Valley View Hospital
Garfield County, Colorado

Community Health Needs Assessment

December, 2015

NATIONAL
RURAL HEALTH
RESOURCE CENTER

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INTRODUCTION

Valley View Hospital is a 49-bed PPS hospital located in Glenwood Springs, Colorado. Valley View Hospital (VVH) participated in a Community Health Needs Assessment administrated by the National Rural Health Resource Center (The Center) of Duluth, Minnesota.

In the autumn of 2015, The Center conferred with leaders from VVH to discuss the objectives of a regional community health assessment. A mailed survey instrument was developed to assess the health care needs and preferences in the VVH service area. The survey instrument was designed to be easily completed by respondents. Responses were electronically scanned to maximize accuracy. The survey was designed to assemble information from local residents regarding:

- Demographics of respondents
- Utilization and perception of local health services
- Perception of community health

The survey was based on a design that has been used extensively in the states of Minnesota, Montana, Wyoming, Washington, Alaska, and Idaho.

Sampling

Glenwood Springs provided The Center with a list of inpatient hospital admissions. Zip codes with the greatest number of admissions were stratified in the initial sample selection. Each area would be represented in the sampling proportionately to both the overall served population and the number of past admissions. Eight hundred residents were selected randomly from PrimeNet Data Source, a marketing organization. Although the survey samples were proportionately selected, actual surveys returned from each population area varied. This may result in slightly less proportional results.

Survey Implementation

In November 2015, the community health needs assessment, a cover letter on Valley View Hospital's letterhead, and a postage paid reply envelope were mailed first class to 800 randomly selected residents in the targeted region (six zip codes). A press release was sent to local newspapers prior to the survey distribution announcing that VVH would conduct a Community Health Needs Assessment throughout the region, in cooperation with The Center.

One hundred and forty-nine of the mailed surveys were returned, providing a 20% response rate. Based on the sample size, surveyors are 95% confident that the responses are representative of the service area population, with a margin of error

of 5.74%. Note that 60 of the original 800 surveys sent were returned by the U.S. Postal Service as undeliverable.

This report includes comparisons to national averages from The Center's Community Health Needs Assessment (CHNA) Database when applicable. Recommendations are included for developing and implementing program plans to address key health issues identified by the community. A copy of the survey instrument is included at the end of the report (Appendix A). This is the second Community Health Needs Assessment survey VVH has done. The first survey was conducted by the Center for Health Administration (CHA) at the University of Colorado Denver in 2012, using data predominantly collected from the Colorado Department of Public Health and Environment.

Report Findings May be Used For:

- Developing and implementing plans to address key issues as required by the Patient Protection and Affordable Care Act §9007 for 501(c)3 charitable hospitals
- Promoting collaboration and partnerships within the community or region
- Supporting community-based strategic planning
- Writing grants to support the community's engagement with local health care services
- Educating groups about emerging issues and community priorities
- Supporting community advocacy or policy development

Community Education about Local Health Care:
Community support of the local health care system is vital if the system is to remain viable. Informed citizens are more likely to use and support the local health care system if they have an understanding of the impact it has on the local economy and quality of life.

SURVEY DEMOGRAPHICS

The following tables indicate the demographic characteristics of survey respondents. **(N=149)**

Q12: Place of Residence	n=	Percent
81601 or 81602 Glenwood Springs	**67**	**45%**
81623 Carbondale	37	25%
81647 New Castle	24	16%
81652 Silt	11	7%
81637 Gypsum	9	6%
No Answer	1	1%

Q11: Age	n=	Percent
18-25	3	2%
26-35	13	9%
36-45	19	13%
46-55	29	20%
56-65	**46**	**31%**
66-75	23	15%
76-85	11	7%
86+	5	3%

Q13: Gender	n=	Percent
Female	**95**	**64%**
Male	50	34%
No answer	4	3%

HEALTH INSURANCE & PRESRICPTIONS

Q4: Reason Respondents Do Not Have Health Insurance Seven percent (n=10) do not have health insurance because they "Cannot afford to pay it". Fifty-four percent (n=80) of respondents have medical insurance. Please note that respondents could select all that apply, so percentages do not total 100%. (**N=149)**

- **54% say "Not applicable, I have medical insurance" (n=80)**
- 36% did not answer (n=53)
- 7% say they "Cannot afford to pay it" (n=10)
- 4% say "Other" (n=6)

Q3: Are you able to afford prescription medications? Thirteen percent (n=19) of respondents can afford medication with insurance, but report that it is a financial hardship. Twenty-two percent (n=33) do not require prescription medications at this time. Two percent did not answer this question (n=3). (**N=149)**

- **58% say "Yes, with my insurance" (n=86)**
- 13% say "Yes, with insurance, but it's a financial hardship" (n=19)
- 5% say "No, because I do not have insurance" (n=7)
- 1% say "No, I can't, despite having insurance" (n=1)

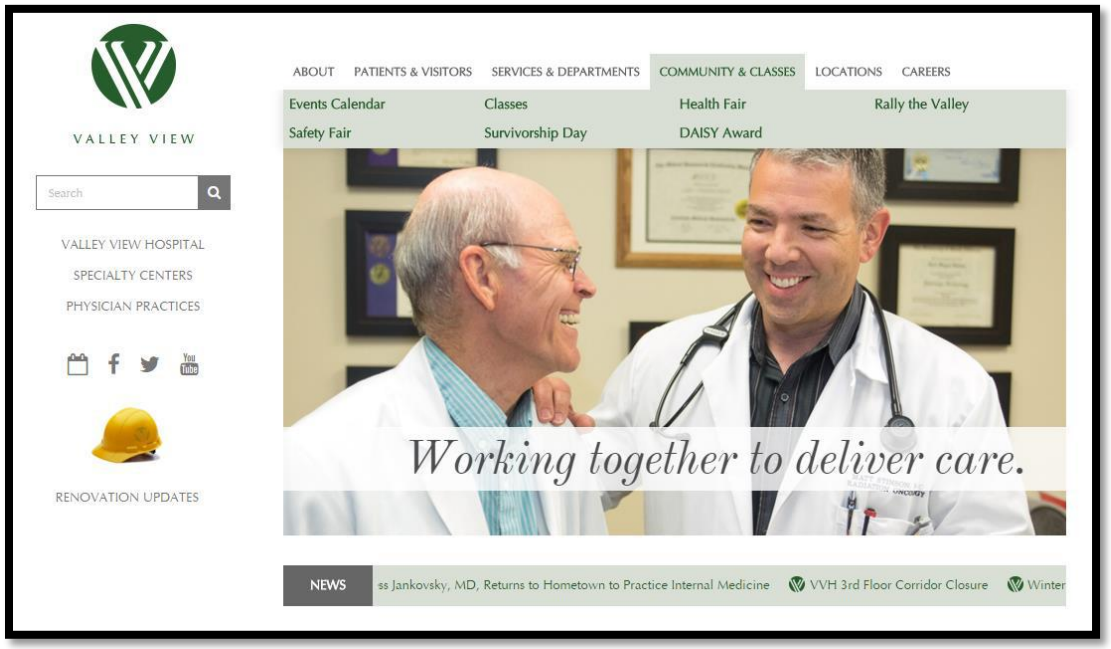
SURVEY FINDINGS

The Center has been administering Community Health Needs Assessments (CHNA) in rural communities across America for over 25 years, which enables historical and comparative analysis if applicable. Comparative analysis from the CHNA Database is included when questions, field selections and methodology are standardized. In the following tables and graphs, the question asked on the mailed survey is emboldened and the question number from the mailed survey is appropriately labeled as "Q10".

Preferred Method to Receive Health Materials

Q10: What is your preferred method to receive health materials from? Respondents were asked to select all that apply, so totals do not equal 100%. **(n=147)**

Preferred Method	n=	Percent
Internet/web	83	56%
Pamphlets or other printed materials	72	49%
Newspaper	59	40%
Classes in the community	25	17%
TV	24	16%
Radio	13	9%

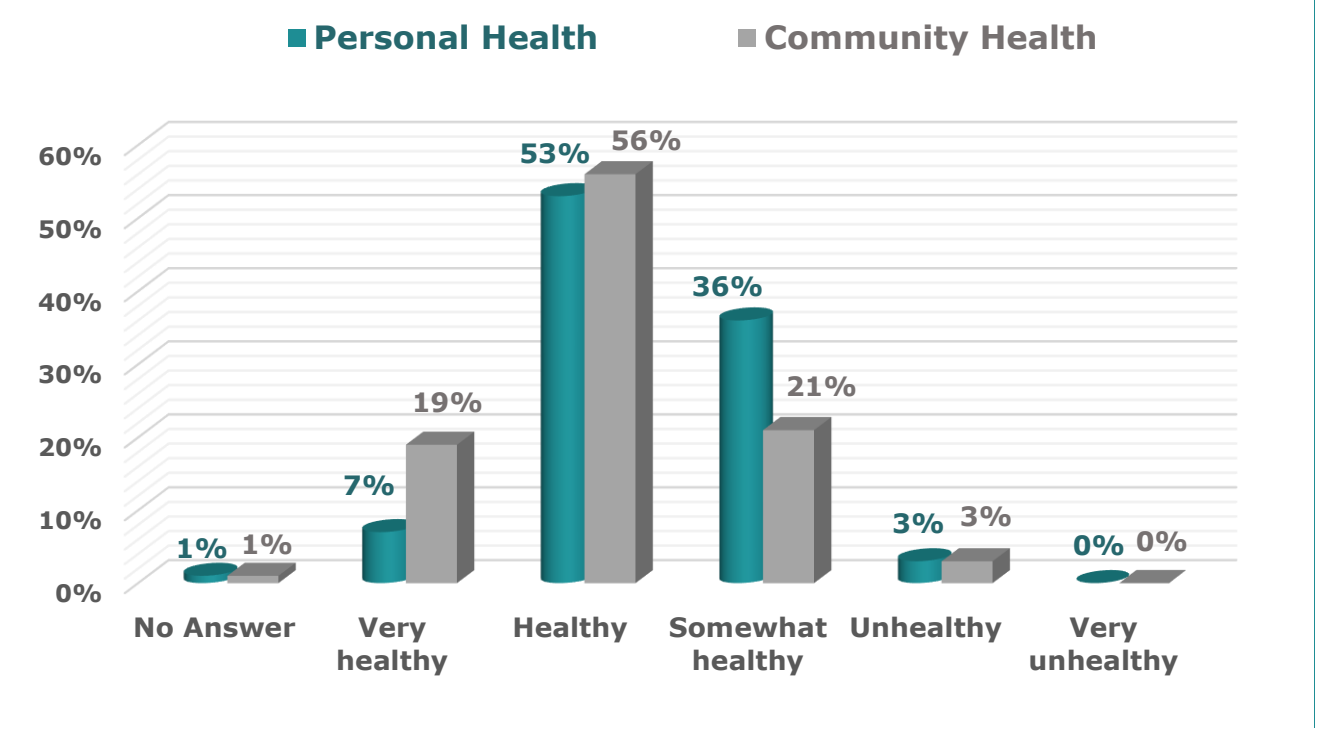


Perception of Personal Health

Q8: Overall, how would you rate your personal health? Fifty-three percent (n= 79) of respondents perceive themselves to be "Healthy", which is 10% higher than the national average of 46%. (**N=149**)

Perception of Community Health

Q5: How would you rate the general health of our community? Fifty-six percent (n=84) of respondents rated the community as "Healthy", which is 16% higher than the national average of 40%. (**N=149**)



Community Health Concerns

Q6: Select the THREE most serious concerns in our community. The perception of "Alcohol/substance abuse" being the top concern is consistent with national averages. "Obesity" and "Diabetes" are two of the lowest rated concerns for these categories The Center has seen in its CHNA database. However, "Mental health issues" is 30% higher than the national average. Respondents were asked to select three that apply, so totals do not equal 100%. **(n=148)**

Health Concerns	n=	VVH	Nation
Alcohol/substance abuse	96	65%	56%
Cancer	79	53%	49%
Mental health issues	59	40%	10%
Heart disease	28	19%	27%
Lack of access to health care	24	16%	9%
Tobacco use	21	14%	16%
Obesity	20	14%	33%
Diabetes	18	12%	25%
Lack of dental care	16	11%	6%
Motor vehicle accidents	15	10%	8%
Lack of exercise	14	9%	17%
Domestic violence	14	9%	7%
Underage alcohol use	11	7%	16%
Other	11	7%	4%
Stroke	8	5%	5%
Child abuse/neglect	6	4%	7%

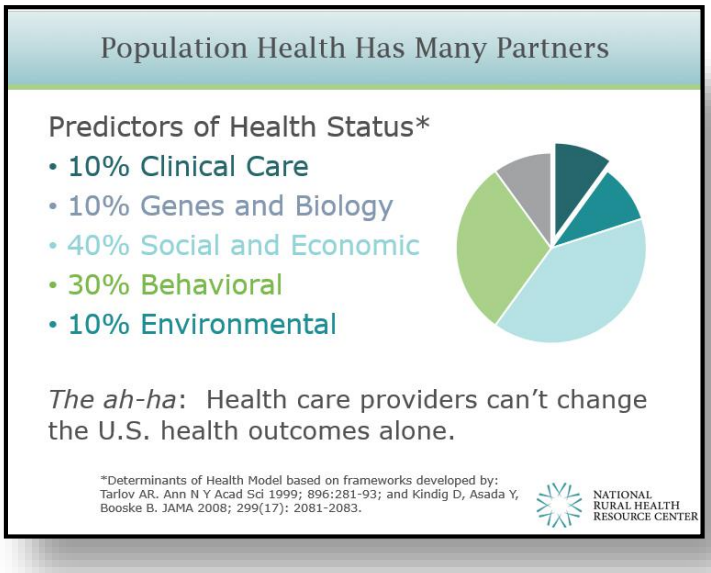
"Many chronic conditions can be prevented by not smoking, being physically active and eating nutritious foods."

Source: CDC, National Center for Chronic Disease Prevention and Health Promotion. (2010).

Criteria for a Healthy Community

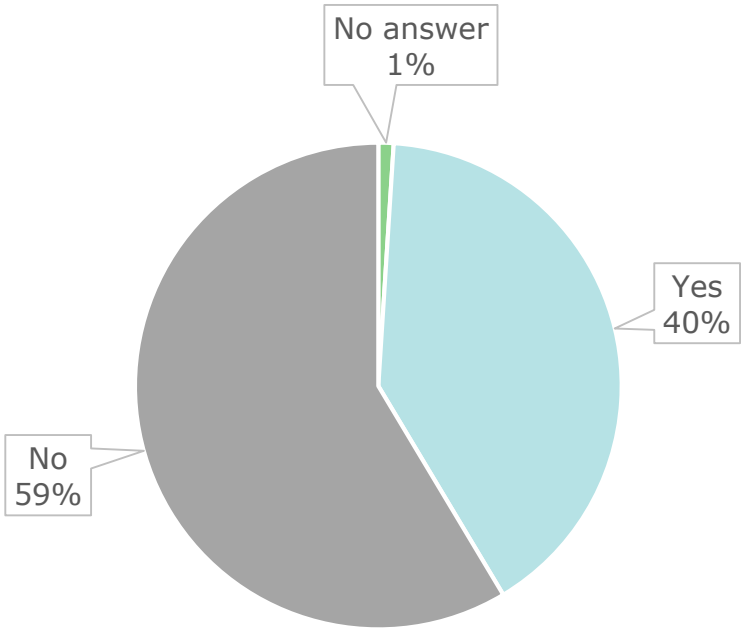
Q7: Select the THREE items below that are most important for a healthy community. The top three criteria for building a healthy community are consistent with national averages. However, the fourth most frequent response, "Affordable housing" is 16% higher than national averages. The highly rated "Healthy behaviors and lifestyles" in VVH mirrors the near record breaking low concerns about obesity and diabetes, shown in Q6. Respondents were asked to select three that apply, so totals do not equal 100%. **(n=148)**

Criteria for a Healthy Community	n=	VVH	Nation
Access to healthcare and other services	98	66%	62%
Good jobs and healthy economy	68	46%	45%
Healthy behaviors and lifestyles	60	41%	36%
Affordable housing	50	34%	18%
Clean environment	31	21%	17%
Low crime/safe neighborhoods	29	20%	20%
Strong family life	29	20%	32%
Good schools	26	18%	23%
Religious or spiritual values	19	13%	25%
Tolerance for diversity	16	11%	5%
Parks and recreation	11	7%	4%
Community involvement	8	5%	9%
Low death and disease rates	7	5%	5%
Arts and cultural events	5	3%	2%
Other	5	3%	2%
Low level of domestic violence	2	1%	3%



Delayed Health Care Services

Q1: In the past three years, was there a time when you or a member of your household thought you needed healthcare services, but you delayed or did not receive medical services? "Yes", 40% (n=60) of respondents reported delaying healthcare services when needed. This is 13% higher than the national average of 27% reporting delayed care. **(N=149)**



Reason to Delay or Not Receive Health Care Services

Q2: If yes, select THREE most important reasons why you did NOT receive healthcare services? "It costs too much" is the most frequently cited response for VVH which is almost 20% higher than the national average. Additional noteworthy reasons for delaying care include: "Language barrier" which is 14% higher than national averages and "Could not get off of work" which is 11% higher. An additional 12 respondents answered this question who had not previously indicated delaying care in Q1. **(n=72)**

Reason to Delay	n=	VVH	Nation
It costs too much	48	67%	48%
No insurance	16	22%	26%
My insurance didn't cover it	15	21%	20%
Other	14	19%	16%
Too long to wait for an appointment	14	19%	24%
Could not get off work	14	19%	8%
Didn't know where to go	11	15%	4%
Language barrier	11	15%	1%
Could not get an appointment	8	11%	18%
Too nervous or afraid	8	11%	8%
Office wasn't open when I could go	7	10%	15%
Don't like providers	3	4%	11%
Transportation problems	3	4%	5%
Not treated with respect	3	4%	12%
Unsure if services were available	3	4%	7%
It was too far to go	2	3%	6%
Had no one to care for the children	0	0%	2%

Additional Health Services Needed

Q9: What additional health services are needed in the community?
Respondents identified the need to support the aging community as a "Senior retirement housing" and an "Assisted living facility" were the most frequently cited responses. This may be a reflection of the primary demographic being between the ages of 56-65. The need for a mental health counselor was also highly requested. Respondents were asked to check all that apply, so totals do not equal 100%
(n=139)

Services Needed	n=	VVH
Senior retirement housing	85	61%
Assisted living facility	67	48%
Additional child/adult day care	57	41%
Mental health counselor	50	36%
Exercise/nutrition programs	45	32%
Substance abuse counselor	40	29%
Health education programs	38	27%
After school programs	34	24%
Marriage & family therapist	29	21%
Head Start programs	16	12%
Other	16	12%
Clubs/leagues	14	10%
Psychiatrist	13	9%
Pediatrician	10	7%
Social worker	9	6%
Pastoral counselor	8	6%
Psychologist	8	6%
Psychiatric nurse	5	4%

SECONDARY DATA ANALYSIS

Introduction

There are two different types of sources used to conduct a community health needs assessment. The first type is a primary source that is the initial material that is collected during the research process. Primary data is the data that The Center collects using methods such as surveys, direct observations, interviews, as well as objective data sources. Primary data is a reliable method to collect data as The Center knows the source, how it was collected and analyzed. Secondary data is from "outside" sources. Secondary data analysis is commonly known as second-hand analysis. It is simply the analysis of preexisting data. Secondary data analysis utilizes the data that was collected by another entity in order to further a study. Secondary data analysis is useful for organizational planning to complement primary data or if there is not time or resources to gather raw data. It has its drawbacks however, as data from the different agencies is collected during different timeframes. This can make direct comparisons of secondary data difficult. Please note, that the data collected for this report is the most current information as of December 2015.

Sources used for the collection of secondary data are primarily from government agencies, including the United States Census Bureau, the Bureau of Labor Statistics, County Health Rankings, Behavioral Health Risk Factors Surveillance System, Centers for Medicaid and Medicare Services and Health Resources and Services Administration.

Demographics

	Garfield County	Eagle County	Pitkin County	Colorado	United States
Population Density (residents per square mile)	19.24	30.97	17.7	49.41	88.2
Percent Rural	24%	19%	44%	13%	19%
Percent Population Change 2000 – 2010	28.7%	25.3%	15.3%	16.92%	9.75%
Population median age by Gender (years)	Male: 34 Female: 35	Male: 34 Female: 35	Male: 43 Female: 43	Male: 35 Female: 37	Male: 36 Female: 39
Percent of Population Age 65 by Gender	Male: 7.47% Female: 9.91%	Male: 5.75% Female: 6.5%	Male: 12.73% Female: 13.34%	Male: 9.24% Female: 12.69%	Male: 10.63% Female: 14.97%
Percent of Families with Children under Age 18	38.6%	33.4%	22.09%	32.1%	32.65%
Percent of Population with any Disability	9.21%	4.64%	6.77%	10.12%	12.13%
Percent of Population who are Veterans	8.35%	4.45%	6.71%	10.35%	8.99%

Social and Economic Factors

	Garfield County	Eagle County	Pitkin County	Colorado	United States
Percent of Population with High School Degrees	72%	76%	94%	76%	82%
Percent of Population with Associate's Degree or Higher	34%	53%	65%	45%	36%
Per Capita Income	$26,602	$39,496	$51,814	$31,109	$28,154
Percent of Households with Public Assistance Income	1.4%	.82%	.97%	2.16%	2.82%
Unemployment Rates	4.5%	4.2%	6.2%	4.1%	5.6%
Percent of Population under Age 18 in Poverty	14.86%	13.93%	12.69%	17.48%	21.58%
Percent Population without Medical insurance	27.32%	25.48%	19.3%	18.81%	20.44%
Percent of Population Living with Low Food Access	3.41%	5.12%	1.36%	6.39%	6.27%
Percent of Population with Food Insecurity	12%	11%	13%	14%	15%
Percent of Households with No Motor Vehicle	4.29%	1.78%	4.26%	5.72%	9.07%

Clinical Care

	Garfield County	Eagle County	Pitkin County	Colorado	United States
Primary Care Physicians Rate per 100,000 Population	70	75	75	79	74
Percent of Adults without any Regular Doctor	32%	23%	13%	23%	22%
Percent of Medicare Population with Diabetes	14%	9%	6%	18%	27%
Percent of Medicare Population with Heart Disease	22%	15%	24%	20%	29%
Percent of Medicare Population with High Blood Pressure	47%	44%	48%	42%	55%
Percent of Medicare Population with High Cholesterol	32%	32%	43%	32%	45%
Percent of Medicare Population with Depression	13%	10%	7%	14%	15%

Behavioral Health Risk Factors of Adults

	Garfield County	Eagle County	Pitkin County	Colorado	United States
Percent Adults Smoking 100+ cigarettes	56%	38%	46%	44%	44%
Percent Smokers with Quit Attempt in past 12 months	58%	69%	78%	58%	60%
Estimated Adults Drinking Excessively (2+ drinks/day)	17%	21%	27%	17%	16%
Percent Adults with Inadequate fruit/vegetable consumption	74%	68%	NA	75%	76%
Percent population with no leisure time physical activity	12%	11%	9%	14%	22%
Percent of Adults with BMI > 30 (Obese)	17%	13%	10%	20%	27%
Percent of Adults with Poor Dental Health	9.4%	3.2%	1.7%	10%	15.7%
Sexually Transmitted Infections (Chlamydia per 100,000)	335	163	245	422	456

Health Outcomes

	Garfield County	Eagle County	Pitkin County	Colorado	United States
Cancer Mortality (Average annual deaths)	125	77	60	145	169
Heart Disease Mortality	121	81	58	130	175
Stroke Mortality	23	21	NA	34	38
Unintentional Injury-Mortality	58	27	26	45	38
Infant Mortality	4	4	2	6	6
Suicide	19	15	NA	18	12

CONCLUSIONS, RECOMMENDATIONS, AND ACKNOWLEDGEMENTS

Conclusions

The perception of personal and community health rated as "healthy" are above national averages. These perceptions are validated in other questions by respondents choosing the field selection, "healthy behaviors and lifestyle" as one of the top criteria needed for a healthy community and rating obesity and diabetes as lower concerns than national averages. Secondary data sources confirm the accuracy of this perception as the percentage of adults with obesity is ten percent lower than the United States. However, Garfield County has a higher percentage of obesity than surrounding counties. Alcohol/substance abuse was rated as the top community health concern. The concern of mental health issues are thirty percent higher than national averages which is validated by secondary data sources indicating that Garfield County has a higher rate of suicide compared to state and national statistics. Respondents recognized the valuable role a mental health counselor could serve in the community. Additional senior services (senior retirement housing, assisted living and additional adult day care) were requested services. Respondents also recognize the value of access to healthcare and other services in the community.

Recommendations

Noting the changes in health care reimbursement structures, hospitals will begin to be reimbursed based on the population's health outcomes. This transformation is changing the definition of hospital volume from the number of procedures and interventions to the number of patients being seen in the service area. Capture a greater market share by expanding efforts towards individuals that are currently healthy and not currently utilizing local health services by engaging the community in prevention/wellness activities and health education.

It is also recommended the hospital increase efforts on role modeling wellness and expanding collaborative community partnerships to improve the overall coordination of care for patients. Reference the section below on "Improving Population Health in Your Community", as cited below.

There is also an opportunity to improve customer processes and perception of quality care by implementing management frameworks such as Baldrige, the Balanced Scorecard, Lean and/or Studer methodologies. These frameworks evaluate and monitor the effectiveness and efficiencies of staff processes, manage ongoing performance improvement, and help create a positive work culture that

can result in greater staff and patient satisfaction. Please contact The Center for more information and guidance on these services or go to www.ruralcenter.org for further details.

Share results and communicate proposed strategies that address community needs as this will promote customer loyalty. It is advised to create a communications strategy for releasing the report findings. It is important to be clear on the intent of these communications (e.g., to share information or to stimulate action).

Acknowledgements

The Center would like to thank Ms. Bonnie Wasli, Ms. Patricia Faler and Ms. Lisa Wilson for their contributions and work with developing and distributing the assessment.

ESTABLISHING HEALTH PRIORITIES

Sufficient resources frequently are not available to address all the health concerns identified in a Community Health Needs Assessment. Identify issues to work on in the short to intermediate term (one to three years). Priorities should reflect the values and criteria agreed upon by the hospital board and community stakeholders, which should include public health.

Once priorities have been established, set aside time to develop, implement and monitor an action plan that assesses progress

Criteria that can be used to identify the most significant health priorities include:

- The magnitude of the health concern
  (the number of people or the percentage of population impacted)
- The severity of the problem
  (the degree to which health status is worse than the state or national norm)
- A high need among vulnerable populations

Criteria that can be used to evaluate which health issues should be prioritized include:

- The community's capacity to act on the issue, including any economic, social, cultural, or political considerations
- The likelihood or feasibility of having a measurable impact on the issue
- Community resources (programs, funding) already focused on an issue
  (to reduce duplication of effort and to maximize effectiveness of limited resources)
- Whether the issue is a root cause of other problems
  (thereby possibly affecting multiple issues)

Consider a comprehensive intervention plan that includes multiple strategies (educational, policy, environmental, programmatic); uses various settings for the implementation (hospital, schools, worksites); targets the community at large as well as subgroups; and addresses factors that contribute to the health priority. Be sure to document and monitor results over the next one to three years to assure that community needs identified within the assessment are being addressed. Maintain records of assessment processes and priorities for obtaining base line information and for pursuing ongoing process improvements. *(Adapted from materials by the Association for Community Health Improvement)*

IMPROVING POPULATION HEALTH IN YOUR COMMUNITY

"If you don't help your community to thrive and grow –How will your organization thrive and grow?"

The U.S. health care industry is undergoing profound change in financing and service delivery, as it shifts from a financial system that rewards "volume" to one that is based on "value". Driven by the health marketplace itself, the new health industry goals are articulated in the Institute for Health Improvement's Triple Aim: better population health, better health quality and lower health costs. Payers are increasingly factoring in population health outcomes into reimbursement formulas.

Population Health Portal

Navigate the journey towards improved population health by accessing a Critical Access Hospital Readiness Assessment, resources and educational modules that offer step-by-step instructions of common population health analytical procedures.

Small Rural Hospital Transition Guides and Toolkit

Informational guides developed by field experts and a toolkit developed by Rural Health Innovations that concentrates on best practices and strategies to support small rural hospital performance improvement and preparation for transitioning to value-based care and purchasing.

Critical Population Health Success Factors

The following section summarizes the 2014 "Improving Population Health: A Guide for Critical Access Hospitals", created by The Center and Stratis Health

Leadership

- Develop awareness and provide education on the critical role of population health in value-based reimbursement
- Shift hospital culture, processes, facilities and business models to include a focus on population health
- Lead the way and model behaviors. Participate in programs, be active in community outreach

Strategic Planning

- Incorporate population health approaches as part of ongoing strategic planning processes

- Engage multiple stakeholders and partners to coordinate strategies aimed at improving the population's health
- Prioritize – what are the one or two things that would make the biggest difference for the population you serve

Engagement

- Use the community health needs assessment (CHNA) process as an opportunity for community and patient engagement
- Articulate vision of hospital contributing to population health based on community conversations
- Engage all types of health care and social service providers to coordinate transitions of care and address underlying needs

Leadership

- Develop awareness and provide education on the critical role of population health in value-based reimbursement
- Shift hospital culture, processes, facilities and business models to include a focus on population health
- Lead the way and model behaviors. Participate in programs, be active in community outreach

Workforce

- Establish wellness programs for employees and role model these programs in the community
- Develop a workforce culture that is adaptable to change in redesigning care to address population health
- Embed a community focused mind-set across the organization so engagement, coordination and cooperation are expectations of staff interaction

Operations and Efficiency

- Maximize the efficiency of operational, clinical, and business processes under current payment structures
- Utilize health information technology (HIT) (such as electronic medical records, health information exchange and telemedicine) to support population health goals

Measurement, Feedback & Knowledge Management, Impact & Outcomes

- Identify measurable goals that reflect community needs
- Utilize data to monitor progress towards strategic goals on population health

- Publicly share goals, data and outcomes. Use it as an opportunity to engage partners and the community

Population Health Critical Access Hospital Case Studies

Leadership
Clearwater Valley Hospital in Idaho is utilizing a dyad management model which is a two-pronged approach to physician/hospital integration. This model places the organization's leadership under the management of qualified physician and non-physician teams aimed to incorporate the concept of value into health care decision-making where departments have been restructured to meet patient needs in both the inpatient and outpatient settings. This facility has received multiple awards for incorporating this management model. For more information: http://healthandwelfare.idaho.gov/Portals/0/Health/Rural%20Health/Orofino%20Case%20Study%20November%202011.pdf

Strategic Planning
Essentia Health Fosston in Minnesota incorporated community health needs assessment findings to improve the health of the community toward retaining a quality and viable agricultural industry. For more information: http://www.ruralcenter.org/tasc/resources/applying-community-health-assessments-rural-hospital-strategy

Partners, Patients, Community
The Community Connector Program was established by Tri County Rural Health Network in Helena, Arkansas which aims to increase access to home and community-based services by creating alternatives to institutionalized living and improving the quality of life for elderly and adults with physical disabilities while maintaining or decreasing costs. The return on investment was $3 of every $1 invested, or a 23.8 percent average reduction in annual Medicaid spending per participant, for a total reduction in spending of $2.619 million over three years. For more information: http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/CommunityConnectors.pdf

Workforce and Culture
Mason District Hospital in Illinois is implementing a three tiered approach to a worksite wellness program which includes a care coordination plan for employees with multiple chronic illnesses. After two years, the hospital has seen nearly $360,000 in reduced employee health care costs and has started offering the program to local businesses which both improves health locally and provides an

additional revenue stream for the program. For more information: http://www.icahn.org/files/White_Papers/ICAHN_PopHealthManagement_Print_FINAL.pdf (page 19)

Operations and Efficiency
Mercy Health Network in Iowa has adopted a Process Excellence tool modeled after Lean to improve operations, efficiency and patient safety. Each hospital in the network was assigned accountabilities, selected process improvements and helped educate the hospital board. After 18 months, process improvements results in a 51 percent decrease in patient falls and a 37 percent decrease in medical errors. For more information:
http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/MercyHealthNetwork.pdf

Measurement, Feedback, & Knowledge Management, Impact & Outcomes
Marcum & Wallace Memorial Hospital in Hazard, Kentucky has adopted the Performance Excellence Blueprint as indicators for their system (Catholic Health Partnership) strategies. Leadership developed a dashboard to track program towards targets in each of the seven Performance Excellence Components. For more information:
https://ruralcenter.org/tasc/resources/marcum-wallace-memorial-hospital-performance-excellence

APPENDIX A

PeopleCare.
That's Valley View.

October 23, 2015

Dear Resident:

Participate in our Community Health survey and have a chance to WIN $100.00!

Valley View is partnering with the National Rural Health Resource Center to administer a community health survey. The purpose of the survey is to obtain information from a wide range of participants to assist in planning our programs, services, and facilities to meet present and future healthcare needs.

You are probably aware of many challenges facing rural healthcare, such as access to services and affordability. Unfortunately, many of the factors that threaten healthcare services in other rural areas challenge our local healthcare system as well. However, by completing the enclosed survey, you can help guide Valley View in developing comprehensive and affordable healthcare services to our area residents.

Your name has been randomly selected as a resident who lives in the Roaring Fork Valley service area. **Your help is critical in determining health priorities and future needs.** The survey covers topics such as: use of healthcare services, awareness of services, community health, health insurance, and demographics. The purpose of the survey is to obtain information from a wide range of participants to assist in planning our programs, services, and facilities to meet present and future needs, in addition to identifying community health and wellness needs.

Once you complete your survey, simply **return it AND one of the raffle tickets in the enclosed self-addressed, postage paid envelope postmarked by December 10, 2015.** Keep the other raffle ticket in a safe place. The winning raffle ticket number will be announced in the Glenwood Springs Post Independent newspaper and on the hospital's website (VVH.ORG) the week of **December 20, 2015.**

We know your time is valuable so we have made an effort to keep the survey to about 15 minutes. Valley View is offering you this chance to win $100 as a thank you for completing the enclosed survey.

All survey responses will go to the National Rural Health Resource Center in Duluth, Minnesota, the organization that is assisting with this project. If you have any questions about the survey, please call Kami Norland at 1-800-997-6685, ext. 223. We believe, with your help, we can continue to improve healthcare services in our region.

Thank you for your assistance. We appreciate your effort.

Sincerely,

Gary Brewer, CEO
Valley View Hospital

2015 Community Health Needs Assessment for Garfield County, Colorado

Please fill in the circle next to the corresponding answer for each question with a #2 pencil or pen and return it in the enclosed postage paid envelope. Contact the National Rural Health Resource Center at 218-216-7039 for assistance completing this survey.

1. In the past three years, was there a time when you or a household member thought you needed healthcare services, but you delayed or did not receive medical services?

○ Yes ○ No **(If no, move to question 3)**

2. If yes, select **THREE** most important reasons why you did NOT receive healthcare services

○ Could not get an appointment
○ Too long to wait for an appointment
○ Office wasn't open when I could go
○ Unsure if services were available
○ Had no one to care for the children
○ No insurance
○ It costs too much
○ Could not get off work
○ Didn't know where to go
○ It was too far to go
○ My insurance didn't cover it
○ Other_____
○ Not treated with respect
○ Too nervous or afraid
○ Language barrier
○ Transportation issues
○ Don't like doctors

3. Are you able to afford prescription medications? **(Please select only ONE)**

○ Yes, with my insurance
○ No, because I do not have insurance
○ I do not require prescription medications at this time
○ Yes, with insurance, but it's a financial hardship
○ No, I can't, despite having with insurance

4. If you do NOT have medical insurance, why? **(Please select only ONE)**

○ Not applicable, I have medical insurance
○ Cannot afford to pay for medical insurance
○ Cannot get medical insurance due to medical issues
○ Other _____
○ Choose not to get medical insurance

5. How would you rate the health of your community?

○ Very healthy ○ Healthy ○ Somewhat healthy ○ Unhealthy ○ Very unhealthy

6. Select the **THREE** most serious health concerns in your community.

○ Alcohol/substance abuse
○ Cancer
○ Child abuse/neglect
○ Diabetes
○ Domestic violence
○ Other_____
○ Heart disease
○ Lack of access to healthcare
○ Lack of dental care
○ Lack of exercise
○ Underage alcohol use
○ Mental health issues
○ Obesity
○ Stroke
○ Tobacco use
○ Motor vehicle accidents

7. Select the **THREE** items below that are most important for a healthy community.

- ○ Access to healthcare and other services
- ○ Affordable housing
- ○ Arts and cultural events
- ○ Clean environment
- ○ Community involvement
- ○ Good jobs and healthy economy
- ○ Good schools
- ○ Healthy behaviors and lifestyles
- ○ Low crime/safe neighborhoods
- ○ Low death and disease rates
- ○ Low level of domestic violence
- ○ Parks and recreation
- ○ Religious or spiritual values
- ○ Strong family life
- ○ Tolerance for diversity
- ○ Other _____

8. How would you rate your personal health?

○ Very healthy ○ Healthy ○ Somewhat healthy ○ Unhealthy ○ Very unhealthy

9. What additional health services are needed in our community? **(Select all that apply)**

- ○ Additional child/adult day care
- ○ Assisted living facility
- ○ After school programs
- ○ Clubs/leagues
- ○ Exercise/nutrition programs
- ○ Health education programs
- ○ HeadStart programs
- ○ Mental health counselor
- ○ Marriage & family therapist
- ○ Pastoral counselor
- ○ Pediatrician
- ○ Psychiatrist
- ○ Psychiatric nurse
- ○ Psychologist
- ○ Senior retirement housing
- ○ Social worker
- ○ Substance abuse counselor
- ○ Other _____

10. What is your preferred method to receive health materials from? **(Select all that apply)**

- ○ Pamphlets or other printed materials
- ○ Classes in the community
- ○ TV
- ○ Radio
- ○ Newspaper
- ○ Internet/web

11. What is your age?

○ 18-25 ○ 26-35 ○ 36-45 ○ 46-55 ○ 56-65 ○ 66-75 ○ 76-85 ○ 86+

12. What is your residential zip code?

- ○ 81623 Carbondale
- ○ 81601 or 81602 Glenwood Springs
- ○ 81647 New Castle
- ○ 81652 Silt
- ○ 81637 Gypsum

13. What is your gender identity? ○ Male ○ Female ○ Other_____

Please return in the postage paid envelope enclosed with this survey or mail to:
National Rural Health Resource Center, 525 S. Lake Ave., Suite 320, Duluth MN 55802

THANK YOU VERY MUCH FOR YOUR TIME

Please note that all information will remain confidential

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APPENDIX B

Community Health Needs Assessment "Other" Survey comments

2. If yes, select THREE most important reasons why you did NOT receive healthcare services.

- Cost (3 responses)
- Insurance didn't cover enough of the expense
- The entire process is impersonal, complicated, bureaucratic, heavy
- Not an emergency
- High deductible insurance
- Hard to find clinic (not ER) entrance, parking is ridiculous
- Could not afford to take off work
- No return phone call for scheduling an appointment
- Feel there is a gender discrepancy by doctors
- I feel like the facilities are more extravagant than they need to be, and the prices reflect that
- Had to travel too far so I didn't have to go to Valley View
- Multiple referrals is exhausting
- Specialist unavailable
- Physicians who won't accept Medicare patients

3. Are you able to afford prescription medications? (Please select only ONE)

- My prescriptions are not expensive so far
- I pay out of pocket when I need them
-

4. If you do NOT have medical insurance, why? (Please select only ONE)

- Medicare (x3)
- Insurance does not cover prescriptions (x2)
- Even Colorado Health Op is too expensive
- Health care is too costly; doesn't cover alternative medicine I use for preventative care
- Lost my job
- VA

6. Select the THREE most serious health concerns in your community.

- Affordability (x3)
- Cost of health insurance (x3)
- Not sure/Don't know (x3)
- I just guessed
- Availability of health insurance
- Suicide
- Injuries resulting from outdoor activities – skiing, mountain biking, hiking
- No detox center i.e. frequent fliers to VV via ambulance
- Homeless
- [selected Mental health issues] Mental health system is inadequate

- Stress of the working class
- Poverty
- Lack of Medicare & Medicaid caregivers
- Nutrition
- Family planning/birth control

7. Select the THREE items below that are most important for a healthy community.
- All of the above (x2)
- Vibrant hope
- Facilities for our elders and hospice/end-of-life care
- Adequate mental health services

9. What additional health services are needed in our community? (Select all that apply)
- Don’t know (x3)
- Affordable mental health options (x2)
- Homeless services (x2)
- [selected Senior retirement housing] Currently inadequate, 3-5 year wait
- Single payer coverage
- Alternative school choices other than public school
- More diverse doctors who are affordable
- Arthritis clinic
- Neurology
- Detox center
- Eye care
- General practice/family docs
- Low cost hospital options
- Better funding for liberal arts in children’s education
- Peace not war
- Birth control/family planning

Additional comments:
- The CEO of Valley View makes $1 million+ and no accountability to the public

APPENDIX C

Description and Source of Secondary Data

Data Areas	Description	Source and Dates
Population	The population of the county	United States Census Bureau 2010
Population Density (per square mile)	The average number of persons living within a square mile within the specified area	United States Census Bureau 2010
Percent population change 2000 - 2010	The percentage of population change	United States Census Bureau 2010
Population median age by Gender	The median age by gender	United States Census Bureau 2010
Percentage of Population Age 65 by Gender	Percentage of population age 65 by gender	United States Census Bureau 2010
Percentage of Families with Children under Age 18	A family household is any housing unit in which the householder is living with one or more individuals related to him or her by birth, marriage, or adoption. A non-family households are any households occupied by the householder alone, or by the householder and one or more unrelated individuals.	American Community Survey. 2009-2013
Percent of Total Households with any Disability	This indicator reports the percentage of the total civilian non-institutionalized population with a disability. This indicator is relevant because disabled individuals comprise a vulnerable population that requires targeted services and outreach by providers.	American Community Survey. 2009-2013
Veteran Population	This indicator reports the percentage of the population age 18 and older that served (even for a short time), but is not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or the Coast Guard, or that served in the US Merchant Marine during World War II.	American Community Survey. 2009-2013

High School Degrees	High School Graduates include people whose highest degree was a high school diploma or its equivalent, people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree. People who reported completing the 12th grade but not receiving a diploma are not included.	US Census Bureau 2009-2013
Associate's Degree or Higher	Persons with a Bachelor's Degree or Higher are those who have received a bachelor's degree from a college or university, or a master's, professional, or doctorate degree	US Census Bureau 2009-2013
Per Capita Income	Includes all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources. The per capita income in this report area is the average (mean) income computed for every man, woman, and child in the specified area.	American Community Survey. 2009-2013
Unemployment Rates	Percentage of population ages 16 and older unemployed but seeking work.	2009-2013 American Community Survey 5-Year Estimates 2015
Persons Below Poverty Level	The Census Bureau uses a set of dollar value thresholds that vary by family size and composition to determine who is in poverty. Further, poverty thresholds for people living alone or with nonrelatives (unrelated individuals) vary by age (under 65 years or 65 years and older). The poverty thresholds for two-person families also vary by the age of the householder. If a family's total income is less than the dollar value of the appropriate threshold, then that family and every individual in it are considered to be in poverty. Similarly, if an unrelated individual's total income is less than the appropriate threshold, then that individual is considered to be in poverty.	US Census Bureau 2009-2013
Percent Uninsured Population	Percentage of population under age 65 without health insurance.	County Health Rankings 2015

Percent of Population with low Food Access	This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract (where a substantial number or share of residents has low access to a supermarket or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.	USDA - Food Access Research Atlas. 2010
Percent of Medicare population with Depression	Percent of Medicare fee-for-service population with depression	Centers for Medicare and Medicaid Services 2012
Percent of Medicare Population with Heart Disease	Percent of Medicare fee-for-service population with ischemic heart disease	Centers for Medicare and Medicaid Services 2012
Percent of Medicare Population with Diabetes	Percent of Medicare fee-for-service population with diabetes	Centers for Medicare and Medicaid Services 2012
Percent of Medicare population with High Cholesterol	Percent of Medicare fee-for-service population with high cholesterol	Centers for Medicare and Medicaid Services 2012
Percent of Medicare population with High blood pressure	Percent of Medicare fee-for-service population with high blood pressure	Centers for Medicare and Medicaid Services 2012

Percent of Households with No Motor Vehicle	This indicator reports the number and percentage of households with no motor vehicle based on the latest 5-year American Community Survey estimates.	American Community Survey. 2009-2013
Primary Care Physician Rate per 100,000	Number of primary care physicians per 100,000 population. (MD, DO)	County Health Rankings 2015
Percent Adults without any Regular Doctor	Adults aged 18 and older who self-report they do not have at least one person who they of as their personal healthcare provider.	Behavioral Health Risk Factors Surveillance System
Adult Obesity	Percentage of adults that report a BMI of 30 or more.	County Health Rankings 2015
Percent Adults Smoking 100+ Cigarettes	Percentage of adults who are former or current smokers.	County Health Rankings 2015
Percent smokers with Quit attempts in past 12 months	Percentage of adults 18+ reporting attempts at quitting smoking within the past year	Behavioral Health Risk Factors Surveillance System 2012
Percent adults with inadequate fruit/vegetable consumption	Adults 18+ who are consuming less than 5 servings of fruits and vegetables daily	Behavioral Health Risk Factors Surveillance System 2012
Estimated adults drinking excessively	Adults 18+ who self-report drinking 2+ drinks daily	Behavioral Health Risk Factors Surveillance System 2012
Percent of population with no leisure time physical activity	Adults 20+ who self-report no leisure time physical activity (such as exercising, golfing, gardening, walking, etc.)	National Center for Chronic Disease Prevention and Health Promotion 2012

Percent adults with poor dental health	Adults aged 18 and older who self-report that 6 or more of their permanent teeth have been removed due to tooth decay, gum disease or infection.	Behavioral Health Risk Factor Surveillance System 2010
Sexually Transmitted Infections	Number of newly diagnosed Chlamydia cases per 100,000 population.	County Health Rankings 2015
Cancer Mortality	This indicator reports the rate of death due to malignant neoplasm (cancer) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. This indicator is relevant because cancer is a leading cause of death in the US.	Community Commons 2006-2010
Heart Disease Mortality	This indicator reports the rate of death due to heart disease per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. This indicator is relevant because heart disease is a leading cause of death in the US.	Community Commons 2006-2010
Suicide	This indicator reports the rate of death due to intentional self-harm per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. This indicator is relevant because lung disease is a leading cause of death in the S.	Community Commons 2006-2010
Stroke Mortality	This indicator reports the rate of death due to stroke per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. This indicator is relevant because stroke is a leading cause of death in the US.	Community Commons 2006-2010
Unintentional Injury-Mortality	This indicator reports the rate of death due to unintentional injury (accident) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. This indicator is relevant because accidents are a leading cause of death in the US.	Community Commons 2009-2013
Infant Mortality	This indicator reports the rate of deaths to infants less than one year of age per 1,000 births. This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.	Community Commons 2006-2010