport ("St. Luke's Brazosport" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community.

Data was gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. A second survey was distributed to the same group that reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The Significant Health Needs for Brazoria County are:

1. Behavioral/Mental Health
2. Suicide
3. Cancer – 2015 Significant Need
4. Prevention – 2015 Significant Need
5. Obesity
6. Heart Disease

The Hospital has developed implementation strategies for these six needs including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

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CHI St. Luke's Health Brazosport ("St. Luke's Brazosport" or the "Hospital") is organized as a not-for-profit hospital. A Community Health Needs Assessment ("CHNA") is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act ("ACA"), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA helps the hospital identify and respond to the primary health needs of its residents.

This study is designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent Schedule H (Form 990) filings made by the hospital.

In addition to completing a CHNA and funding necessary improvements, a not-for-profit hospital must document the following:

- Financial assistance policy and policies relating to emergency medical care
- Billing and collections
- Charges for medical care

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury.[3]

Project Objectives

St. Luke's Brazosport partnered with Quorum Health Resources (Quorum) to:[4]

- Complete a CHNA report, compliant with Treasury – IRS
- Provide the Hospital with information required to complete the IRS – Schedule H (Form 990)
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided those who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602

[3] As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 Schedule H instructions i990sh—dft(2) and tax form

[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule H (Form 990) V B 6 b

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- An Emergency Room open to all, regardless of ability to pay
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility must conduct a CHNA at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through the assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization, and may be conducted together with one or more other organizations, including related organizations.
- The assessment process must consider input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources).
- Each hospital facility is required to make the assessment widely available and downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[5]

Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a*

[5] Section 6652

hospital facility must take into account input received from, at a minimum, the following three sources:

(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;

(2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and

(3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.[6]

…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must ''solicit'' input from these categories and take into account the input ''received.'' The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the CHNA report to describe any such efforts."

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this Assessment.

To complete a CHNA:

"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:

(1) A definition of the community served by the hospital facility and a description of how the community was determined;

(2) a description of the process and methods used to conduct the CHNA;

(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and

(5) a description of resources potentially available to address the significant health needs identified through the CHNA.

… final regulations provide that a CHNA report will be considered to describe the process and methods

[6] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602 P. 78963 and 78964

used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."[7]

Additionally, all CHNAs developed after the very first CHNA must consider written commentary on the prior Assessment and Implementation Strategy efforts. The Hospital followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments."[8]

The methodology takes a comprehensive approach to the solicitation of written comments. As previously cited, input was obtained from the required three minimum sources and expanded input to include other representative groups. The Hospital asked all participating in the written comment solicitation process to self-identify themselves into any of the following representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

The methodology also takes a comprehensive approach to assess community health needs by performing several independent data analyses based on secondary source data, augmenting this with Local Expert Advisor[9] opinions, and resolving any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis.

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[7] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources. Response to Schedule H (Form 990) B 6 b

[8] Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) B 3 h

[9] "Local Expert" is an advisory group of at least 15 local residents, inclusive of at least one-member self-identifying with each of the five written comment solicitation classifications, with whom the Hospital solicited to participate in the CHNA process. Response to Schedule H (Form 990) V B 3 h

Local expert area residents were asked to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.[10]

Most data used in the analysis is available from public Internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating in this study are displayed in the CHNA report appendix.

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Brazoria County compared to all New Mexico counties	May 3, 2018	2012-2014
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	May 2, 2018	2017
http://svi.cdc.gov	To identify the Social Vulnerability Index value	May 8, 2018	2010-2014
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	May 9, 2018	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	May 8, 2018	2016

Federal regulations surrounding CHNA require local input from representatives of particular demographic sectors. For this reason, a standard process of gathering community input was developed. In addition to gathering data from the above sources:

- A CHNA "Round 1" survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's

[10] Response to Schedule H (Form 990) Part V B 3 i

[11] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) Part V B 3 d

geographically and ethnically diverse population. Community input from 22 Local Expert Advisors was received. Survey responses started May 7, 2018 and ended with the last response on May 18, 2018.

- Information analysis augmented by local opinions showed how Brazoria County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - Low income residents
  - People with major co-morbidity and complications
  - Racial and ethnic minority groups
  - Access to care for these populations was expressed

When the analysis was complete, the information and summary conclusions was put before the Hospital's Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need.[14] Consultation with 17 Local Experts occurred again via an internet-based survey (explained below) beginning May 30, 2018 and ending June 15, 2018.

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.[15]

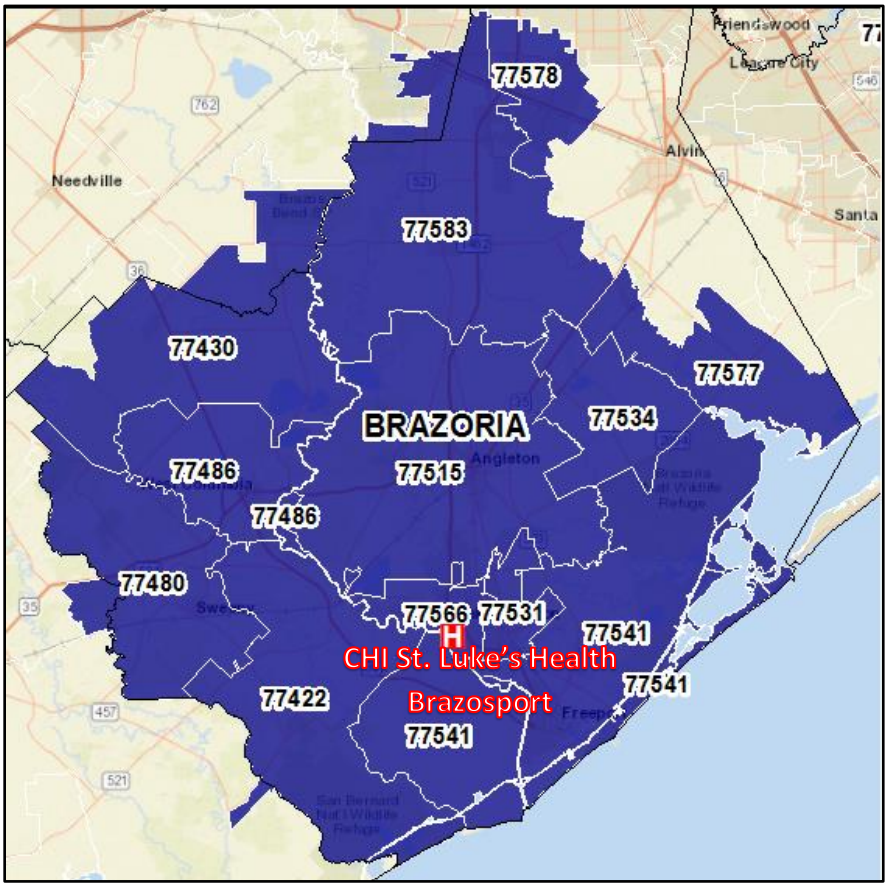
In the St. Luke's Brazosport process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list of all needs identified by any of the analyzed data was developed. The Local Experts then allocated 100 points among the list of health needs, including the opportunity to list additional needs that were not identified from the data.

The ranked needs were divided into two groups: "Significant" and "Other Identified Needs." The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable break point in rank order occurred.[16]

[12] Response to Schedule H (Form 990) Part V B 3 f
[13] Response to Schedule H (Form 990) Part V B 3 h
[14] Response to Schedule H (Form 990) Part V B 3 h
[15] Response to Schedule H (Form 990) Part V B 5
[16] Response to Schedule H (Form 990) Part V B 3 g

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



For the purposes of this study, CHI. St. Luke's Health Brazosport defines its service area as Brazoria County in Texas, which includes the following ZIP codes:[18]

77422 – Brazoria	77430 – Damon	77480 – Sweeny	77486 – West Columbia
77515 – Angleton	77531 – Clute	77534 – Danbury	77541 – Freeport
77566 – Lake Jackson	77577 – Liverpool	77578 – Manvel	77583 – Rosharon

(Zip codes 77431, 77463, 77516, and 77542 are included in the above zip codes)

From 10/1/2015 – 9/30/2016, the Hospital received 92.4% of its patients from this service area.[19]

[17] Responds to IRS Schedule H (Form 990) Part V B 3 a
[18] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[19] IBM Watson Health patient origin data for the hospital; Responds to IRS Schedule H (Form 990) Part V B 3 a

Demographics of the Community[20] [21]

	Brazoria County	Texas	U.S.
2018 Population[22]	**190,935**	**25,531,631**	**326,533,070**
% Increase/Decline	**7.02%**	**7.10%**	**3.50%**
Estimated Population in 2023	**204,341**	**30,558,783**	**337,947,912**
Median Age	**37.0**	**35.0**	**38.2**
Median Household Income	**$70,520**	**$61,912**	**$59,039**
% Population over age 65	**12.96%**	**12.63%**	**15.86%**
% Women of Childbearing Age	**19.10%**	**20.62%**	**19.58%**
% White, non-Hispanic	**49.92%**	**41.84%**	**60.35%**
% Hispanic	**33.04%**	**39.38%**	**18.25%**
Unemployment Rate (December 2017)	**4.60%**	**3.90%**	**4.10%**

2018 Benchmarks
Area: CHI St. Luke's Brazoria - 2018 CHNA
Level of Geography: ZIP Code

Area	2018-2023 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2018-2023	Females 15-44 % of Total Population	Females 15-44 % Change 2018-2023	Median Household Income
USA	**3.50%**	**38.2**	**15.86%**	**17.00%**	**19.58%**	**1.40%**	**$59,039**
Texas	**7.10%**	**35.0**	**12.63%**	**22.70%**	**20.62%**	**4.70%**	**$61,912**
Selected Area	**7.02%**	**37.0**	**12.96%**	**24.80%**	**19.10%**	**5.80%**	**$70,520**

Demographics Expert 2.7
DEMO0003.SQP

[20] Responds to IRS Schedule H (Form 990) Part V B 3 b
[21] The tables below were created by IBM Watson Health
[22] All population information, unless otherwise cited, sourced from IBM Watson Health (formally Truven Health Analytics)

Demographics Expert 2.7
2018 Demographic Snapshot
Area: CHI St. Luke's Health Brazosport - CHNA 2018
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	168,684	308,745,538
2018 Total Population	190,935	326,533,070
2023 Total Population	204,341	337,947,861
% Change 2018 - 2023	7.0%	3.5%
Average Household Income	$91,933	$86,278

	2018	2023	% Change
Total Male Population	98,819	105,336	6.6%
Total Female Population	92,116	99,005	7.5%
Females, Child Bearing Age (15-44)	36,411	38,529	5.8%

POPULATION DISTRIBUTION

Age Distribution

Age Group	2018	% of Total	2023	% of Total	USA 2018 % of Total
0-14	39,325	20.6%	40,077	19.6%	18.7%
15-17	8,470	4.4%	9,106	4.5%	3.9%
18-24	17,895	9.4%	20,042	9.8%	9.7%
25-34	25,464	13.3%	26,655	13.0%	13.4%
35-54	51,248	26.8%	52,859	25.9%	25.5%
55-64	23,780	12.5%	24,721	12.1%	12.9%
65+	24,753	13.0%	30,881	15.1%	15.9%
Total	190,935	100.0%	204,341	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

Income Distribution

2018 Household Income	HH Count	% of Total	USA % of Total
<$15K	6,502	10.0%	10.9%
$15-25K	4,487	6.9%	9.5%
$25-50K	12,769	19.6%	22.1%
$50-75K	10,750	16.5%	17.1%
$75-100K	9,333	14.4%	12.3%
Over $100K	21,150	32.5%	28.2%
Total	64,991	100.0%	100.0%

EDUCATION LEVEL

Education Level Distribution

2018 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	10,260	8.2%	5.6%
Some High School	9,910	7.9%	7.4%
High School Degree	37,395	29.9%	27.6%
Some College/Assoc. Degree	40,266	32.1%	29.1%
Bachelor's Degree or Greater	27,414	21.9%	30.3%
Total	125,245	100.0%	100.0%

RACE/ETHNICITY

Race/Ethnicity Distribution

Race/Ethnicity	2018 Pop	% of Total	USA % of Total
White Non-Hispanic	95,312	49.9%	60.4%
Black Non-Hispanic	23,261	12.2%	12.4%
Hispanic	63,094	33.0%	18.2%
Asian & Pacific Is. Non-Hispanic	5,546	2.9%	5.8%
All Others	3,722	1.9%	3.2%
Total	190,935	100.0%	100.0%

Customer Segmentation[23]

Claritas Prizm uses Census data, sources of demographic and consumer information, and 30 years of annual consumer surveys to classify all U.S. households into 66 demographically and behaviorally distinct groups. These segments represent clusters of at least 250 households that have comparable characteristics and exhibit similar behaviors. The top segments in Brazoria County are:

Claritas Prizm Segments	Characteristics	
Winner's Circle (9.6%)	• Urbanicity: Metro Mix • Income: Wealthy • Household Technology: Above Avg • Income Producing Assets: Elite • Age Ranges: Age 35-54	• Presence of Kids: Mostly w/ Kids • Homeownership: Mostly Owners • Employment Levels: Management and Professional • Education Levels: Graduate Plus
Big Sky Families (8.4%)	• Urbanicity: Rural • Income: Upper Mid-Scale • Household Technology: Average • Income Producing Assets: Above Avg • Age Ranges: Age 35-54	• Presence of Kids: Mostly w/ Kids • Homeownership: Mostly Owners • Employment Levels: Management and Professional • Education Levels: College Graduate
Networked Neighbors (8.2%)	• Urbanicity: Suburban • Income: Wealthy • Household Technology: Highest • Income Producing Assets: Millionaires • Age Ranges: Age 35-54	• Presence of Kids: Mostly w/ Kids • Homeownership: Mostly Owners • Employment Levels: Management and Professional • Education Levels: College Plus
Kid Country, USA (7.4%)	• Urbanicity: Town • Income: Mid-Scale • Household Technology: Average • Income Producing Assets: Low • Age Ranges: Age 25-44	• Presence of Kids: Mostly w/ Kids • Homeownership: Mix • Employment Levels: Service Mix • Education Levels: College Graduate
New Homesteaders (4.5%)	• Urbanicity: Town • Income: Upscale • Household Technology: Above Avg • Income Producing Assets: High • Age Ranges: Age 25-44	• Presence of Kids: Mostly w/ Kids • Homeownership: Mostly Owners • Employment Levels: Management and Professional • Education Levels: College Graduate
Country Strong (4.2%)	• Urbanicity: Rural • Income: Lower Mid-Scale • Household Technology: Below Avg • Income Producing Assets: Below Avg • Age Ranges: Age <55	• Presence of Kids: Family Mix • Homeownership: Mostly Owners • Employment Levels: Blue Collar Mix • Education Levels: High School

[23] IBM Watson Health Household Targeter

Each of the 68 Claritas Prizm segments exhibit prevalence toward specific health behaviors. In the second column of the chart below, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

Where Brazoria County varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered noteworthy. Items in the table with **red text** are viewed as **adverse** findings. Items with **blue text** are viewed as **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	98%	29.8%	Cancer Screen: Skin 2 yr	109.2%	11.7%
Vigorous Exercise	105.2%	60.1%	Cancer Screen: Colorectal 2 yr	101.1%	20.8%
Chronic Diabetes	84.0%	13.2%	Cancer Screen: Pap/Cerv Test 2 yr	111.1%	53.6%
Healthy Eating Habits	97.3%	22.7%	Routine Screen: Prostate 2 yr	96.4%	27.4%
Ate Breakfast Yesterday	100.1%	79.2%	**Orthopedic**		
Slept Less Than 6 Hours	96.5%	13.2%	Chronic Lower Back Pain	96.1%	29.7%
Consumed Alcohol in the Past 30 Days	103.0%	55.3%	Chronic Osteoporosis	88.3%	9.0%
Consumed 3+ Drinks Per Session	94.1%	26.5%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	98.7%	80.2%
Search for Pricing Info	106.3%	28.6%	NP/PA Last 6 Months	111.3%	46.2%
I am Responsible for My Health	97.9%	88.5%	OB/Gyn 1+ Visit	110.8%	42.5%
I Follow Treatment Recommendations	100.3%	77.2%	Medication: Received Prescription	102.0%	61.8%
Pulmonary			**Internet Usage**		
Chronic COPD	78.7%	4.2%	Use Internet to Look for Provider Info	106.2%	42.4%
Chronic Asthma	86.8%	10.2%	Facebook Opinions	100.9%	10.2%
Heart			Looked for Provider Rating	122.4%	28.8%
Chronic High Cholesterol	92.4%	22.6%	**Emergency Services**		
Routine Cholesterol Screening	98.9%	43.8%	Emergency Room Use	95.5%	33.1%
Chronic Heart Failure	85.7%	3.5%	Urgent Care Use	105.5%	34.8%

Leading Causes of Death[24]

The Leading Causes of Death are determined by official Centers for Disease Control and Prevention (CDC) final death total. Texas's Top 15 Leading Causes of Death are listed in the table below in Brazoria county's rank order. Brazoria county was compared to all other Texas counties, Texas state average, and whether the death rate was higher, lower or as expected compared to the U.S. average.

Cause of Death			Rank among all counties in TX (#1 rank = worst in state)	Rate of Death per 100,000		Observation (Compared to U.S.)
TX Rank	Brazoria Rank	Condition		TX	Brazoria	
19	1	Heart Disease	155 of 247	167.7	207.5	Higher than expected
39	2	Cancer	110 of 247	148.5	183.4	Higher than expected
31	3	Lung	127 of 247	39.5	49.7	Higher than expected
9	4	Stroke	156 of 247	42.0	47.2	Higher than expected
46	5	Accidents	206 of 247	38.6	40.7	Lower than expected
10	6	Alzheimer's	55 of 247	37.8	34.6	Higher than expected
29	7	Diabetes	193 of 247	20.3	21.2	As expected
14	8	Kidney	81 of 247	15.8	17.0	Higher than expected
6	9	Blood Poisoning	56 of 247	16.1	15.9	Higher than expected
40	10	Flu - Pneumonia	211 of 246	11.1	14.5	As expected
40	11	Suicide	163 of 247	12.6	12.5	Lower than expected
7	12	Liver	128 of 246	13.5	12.2	Higher than expected
23	13	Hypertension	83 of 245	8.0	8.4	As expected
11	14	Parkinson's	75 of 243	8.9	7.2	As expected
25	15	Homicide	148 of 234	6.0	3.8	Lower than expected

[24] www.worldlifeexpectancy.com/usa-health-rankings

Priority Populations[25]

Information about Priority Populations in the service area of the Hospital is difficult to encounter if it exists. The Hospital's approach is to understand the general trends of issues impacting Priority Populations and to interact with the Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

Begin by analyzing the National Healthcare Quality and Disparities Reports (QDR), which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of the Hospital's health system and to identify areas of strengths and weaknesses in the healthcare system along three main axes: **access to healthcare**, **quality of healthcare**, and **priorities of the National Quality Strategy** (NQS). The complete report is provided in Appendix C.

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[26]

- Low income residents
- People with major co-morbidity and complications
- Racial and ethnic minority groups
- Access to care for these populations was expressed

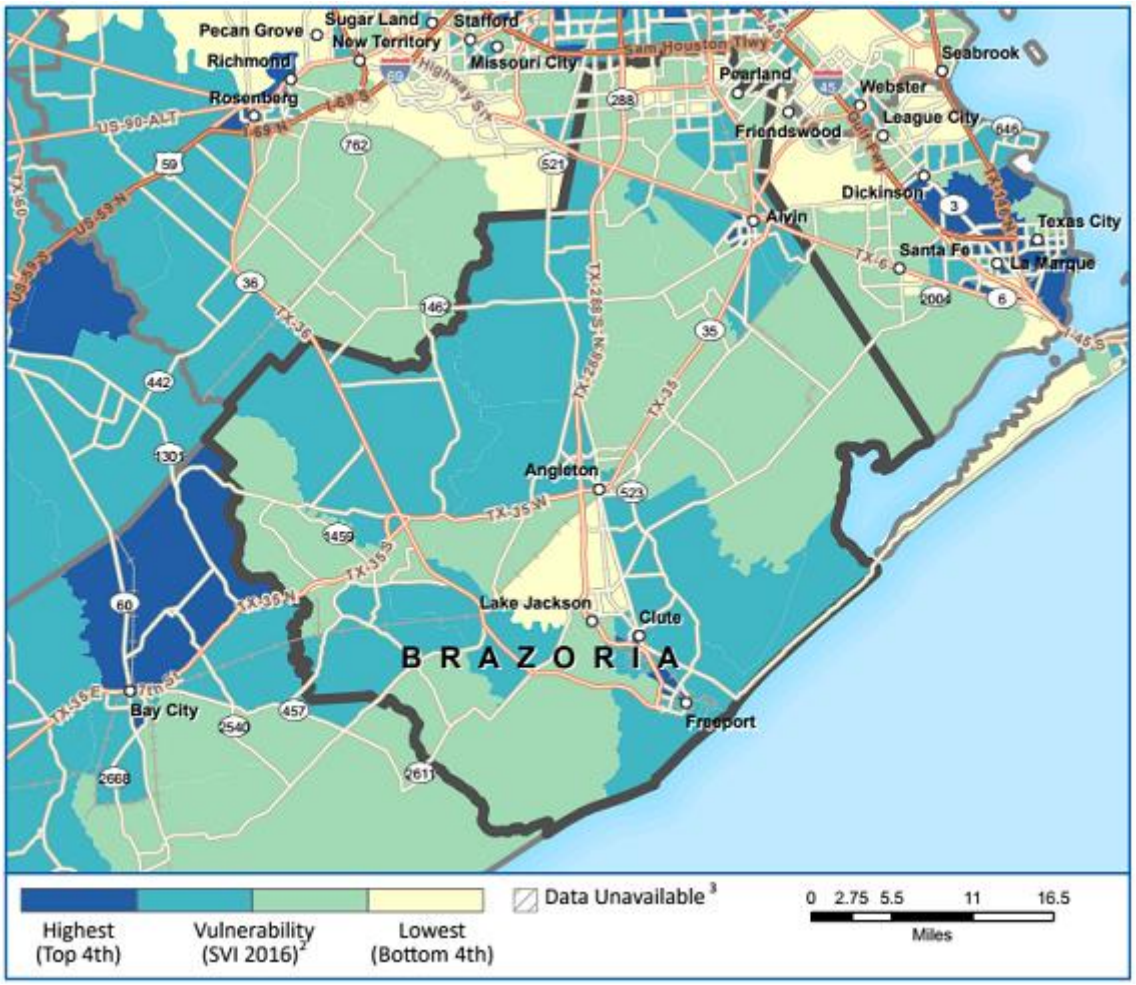
[25] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i
[26] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability[27]

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, such as natural or human-caused disasters, or disease outbreaks.

Overall, regions of Brazoria County fall into all four quartiles:

- The majority if the county fall into the second lowest quartile (light green) and second highest quartile (light blue).
- A region in the center of the county is in the lowest quartile, making that area's vulnerability very low.



[27] http://svi.cdc.gov

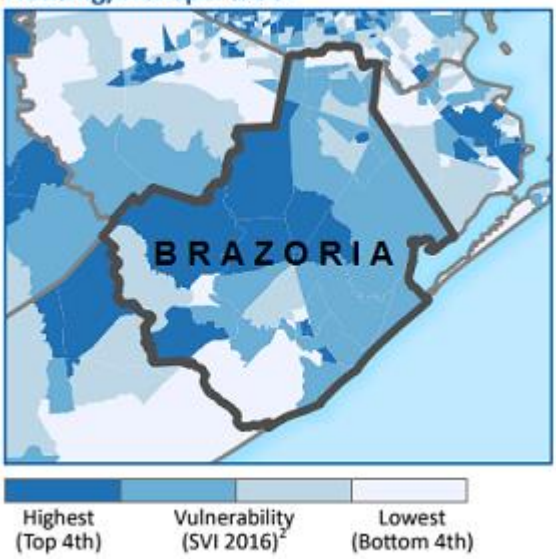
SVI Themes

Socioeconomic Status

Household Composition/Disability

Race/Ethnicity/Language

Housing/Transportation



Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 22 individuals provided feedback on the 2015 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	7	9	16
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	6	8	14
3) **Priority Populations**	7	8	15
4) Representative/Member of **Chronic Disease Group** or Organization	2	11	13
5) Represents the **Broad Interest of the Community**	18	2	20
Other			
Answered Question			22
Skipped Question			0

Priorities from the last assessment where the Hospital intended to seek improvement:

- Low-income groups
- People with major co-morbidity and complications
- Racial and ethnic minority groups

St. Luke's Brazosport received the following responses to the question: **"Should the hospital continue to consider the 2015 Significant Health Needs as the most important health needs currently confronting residents in the county?**

	Yes	No	Response Count
Doctor Availability/Access/Awareness and Wait Time	21	0	21
Emergency	12	7	19
Access/Cost	18	3	21
Prevention	20	0	20
Cancer	17	2	19

St. Luke's Brazosport received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?"**

	Yes	No	Response Count
Doctor Availability/Access/Awareness and Wait Time	21	0	21
Emergency	11	7	18
Access/Cost	18	2	20
Prevention	19	0	19
Cancer	17	2	19

Comparison to Other State Counties[28]

To better understand the community, Brazoria County has been compared to all 242 counties in the state of Texas across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

In the chart below, the county's rank compared to all counties is listed along with any measures in each area that are ***worse than*** the state average and U.S. Best (90th percentile).

	Brazoria County	Texas	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	22/242		
Health Behaviors			
Overall Rank *(best being #1)*	49/242		
Adult Obesity	31%	28%	26%
Access to Exercise Opportunities	79%	81%	91%
Alcohol-impaired Driving Deaths	34%	28%	13%
Clinical Care			
Overall Rank *(best being #1)*	40/242		
Population to Dentist	1,910:1	1,790:1	1,280:1
Population to Mental Health Provider	1,770:1	1,010:1	330:1
Preventable Hospital Stays	63	53	35
Diabetes Monitoring	83%	84%	91%
Mammography Screening	54%	58%	71%
Social & Economic Factors			
Overall Rank *(best being #1)*	28/242		
Unemployment	5.2%	4.6%	3.2%
Social Associations	7.0	7.6	22.1
Physical Environment			

[28] www.countyhealthrankings.org

	Brazoria County	Texas	U.S. Best
Overall Rank *(best being #1)*	240/242		
Air Pollution (PM2.5 concentration)	11.2 µg/m^3	8.0 µg/m^3	6.7 µg/m^3
Driving alone to work	87%	80%	72%
Long commute – driving alone	48%	37%	15%

Per 100,000

Comparison to Peer Counties[29]

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile).

In the below chart, Brazoria County is compared to its peer counties and the U.S. average, but only areas where the county is Better or Worse are listed. (The list and number of peer counties used in each ranking may differ.)

	Brazoria County	Peer Ranking	U.S. Best
BETTER			
Health Outcomes			
Premature death	6,400	3 of 23	5,300
Health Behaviors			
Adult smoking	14%	3 of 21	14%
Physical inactivity	23%	2 of 22	20%
Access to exercise opportunities	79%	5 of 23	91%
Clinical Care			
Population to primary care provider ratio	1,530:1	3 of 24	1,030:1
Population to dentist ratio	1,910:1	2 of 24	1,280:1
Social and Economic Factors			
Some college	66%	2 of 24	72%
Children in poverty	13%	1 of 20	12%
Children in single-parent households	25%	4 of 22	20%
Injury deaths	52	3 of 24	55
WORSE			
Health Behaviors			
Alcohol-impaired driving deaths	34%	21 of 24	13%
Teen births *(per 1,000 population ages 15-19)*	36	16 of 21	15
Clinical Care			
Diabetes monitoring	83%	19 of 23	91%
Mammography screening	54%	19 of 23	71%
Social and Economic Factors			
Unemployment	5.2%	19 of 24	3.2%
Social associations	7.0	20 of 24	22.1
Physical Environment			
Air pollution - particulate matter	11.2	23 of 24	6.7
Severe housing problems	15%	17 of 20	9%
Driving alone to work	87%	22 of 23	72%

[29] www.cdc.gov/communityhealth

Conclusions from Demographic Analysis Compared to National Averages

The following areas were identified from a comparison of the county to national averages. **Adverse** metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- None

Beneficial metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- 5.2% more likely to **Vigorously Exercise**, affecting 60.1%
- 11.1% more likely to receive **Cervical Cancer Screening every 2 years**, affecting 53.6%
- 10.8% more likely to **Visit OB/Gyn Annually**, affecting 42.5%
- 11.3% more likely to **Visit NP/PA Last 6 Months**, affecting 46.2%

Conclusions from Other Statistical Data[30]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Brazoria County statistics to the U.S. average, and lists the change since the last date of measurement.

	Current Date of Data	Statistic	Change	Last Date of Data
Brazoria County measures that are **WORSE** than the U.S. average and **GOT WORSE**				
Male Diabetes, Urogenital, Blood, Endocrine Disease Deaths	2014	64.0* cases	9.4%	1980
Female Liver Disease Deaths	2014	15.6* cases	33.9%	1980
Male Liver Disease Deaths	2014	30.2* cases	29.4%	1980
Male Obesity	2011	33.9%	11.5%	2001
Brazoria County measures that are **WORSE** than the U.S. average but **IMPROVED**				
Female Heart Disease	2014	145.6* cases	-41.0%	1980
Male Heart Disease	2014	202.9* cases	-55.1%	1980
Female Stroke	2014	54.2* cases	-37.6%	1980
Male Stroke	2014	50.1* cases	-44.6%	1980
Female Tracheal, Bronchus, and Lung Cancer	2014	47.6* cases	-2.1%	1980
Male Tracheal, Bronchus, and Lung Cancer	2014	69.1* cases	-53.5%	1980
Female Breast Cancer	2014	27.9* cases	-12.5%	1980
Female Diabetes, Urogenital, Blood, Endocrine Disease Deaths	2014	51.3* cases	-11.0%	1980
Female Transport Injury Deaths	2014	10.8* cases	-44.8%	1980
Male Transport Injury Deaths	2014	23.3* cases	-55.0%	1980
Brazoria County measures that are **BETTER** than the U.S. average but **GOT WORSE**				

[30] http://www.healthdata.org/us-county-profiles

	Current Date of Data	Statistic	Change	Last Date of Data
Female Mental and Substance Use Disorder Deaths	2014	7.6* cases	399.2%	1980
Male Mental and Substance Use Disorder Deaths	2014	11.1* cases	236.6%	1980
Female Heavy Drinking	2012	5.4%	43.6%	2005
Male Heavy Drinking	2012	9.1%	9.9%	2005
Female Obesity	2011	35.9%	20.0%	2001
Brazoria County measures that are **BETTER** than the US average and **IMPROVED**				
Female Malignant Skin Melanoma	2014	1.6* cases	-29.3%	1980
Male Malignant Skin Melanoma	2014	3.4* cases	-19.1%	1980
Female Life Expectancy	2014	80.2 years	4.1%	1980
Male Life Expectancy	2014	76.1 years	8.8%	1980
Male Breast Cancer	2014	0.3* cases	-17.7%	1980
Female Self-Harm/Interpersonal Violence Deaths	2014	7.7* cases	-37.4%	1980
Male Self-Harm/Interpersonal Violence Deaths	2014	29.2* cases	-29.0%	1980
Female Binge Drinking	2012	9.4%	-11.5%	2002
Male Binge Drinking	2012	23.4%	-8.4%	2002
Female Smoking	2012	14.2%	-33.8%	1996
Male Smoking	2012	22.1%	-22.4%	1996

Other Needs Identified During CHNA Process

1. **Behavioral/Mental Health (emotional, psychological, and social well-being)**
2. **Suicide**
3. **Cancer**
4. **Prevention**
5. **Obesity**
6. **Heart Disease**

Other Needs Identified During CHNA Process

7. **Doctor Availability, Access/Awareness and Wait Time – 2015 Significant Need**
8. **Substance Use/Abuse**
9. **Diabetes**
10. **Emergency – 2015 Significant Need**
11. **Alzheimer's**
12. **Alcohol Use**
13. **Stroke**
14. **Kidney Disease**
15. **Women's Health**
16. **Lung Disease**
17. **Accidents**
18. **Flu/Pneumonia**
19. **Tobacco Use**
20. **Liver Disease**

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Round 1)

Hospital solicited written comments about its 2015 CHNA.[31] 22 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.**

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	7	9	16
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	6	8	14
3) **Priority Populations**	7	8	15
4) Representative/Member of **Chronic Disease Group** or Organization	2	11	13
5) Represents the **Broad Interest of the Community**	18	2	20
Other			
Answered Question			22
Skipped Question			0

Congress defines "Priority Populations" to include:

- **Racial and ethnic minority groups**
- **Low-income groups**
- **Women**
- **Children**
- **Older Adults**
- **Residents of rural areas**
- **Individuals with special needs including those with disabilities, in need of chronic care, or in need of end-of-life care**
- **Lesbian Gay Bisexual Transsexual (LGBT)**
- **People with major comorbidity and complications**

2. **Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed?**

- *Access to healthcare (including immunizations), access to public transportation; access to information that helps prevent obesity and other chronic illnesses (DM, HTN, etc.); and access to mental health care!!!*
- *Homeless with/without children hospice or LTAC near by*
- *Psychiatric needs; readmissions; problems getting medications/noncompliance*
- *There is a severe need in our area for additional mental health support. While we do have a good number of*

[31] Responds to IRS Schedule H (Form 990) Part V B 5

reputable therapists, when someone is needing hospitalization due to a mental health condition, there are no resources in our immediate area.

- *Access to medical specialists to treat complications resulting from poor control of their chronic conditions.*
- *Specifically, we need more specialist able to treat older adults. And those with multiple issues.*
- *Patient overall satisfaction of services provided. Increase in drug overdoses among adolescents needs to be addressed. Teen pregnancy rate and teen suicides in Brazoria county doubled in 2017.*
- *Limited available health care available for individuals without health insurance or disability. Many members of population with major chronic health disease that could be managed better. Availability of psychiatric care is also a concern.*
- *Behavioral Health*
- *There is a large Hispanic population and they are generally low to moderate income.*
- *Transportation to Medical Care*
- *Transportation to health care providers, assistance in home for custodial care, assistance with prescription drug costs, access to specialist care locally.*
- *Access…it is more difficult for low income and rural residents to access primary care.*

In the 2015 CHNA, there were five health needs identified as "significant" or most important:

1. **Doctor Availability/Access/Awareness and Wait Time**
2. **Emergency**
3. **Access/Cost**
4. **Prevention**
5. **Cancer**

3. Should the hospital continue to consider the 2015 Significant Health Needs the most important health needs currently confronting residents in the county?

	Yes	No	Response Count
Doctor Availability/Access/Awareness and Wait Time	21	0	21
Emergency	12	7	19
Access/Cost	18	3	21
Prevention	20	0	20
Cancer	17	2	19

Comments:

- *Need to recruit more mental health staff to the area (Psychiatrist, trained counselors, etc.)*
- *Lack of access to medical specialists including but not limited to the following: Endocrinology, Urology, Psychiatry, Otolaryngology, Rheumatology & Dermatology.*
- *Wider range of doctors to treat more specialized cases*

- *Patient overall satisfaction of services provided. Increase in drug overdoses among adolescents needs to be addressed. Teen pregnancy rate and teen suicides in Brazoria county doubled in 2017.*
- *Psychiatric care/Suicide awareness and prevention*
- *Recruitment of specialty physicians, Urology, Cardiology and GI*
- *Primary and specialist care access remains a problem.*
- *Health complications*

4. Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?

	Yes	No	Response Count
Doctor Availability/Access/Awareness and Wait Time	21	0	21
Emergency	11	7	18
Access/Cost	18	2	20
Prevention	19	0	19
Cancer	17	2	19

Comments:

- *Improve access to mental health care*
- *With the addition of the new emergency center at CHI St. Luke's Brazosport, more patients are able to be seen in a timely manner, the left without being seen has decreased, and patients per day has increased.*
- *A large number of the uninsured indigent population in our area is currently being treated by volunteer physicians and nurse practitioners, almost all of them associated with CHI Brazosport. The goal is to keep these people working and out of the emergency department. This has been an ongoing endeavor for the last 10 years. I am not certain this is a sustainable model - I certainly hope so, but there are many challenges.*
- *Patient overall satisfaction of services provided. Increase in drug overdoses among adolescents needs to be addressed. Teen pregnancy rate and teen suicides in Brazoria county doubled in 2017.*

5. Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.

- *Recruit mental health staff!!*
- *Psychiatric needs*
- *In addition to the categories above, something needs to be done to help with the mental health crisis our community is facing. With Brazoria County having one of the highest suicide rates in the state, additional resources are definitely needed.*
- *Assuring that medical records such as test images given to the patient on DVD aren't damaged or blank.*
- *I have recently experienced a situation where a family member had to be transferred to Houston because the local specialist was unwilling to treat the patient due to age (81) We need specialists that are trained and able to take care of our elderly and not just refer to Houston.*

- *Patient overall satisfaction of services provided. Increase in drug overdoses. Teen pregnancy rate and teen suicides in Brazoria county.*
- *Transportation in the community, behavioral health population, suicide awareness*
- *Mental health resources*
- *Is there any way to find out how many low-income families do not have access to affordable health care to see if this is still a large need?*
- *There is a great need for psychiatric resources in the county. It is very difficult to find a psychiatrist, and most often these physicians are in Houston. We need more resources and access for people with mental health challenges.*
- *Psych and drug abuse…we are very limited in terms of resources. The ED is where these patients seek care in a crisis, when it is often too late.*
- *Mental health*

6. **Please share comments or observations about keeping <u>Doctor Availability/Access/Awareness and Wait Time</u> among the most significant needs for the Hospital to address.**

- *More scale for the uninsured*
- *I have seen some improvement in the wait time at the Doctor's office. There is still a need for doctors specializing in certain fields.*
- *The need for local access to specialty medical care is critical. Our population is aging, and many are finding it necessary to travel to Angleton (UTMB) or Pearland for care by specialists. They would certainly prefer to receive all of their medical care close to home. These older patients are seeking care by specialists who are physicians, not physician extenders.*
- *Why are so many of our local doctors not given hospital access. Only staff doctors seeing patients.*
- *I believe we still need more physicians in our community – family medicine and specialists*
- *There have been great improvements made on this front, the next steps would be access to specialty physicians such as GI, urology, cardiology and ENT*
- *It seems to me that making citizens aware of services/doctors available to them is a great need.*
- *The opening of three primary care clinics has improved access, however, same day access for sick visits remain a problem. Recommend scheduling solutions to improve same day access.*
- *Some specialties are difficult to access. Urology, ENT,*
- *The hospital needs to continue to monitor this situation. Several local physicians are near retirement age.*
- *Especially in emergencies to avoid premature death*
- *Consistent access to primary when preventative care would decrease non-emergent use of the ED and avoidable hospitalizations*
- *Access to primary care providers in a timely manner could continue to help the allocation of resources for*

patients and the hospital.

7. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Doctor Availability/Access/Awareness and Wait Time</u>.**

- *All are valid*
- *Continue to address the needs of patients with Diabetes and refer to partners who offer education and support.*
- *I think the hospital has done an excellent job in this area.*
- *CHI Brazosport has been successful in attracting several much-needed family practice physicians. Unfortunately, the community is not aware of these additional practitioners. As the hospital staff has increased their interactions with the community through senior events, etc., perhaps it would be helpful to mention the many new practitioners who are now serving our community. Something as simple as a large video loop with physicians faces, names & specialty for viewing by the attendees.*
- *I'm not aware of specific actions*
- *Goals achieved*
- *The hospital did accomplish the actions mentioned above.*
- *We have decreased our LWBS to less than 2%. Implemented Teletracking to improve patient flow. Changed staffing models to match flow of volume in the ED to improve wait times*
- *I can see and appreciate the efforts to increase the number of physicians serving our community.*
- *The hospital actions have greatly improved access to primary care, but as the area grows, wait time for sick visits or new patients is still an issue.*
- *Recruited Primary Care*
- *It has been difficult to recruit to this area--physicians tend to be attracted to larger urban communities.*
- *Not aware of any actions*
- *Increased providers in the clinics*

8. **Please share comments or observations about keeping <u>Emergency</u> among the most significant needs for the Hospital to address.**

- *The new emergency center is a vast improvement. Wait time is down significantly and more beds are available.*
- *My experience both personal and observed is that wait times are still long. As well as it seems that stay in the ER is long, 6-8 hours and more.*
- *The new ED is open and very busy. Accomplished.*
- *90% of our admissions come through the ED and we see over 100 patients per day. Access to care must continually be evaluated as well as flow through the ED.*
- *Patients continue to use the ED instead of primary care.*
- *The new ER has been helpful in providing the capacity to see additional patients.*

- *Brazosport is the safety net hospital for the community*

9. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Emergency</u>.**
    - *The new Emergency center is just what the community needed. I have had the opportunity to use the ER as well as my husband and Mother. Was treated very well, everyone was very professional with hardly any wait time at all. Great Job!!*
    - *Enlarging the emergency department, both the space and the number of staff, has been a huge public opinion WIN for the hospital. Change seems to be greeted with initial skepticism until it's no longer new. The imminent move of the Urgent Care to a more visible location is another huge step in the right direction for the hospital and the community it serves.*
    - *The facility has been updated and seems to be first class.*
    - *This concern has been addressed.*
    - *Last year our organization built a new ED with 28 beds which has allowed us to serve our community and provide better access to our emergency physicians.*
    - *Y'all got this one down!*
    - *The new emergency room has greatly improved patient flow and care. It also seems that the area has expanded in population and use of the emergency department.*
    - *Actions appear to have been effective.*
10. **Please share comments or observations about keeping <u>Access/Cost</u> among the most significant needs for the Hospital to address.**
    - *This is certainly important, and I think the hospital has taken measures to address this issue.*
    - *Continued improvement needed*
    - *Still need additional physicians. Still limited options for people without health insurance.*
    - *There is a significant population of low income individuals and families in southern Brazoria county. Access to quality healthcare that they can afford is a must.*
    - *Uninsured patients are an issue for cost. The out of pocket for PCP visit is prohibitive.*
    - *Still difficult to be seen timely or some key specialties*
    - *Lower income people tend to have higher health problems*
    - *Though Lake Jackson has a significant number of citizens who are financially sound, there is a large population of under and uninsured*
11. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Access/Cost</u>.**
    - *Again, the hospital, I think, has done what it could to address the rising cost.*
    - *Continued improvement needed*

- *Did expand the clinics and provides*
- *We have become part of the CHI St. Luke's Health System which gives us the ability to transfer to sister hospitals within the Division including BSLMC- so we have increased our access to care and resources*
- *I'm not sure what "financial assistance" looks like, but I appreciate the efforts to treat people regardless of their ability to pay right away. It does seem though that some patients may not be able to pay much, if anything.*
- *We do provide charity care, but there continues to be a great need for uninsured and under-insured people.*
- *Renegotiated Contracts Reduced staff to control cost*
- *Limited improvement*

12. Please share comments or observations about keeping <u>Prevention</u> among the most significant needs for the Hospital to address.

- *This is certainly important, and I think the hospital has taken measures to address this issue.*
- *I think prevention is extremely important. It would be great if certain tests could be incorporated into the routine physical, thus preventing many diseases before they become an emergency. For example, heart scans. If these were given every 2 - 3 years, most heart attacks could be prevented or treated way before it becomes serious. Insurance should pay for these types of tests because it would save them a considerable amount of money in the long run and at the same time, prevent an untimely death.*
- *Continued improvement needed*
- *Focused diabetic education and management*
- *Readmissions is a focus point for our organization with primary focus on Health Failure Readmissions. It causes us to score low on VBP is the OE ratio is more than expected. We need HF education and follow up and understanding. Our community needs more clarity of the prevention of readmission and management of Heart Failure.*
- *I think prevention and education will always be priorities, so that we can hopefully prevent and delay major health concerns/comorbidities.*
- *I honestly do not know what is being done. One of my biggest concerns is the obesity epidemic among our children. Are there holistic initiatives with the schools and parents that are addressing this problem?*
- *Diabetes and heart disease continue to be widespread in the community.*
- *Flu clinics every year.*
- *It would almost be impossible to direct too many resources to prevention. Needs to start in grade school.*
- *I firmly believe the hospital model should maintain a balance between the curative and preventative models*

13. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Prevention</u>.

- *I think more awareness, to the public, should be given on the many programs that they can take advantage of at the hospital.*

- *I have noticed more public education classes offered by the hospital*
- *This was accomplished through the hospital program and now with Health South Texas*
- *Partnered with Health South Texas for Diabetes education*
- *Screenings and support groups are great ideas; however, I'm curious about how many people actually participate in such events/groups. How are we drawing people in? Are we incentivizing participation?*
- *We could do more through primary care and outreach to address prevention.*
- *Better access with clinics*
- *Recruited primary care*

14. Please share comments or observations about keeping <u>Cancer</u> among the most significant needs for the Hospital to address.

- *Even though many new treatments have improved for the various types of cancer, this horrible disease is still prevalent and everything that can be done should be done to hopefully eradicate this disease.*
- *Still need to increase awareness of local care that is available.*
- *Our cancer center has huge opportunity for growth*
- *I haven't lived in this area for long, so my observation may be off, but it seems like cancer is very prevalent in this part of the world.*
- *Cancer awareness/screenings are needed*
- *Cancer screening and care are paramount to health communities*

15. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Cancer</u>.

- *I think the purchase of a new scanner will be very beneficial to so many of our citizens will not have to go to Houston.*
- *Most people that I hear of with cancer end up in Houston or give up on trying to defeat it. Seems that it would be beneficial to tell about local capabilities and options.*
- *The screenings and support groups were accomplished*
- *Are there any other types of cancer screenings we could offer at no cost?*
- *I am excited about the free screening services. Are there any partnership efforts with the local VA center?*
- *Too few resources devoted to awareness and screening activities.*
- *Own cancer center with medical and radiation oncologists*

16. Finally, after thinking about our questions and the information we seek, is there anything else you think is important as we review and revise our thinking about significant health needs in the county?

- *It would be important to involve as many community partners as possible (i.e. nursing homes, assisted living facilities, urgent cares, school districts, pharmacies, CONNECT transit, etc.) in this assessment to get a good*

picture of the needs.

- *I think the hospital is doing everything it can to serve the Brazosport and beyond community.*
- *Keeping community outreach as a significant focus might be important in engendering goodwill in our small community.*
- *MENTAL HEALTH! Drug abuse.*
- *We, as a community, have failed to address the current epidemic that is facing our children/teenagers in Brazoria county and the number of deaths/ incidents have doubled. I realize that we are not "Pediatric Only" facility, but that should not keep us from meeting the needs of that population. I would love to see our community partners work along beside us as a collaboration and establish an education program addressing children/teen issues of 2018.*
- *Psych care and suicide prevention*
- *Suicide awareness and prevention should be a priority as well as access to for behavioral health populations.*
- *We have a major crisis with childhood obesity. I know this is a huge systematic family and low-income issues but if nothing changes healthcare cost and quality of life standards will be dramatically impacted. Are there many models in the US that we can learn from?*
- *Transportation is a significant problem. Public transportation doesn't serve our rural areas well, and there is often delay in transportation, resulting in missed visits.*
- *Psych and drug use issues seem to be increasing.*
- *Still need to address better access to mental health care*

Appendix B – Identification & Prioritization of Community Needs (Round 2)

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Behavioral/Mental Health (emotional, psychological, and social well-b	390	14	24.38%	24.38%	Significant Needs
Suicide	152	11	9.50%	33.88%	
Cancer - 2015 Significant Need	147	12	9.19%	43.06%	
Prevention - 2015 Significant Need	110	12	6.88%	49.94%	
Obesity	95	9	5.94%	55.88%	
Heart Disease	91	9	5.69%	61.56%	
Doctor Availability, Access/Awareness and Wait Time – 2015 Significar	90	9	5.63%	67.19%	Other Identified Needs
Substance Use/Abuse	89	9	5.56%	72.75%	
Access/Cost - 2015 Significant Need	65	8	4.06%	76.81%	
Diabetes	58	8	3.63%	80.44%	
Emergency – 2015 Significant Need	50	7	3.13%	83.56%	
Alzheimer's	48	7	3.00%	86.56%	
Alcohol Use	46	7	2.88%	89.44%	
Stroke	36	5	2.25%	91.69%	
Kidney Disease	23	5	1.44%	93.13%	
Women's Health	20	5	1.25%	94.38%	
Lung Disease	17	4	1.06%	95.44%	
Accidents	15	4	0.94%	96.38%	
Flu/Pneumonia	15	4	0.94%	97.31%	
Tobacco Use	15	5	0.94%	98.25%	
Senior Adult Care	15	1	0.94%	99.19%	
Liver Disease	13	4	0.81%	100.00%	
Total	1600		100.00%		

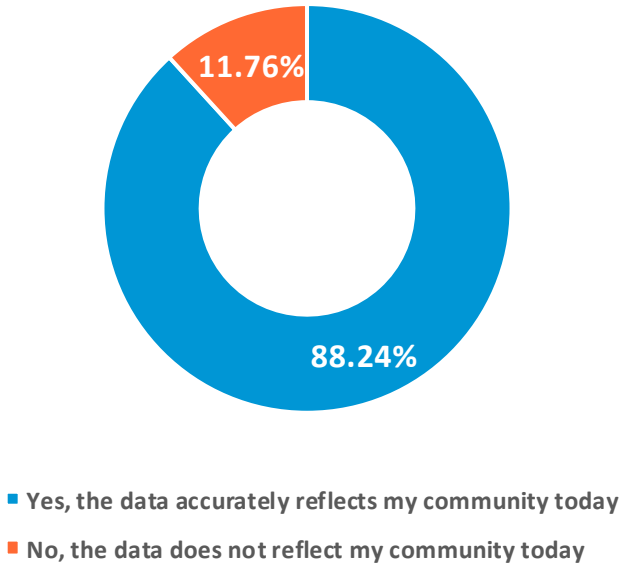
Individuals Participating as Local Expert Advisors[32]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	5	5	10
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	9	3	12
3) **Priority Populations**	4	6	10
4) Representative/Member of **Chronic Disease Group** or Organization	1	7	8
5) Represents the **Broad Interest of the Community**	10	2	12
Other			
Answered Question			16
Skipped Question			0

[32] Responds to IRS Schedule H (Form 990) Part V B 3 g

Advice Received from Local Expert Advisors

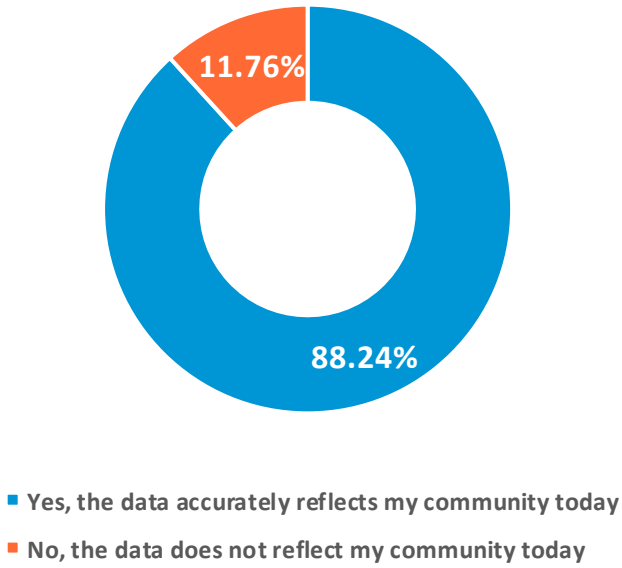
Question: Do you agree with the comparison of Brazoria County to all other Texas counties?



Comments:

- *We have numerous exercise facilities in our area available for the public. The unemployment rate is down to 4.6. Last June is was 5.9 - Social Associations: there are many civic, religious, etc. organizations. I do not agree with the Air Pollution. Don't understand driving alone?*
- *As far as I know, this data could be correct. Not sure about the unemployment rate. Also, transportation within the county and access to mental health services are a VERY big concern!!!*
- *I don't know what "social associations" mean.*
- *I am not that familiar with the data, but it does sound reasonable to me*

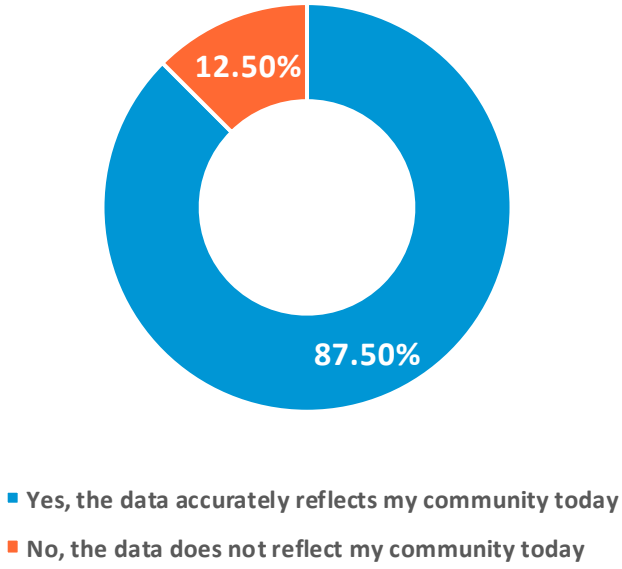
Question: Do you agree with the comparison of Brazoria County to its peer counties?



Comments:

- *Air Pollution. Driving alone to work? Unemployment is 4.6*
- *As far as I know, this data could be correct. I have received reports about a very large number of students in schools being HOMELESS!!! Not sure that is reflected in "children in poverty"?*
- *How is the Physical Inactivity determined?*
- *Reasonable*

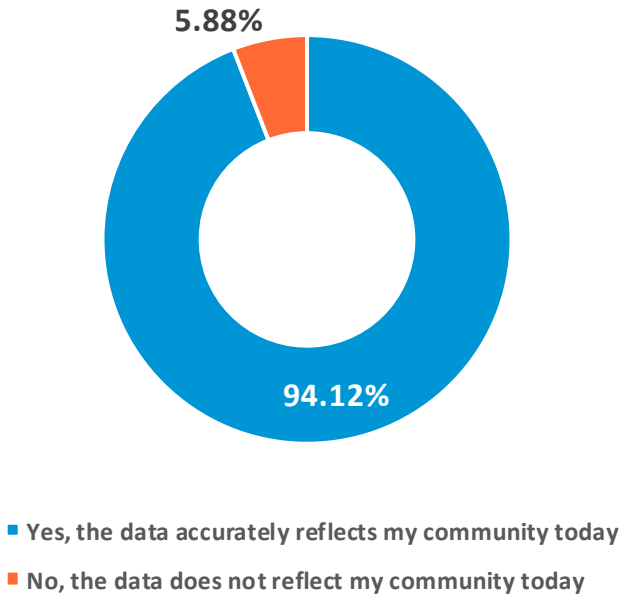
Question: Do you agree with the demographics and common health behaviors of Brazoria County?



Comments:

- *Median household income seems high.*
- *question the unemployment rate*
- *I question the populations over 65 number.*
- *I wonder if the income data is skewed high because of Pearland being in Brazoria County. My sense is that incomes in Southern Brazoria county are lower.*

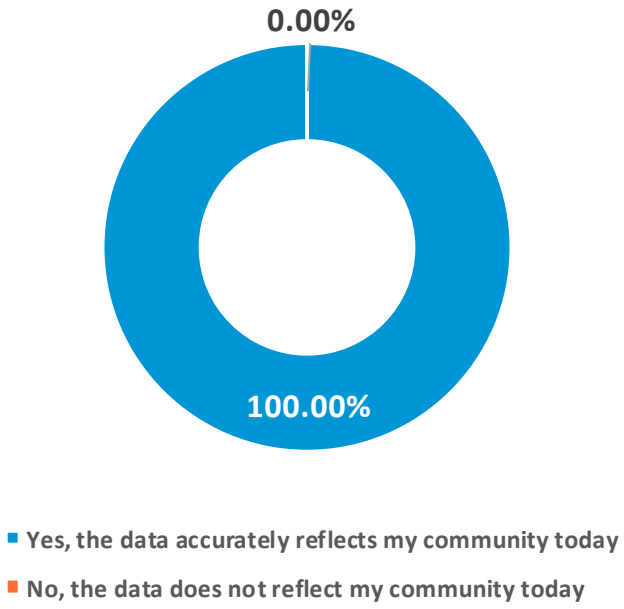
Question: Do you agree with the overall social vulnerability index for Brazoria County?



Comments:

- *I think the housing and transportation data may not accurately reflect our community.*
- *there is no way for me to accurately answer this. I have little information or awareness of some of these categories.*

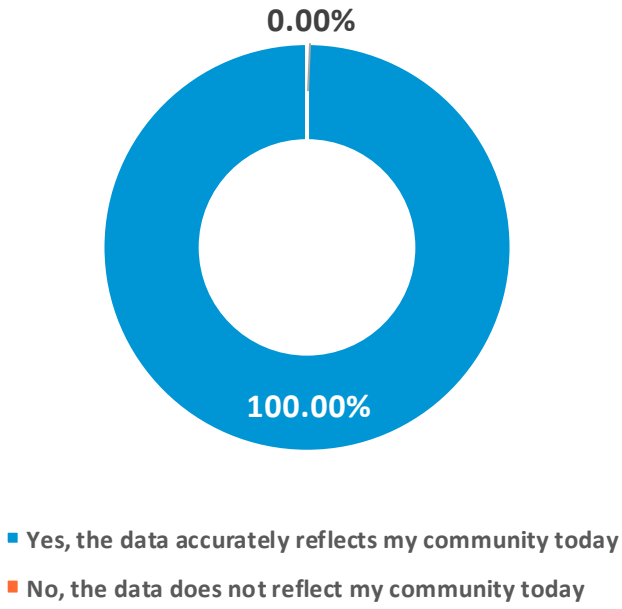
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *Not sure. Numbers very high.*

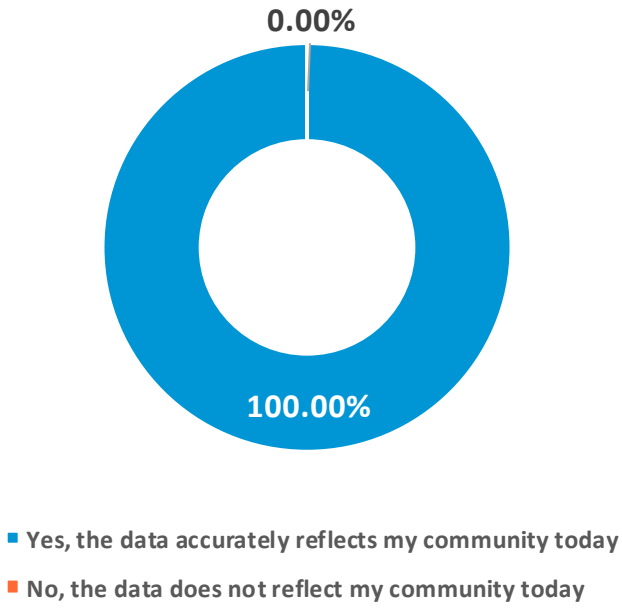
Question: Do you agree with the health trends in Brazoria County?



Comments:

- *May be correct; what about male obesity as well? What about STD rates and TB rates?*
- *What qualifies as a mental and substance use disorder death?*

Question: Do you agree with the written comments received on the 2015 CHNA?



Comments:

- *Agree with some observations, though there are resources available through local mental health authority, thus more efforts are needed to educate community as to how to access available.*
- *Most of them*
- *We have a crisis of obesity and overweight that is increasing the likelihood of diabetes and liver problems. both of these were recognized as being on the increase in our county.*
- *Yes!! Mental Health needs to be top priority.*

Appendix C – National Healthcare Quality and Disparities Report[33]

The National Healthcare Quality and Disparities Reports (QDR) (annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Beginning with this 2014 report, findings on healthcare quality and healthcare disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report (QDR) highlights the importance of examining quality and disparities together to gain a complete picture of healthcare. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The key findings of the 2014 QDR are organized around three axes: **access to healthcare**, **quality of healthcare**, and **NQS priorities**.

To obtain high-quality care, Americans must first gain entry into the healthcare system. Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location.

ACCESS: After years without improvement, the rate of un-insurance among adults ages 18-64 decreased substantially during the first half of 2014.

The Affordable Care Act is the most far-reaching effort to improve access to care since the enactment of Medicare and Medicaid in 1965. Provisions to increase health insurance options for young adults, early retirees, and Americans with pre-existing conditions were implemented in 2010. Open enrollment in health insurance marketplaces began in October 2013 and coverage began in January 2014. Expanded access to Medicaid in many states began in January 2014, although a few had opted to expand Medicaid earlier.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[34] consistent with these trends.

[33] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i

[34] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.

ACCESS: Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.

Trends

- From 2002 to 2012, the percentage of people who were able to get care and appointments as soon as wanted improved for children but did not improve for adults ages 18-64.

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18-64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

ACCESS DISPARITIES: During the first half of 2014, declines in rates of un-insurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[35]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[36]

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities, followed by Hispanics and Blacks.

Disparities

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).

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[35] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

[36] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

ACCESS DISPARITIES: Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- I n four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

QUALITY: Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).
- Almost all measures of Person-Centered Care improved.
- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.
- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

QUALITY: Through 2012, the pace of improvement varied across NQS priorities.

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities:
  - Median change in quality was 3.6% per year among measures of Patient Safety.
  - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
  - Median improvement in quality was 1.7% per year among measures of Effective Treatment.
  - Median improvement in quality was 1.1% per year among measures of Healthy Living.
  - There were insufficient data to assess Care Coordination and Care Affordability.

QUALITY: Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall

performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

- *Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes*
- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year
- *Hospital patients with pneumonia who had blood cultures before antibiotics were administered*
- *Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination*
- *Hospital patients age 50+ with pneumonia who received influenza screening or vaccination*
- *Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge*
- *Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations*
- *Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival*
- Adults with HIV and CD4 cell counts of 200 or less who received Pneumocystis pneumonia prophylaxis during the year
- People with a usual source of care for whom health care providers explained and provided all treatment options
- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data are available to ensure that they do not fall below 95%.

Improving Quickly

Through 2012, a number of measures showed rapid improvement, defined as an average annual rate of change greater than 10% per year. Of these measures that improved quickly, four are adolescent vaccination measures (italic).

- *Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- Hospital patients with heart failure who were given complete written discharge instructions
- *Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of meningococcal conjugate vaccine*
- Patients with colon cancer who received surgical resection that included 12+ lymph nodes pathologically examined
- Central line-associated bloodstream infection per 1,000 medical and surgical discharges, age 18+ or obstetric admissions
- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at

time of surgery

Worsening

Through 2012, a number of measures showed worsening quality. Of these measures that showed declines in quality, three track chronic diseases (italic). Note that these declines occurred prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

- Maternal deaths per 100,000 live births
- Children ages 19-35 months who received 3 or more doses of Haemophilus influenzae type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- *Admissions with diabetes with short-term complications per 100,000 population, age 18+*
- *Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year*
- Women ages 50-74 who received a mammogram in the last 2 years
- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- *People with current asthma who are now taking preventive medicine daily or almost daily*
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

QUALITY DISPARITIES: Disparities remained prevalent across a broad spectrum of quality measures. People in poor households experienced the largest number of disparities, followed by Blacks and Hispanics.

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).
- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems.

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller, but most were not improving across a broad spectrum of quality measures.

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.

- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

QUALITY DISPARITIES: Through 2012, few disparities in quality of care were eliminated while a small number became larger.

Disparities Trends

- Through 2012, several disparities were eliminated.
  - One disparity in vaccination rates was eliminated for Blacks (measles-mumps-rubella), Asians (influenza), American Indians and Alaska Natives (hepatitis B), and people in poor households (human papillomavirus).
  - Four disparities related to hospital adverse events were eliminated for Blacks.
  - Three disparities related to chronic diseases and two disparities related to communication with providers were eliminated for Asians.
  - On the other hand, a few disparities grew larger because improvements in quality for Whites did not extend uniformly to other groups.
  - At least one disparity related to hospice care grew larger for Blacks, American Indians and Alaska Natives, and Hispanics.
  - People in poor households experienced worsening disparities related to chronic diseases.

QUALITY DISPARITIES: Overall quality and racial/ethnic disparities varied widely across states and often not in the same direction.

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality while states in the South census region tended to have lower quality.
- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities.
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

National Quality Strategy: Measures of Patient Safety improved, led by a 17% reduction in hospital-acquired conditions.

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[37]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

- Black-White differences in four Patient Safety measures were eliminated.
- Asian-White differences in admissions with iatrogenic pneumothorax grew larger.

National Quality Strategy: Measures of Person-Centered Care improved steadily, especially for children.

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial/ethnic and income groups.
- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

Disparities

In almost all years, the percentage of children whose parents reported poor communication with their health providers was:

- Higher for Hispanics and Blacks compared with Whites.
- Higher for poor, low-income, and middle-income families compared with high-income families.

Disparities Trends

- Asian-White differences in two measures related to communication were eliminated.
- Four Person-Centered Care disparities related to hospice care grew larger.

[37] Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html

National Quality Strategy: Measures of Care Coordination improved as providers enhanced discharge processes and adopted health information technologies.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes, and for all racial/ethnic groups.
- There are few measures to assess trends in Care Coordination.

Disparities

- In all years, the percentage of hospital patients with heart failure who were given complete written discharge instructions was lower among American Indians and Alaska Natives compared with Whites.

National Quality Strategy: Many measures of Effective Treatment achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.
- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.
- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often disappeared as measures achieved high levels of performance.

Disparities Trends

- Asian-White differences in three chronic disease management measures were eliminated but income-related disparities in two measures related to diabetes and joint symptoms grew larger.

National Quality Strategy: Healthy Living improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.

- About half of all Healthy Living measures tracked in the QDR improved.
- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

- Adolescents ages 16-17 in nonmetropolitan areas were less likely to receive meningococcal conjugate vaccine than adolescents in metropolitan areas in all years.
- Adolescents in poor, low-income, and middle-income households were less likely to receive meningococcal conjugate vaccine than adolescents in high-income households in almost all years.

Disparities Trends

- Four disparities related to child and adult immunizations were eliminated.
- Black-White differences in two Healthy Living measures grew larger.

National Quality Strategy: Measures of Care Affordability worsened from 2002 to 2010 and then leveled off.

From 2002 to 2010, prior to the Affordable Care Act, care affordability was worsening. Since 2010, the Affordable Care Act has made health insurance accessible to many Americans with limited financial resources.

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[38]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or

[38] Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en

prescription medicines who indicated a financial or insurance reason for the problem was:

- Higher among uninsured people and people with public insurance compared with people with any private insurance.
- Higher among poor, low-income, and middle-income families compared with high-income families.

CONCLUSION

The 2014 Quality and Disparities Reports demonstrate that access to care improved. After years of stagnation, rates of un-insurance among adults decreased in the first half of 2014 as a result of Affordable Care Act insurance expansion. However, disparities in access to care, while diminishing, remained.

Quality of healthcare continued to improve, although wide variation across populations and parts of the country remained. Among the NQS priorities, measures of Person-Centered Care improved broadly. Most measures of Patient Safety, Effective Treatment, and Healthy Living also improved, but some measures of chronic disease management and cancer screening lagged behind and may benefit from additional attention. Data to assess Care Coordination and Affordable Care were limited and measurement of these priorities should be expanded.