2016 COMMUNITY HEALTH NEEDS ASSESSMENT

Our name says good. Our care is great.

Contents

Introduction

Internal Revenue Code (IRC) Section 501(r) requires health care organizations to assess the health needs of their communities and adopt implementation strategies to address identified needs. Per IRC Section 501(r), a byproduct of the *Affordable Care Act*, to comply with federal tax-exemption requirements, a tax-exempt hospital facility must:

- ✓ Conduct a community health needs assessment (CHNA) every three years.
- ✓ Adopt an implementation strategy to meet the community health needs identified through the assessment.
- ✓ Report how it is addressing the needs identified in the CHNA and a description of needs that are not being addressed with the reasons why such needs are not being addressed.

The CHNA must take into account input from persons who represent the broad interest of the community served by the hospital facility, including those with special knowledge of or expertise in public health. The hospital facility must make the CHNA widely available to the public.

This CHNA, which describes both a process and a document, is intended to document Good Shepherd Medical Center's compliance with IRC Section 501(r). Health needs of the community have been identified and prioritized so that Good Shepherd may adopt an implementation strategy to address specific needs of the community.

The *process* involved:

- ✓ A comprehensive evaluation of the implementation strategy for fiscal years ending June 30, 2014, through June 30, 2016, which was adopted by Good Shepherd Medical Center board of directors in 2013. The implantation strategy was updated in 2015.
- ✓ Collection and analysis of a large range of data, including demographic, socioeconomic and health statistics, health care resources and hospital data.
- ✓ Obtaining community input through:
    - Surveys with key stakeholders who represent a) broad interests of the community, b) populations of need or c) persons with specialized knowledge in public health.

This *document* is a summary of all the available evidence collected during the CHNA conducted in tax year 2015. It will serve as a compliance document, as well as a resource, until the next assessment cycle. Both the *process* and *document* serve as the basis for prioritizing the community's health needs and will aid in planning to meet those needs.

Summary of Community Health Needs Assessment

The purpose of the CHNA is to understand the unique health needs of the community served by Good Shepherd and to document compliance with new federal laws outlined above.

Good Shepherd engaged **BKD, LLP** to conduct a formal CHNA. **BKD, LLP** is one of the largest CPA and advisory firms in the United States, with approximately 2,000 partners and employees in 34 offices. BKD serves more than 900 hospitals and health care systems across the country. The CHNA was conducted during the fiscal year ending September 30, 2016.

Based on current literature and other guidance from the U.S. Department of the Treasury and the IRS, the following steps were conducted as part of Good Shepherd's CHNA:

- An evaluation of the impact of actions taken to address the significant health needs identified in the tax year 2013 CHNA was completed and an implementation strategy scorecard was prepared to understand the effectiveness of Good Shepherd's current strategies and programs.
- The "community" served by Good Shepherd was defined by utilizing inpatient data regarding patient origin. This process is further described in *Community Served by the Hospital*.
- Population demographics and socioeconomic characteristics of the community were gathered and reported utilizing various third parties (see references in *Appendices*). The health status of the community was then reviewed. Information on the leading causes of death and morbidity information was analyzed in conjunction with health outcomes and factors reported for the community by CountyHealthrankings.org. Health factors with significant opportunity for improvement were noted.
- Community input was provided through key stakeholder surveys. Results and findings are described in the *Key Stakeholder Survey Results* section of this report.
- Information gathered in the above steps was analyzed and reviewed to identify health issues of uninsured persons, low-income persons and minority groups and the community as a whole. Health needs were ranked utilizing a weighting method that weighs 1) the size of the problem, 2) the seriousness of the problem, 3) the impact of the issues on vulnerable populations, 4) the prevalence of common themes and 5) how important the issue is to the community.
- An inventory of health care facilities and other community resources potentially available to address the significant health needs identified through the CHNA was prepared and collaborative efforts were identified.

Health needs were then prioritized taking into account the perceived degree of influence Good Shepherd has to impact the need and the health needs impact on overall health for the community. Information gaps identified during the prioritization process have been reported.

Executive Summary

Good Shepherd Medical Center (Good Shepherd) conducted a comprehensive, multifactor health and wellness assessment of Good Shepherd's neighborhood and surrounding communities. The assessment provides a guide for the development and implementation of Good Shepherd's strategic plans while promoting opportunities to work collaboratively to address the health needs of service area residents.

To conduct this Community Health Needs Assessment (CHNA) Good Shepherd collected and analyzed the most current health, social, economic, housing and other data, as well as qualitative input directly from community leaders, representatives and agencies through surveys of key stakeholders. This approach allowed Good Shepherd to analyze both quantitative data and qualitative input on our community's health status. The steering committee reviewed all data available and collectively, through discussion, prioritized the health needs of our community that varied substantially from benchmark data and often times were also aligned with national and state-level health priorities.

This CHNA helps Good Shepherd to ensure our resources are appropriately directed towards opportunities with the greatest impact on the community. Good Shepherd will focus on providing resources that address each of the following health needs through direct patient care, health education and promotion and developing and supporting community partnerships aligned with the identified health needs in our community.

Since Good Shepherd last completed a CHNA, we have seen improvements in our community as well as areas that continue to represent challenges to individuals in the community. The community has experienced a decline in preventable hospital stays which may indicate the population has begun to better manage conditions that might not require hospitalization and are possibly more successfully supervised by primary care providers in outpatient settings. Managing health conditions in outpatient settings may reduce the likelihood of medical conditions which require emergency treatment as well as easier to manage medical expenses by the individual.

While a decrease in preventable hospital stays is a positive sign the community has taken proactive steps to better manage and protect their health, the community continues to struggle in areas already identified in the community research. Some areas for improvement in the community's health include the lack of mental health providers and resources and affordable primary and preventative care options for residents. The community also struggled with health issues such as obesity, heart disease and other chronic diseases.

General Description of Good Shepherd Health System

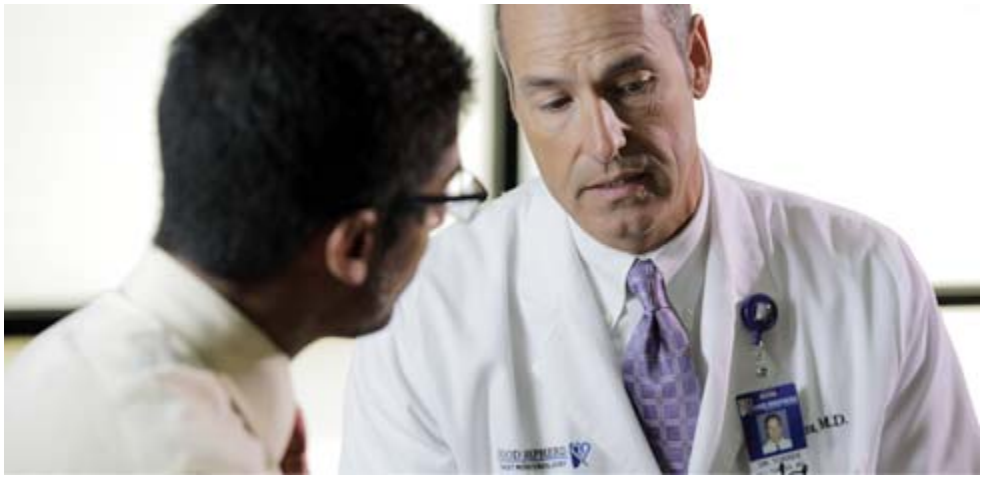
Good Shepherd Health System includes two medical centers, more than 30 provider office locations, emergency services, immediate care centers, a full range of outpatient services and our health and wellness facility, the Institute for Healthy Living. Our multi-specialty network of providers is focused on patient-centered care that improves the lives of patients as well as the overall wellness of the communities we serve. As a cornerstone of the rich heritage of Good Shepherd Health System, we are committed to providing excellence in health care.

Good Shepherd Medical Center

Good Shepherd Medical Center is the area's preferred hospital with a strong history and reputation for providing high quality, compassionate medical care. A full service, acute-care 425-bed regional referral center, Good Shepherd operates specialty nursing units including cardiology, orthopedics, general surgery, neurology/neurosurgery, oncology, critical care, obstetrics and pediatrics, where nurses are able to provide specialized care.

Good Shepherd Medical Center has received recognition by independent rating companies like HealthGrades and CareChex, a division of the Delta Group, for providing high quality health care to patients.

As a Primary Stroke Center, Accredited Chest Pain and Heart Failure Center and a Level III Trauma Center, Good Shepherd in Longview is ready and able to care for you and your loved ones during your time of health care needs.



Mission Statement
It is the mission of Good Shepherd Medical Center to improve the health of the communities we serve.

Vision Statement
To be the Health System of choice for the communities we serve.

Good Shepherd Health System's Values
CHOICE: Compassion, High Quality, Outstanding Services, Innovation, Community, Education

Significant Community Benefit Programs

A Fair of the Heart
Heart disease is the leading cause of death in the United States. Many of the risk factors leading to heart disease are controllable through good health habits. Each February, Good Shepherd sponsors a community-wide health fair. The fair's purpose is to educate area residents on the risk factors leading to heart disease, including high blood pressure, excess weight, elevated cholesterol, inactivity and tobacco usage. In February 2015, Good Shepherd held this event at Maude Cobb Activity and Convention Center. Offerings included free cholesterol and glucose screenings, blood pressure checks and a multitude of health information and health-related activities. At this annual event, 275 individuals received the screenings, a value of $70,675. The screening results were either mailed to the individual, or to a physician, at the individual's request. Physician referral services were also offered for those without primary care physicians.

Care Direct
The Care Direct program at Good Shepherd was established in 2009 as a service to patients who were utilizing the Emergency Department for minor emergent needs. It was apparent to the leadership of Good Shepherd that many of these patients were without a primary care physician, and could use a referral system to direct them to the most appropriate level of care, both lessening the volume of minor emergent needs in the ED, as well as saving the patient money by being seen in a clinic setting with appropriate charges.

With the assistance of the Care Direct team, patients who do not have a primary care physician are able to schedule their follow-up appointment with an appropriate physician who can provide oversight for ongoing health needs. In 2015, the Care Direct team met with 3,212 patients who did not have primary care physicians and scheduled 509 of them to see primary care doctors and scheduled 492 with specialists for advanced care. Of the patient mix for scheduled appointments, 23 percent were Medicaid, 20 percent were Medicare, 19 percent were self-pay and 38 percent had private insurance. Since the program's inception, we have seen 16,581 patients scheduling 2,865 with a primary care physician and 1,818 with a specialist. This program is at no cost to the patients, and in many cases, payment arrangements are able to be made with the clinic, also eliminating the high cost of emergency room care.

Medical Simulation Center

The Medical Simulation Center in 2015 provided educational opportunities to 3,573 learners. Learners representing the spectrum of health care have participated including medical and nursing students, patient care technicians, respiratory therapist, nurses and physicians. Specialized training events last year include:

- Provided High Fidelity simulation Neonatal Resuscitation Programs for staff & health care providers
- Provided High Fidelity simulation in Intermediate Fetal Monitoring for staff & health care providers
- Provided Emergency Nursing Pediatric Courses for staff & health care providers
- Provided Trauma Nursing Core courses to staff & health care providers
- Provided High Fidelity simulation week long orientations for Nurse Extern and GN programs
- Provided High Fidelity simulation for nursing student with UT Tyler and Kilgore College
- Provided CPR for The Chamber of Commerce, Wellness Pointe, Highway 80 Rescue Mission along with OSHA program for STEMCO and LEBUS International
- Weber State University designated testing site
- UTMB designated testing site for The Medical Student Program
- Texas A&M University-Corpus Christi designated testing site
- Provided Advanced courses in Cardiac & Pediatric to staff and health care providers

Good Shepherd provides many other community benefit programs which are detailed in our FY2015 Longview Community Benefit Report.

Identified Community Health Needs

The following health needs were identified based on the information gathered and analyzed through the 2016 CHNA conducted by Good Shepherd.

These needs have been prioritized based on information gathered through the CHNA.

Identified Community Health Needs

1. Lack of Mental Health Providers/Services
2. Obesity, Diabetes, Heart Disease and other Chronic Health Disorders
3. Affordable Primary and Preventative Care Options
4. Unemployment and Decrease in Income in the Community Due to Economic Downturn
5. Healthy Behaviors/Lifestyle Choices
6. Substance Abuse
7. Lack of Health Knowledge/Education
8. Lack of Community Resources to Promote Health (facilities, outdoor spaces)
9. Poor Nutrition/Limited Access to Healthy Food Options
10. Uninsured/Limited Insurance due to Lack of Medicaid Expansion or High Deductible Plans
11. Adult Smoking/Tobacco Use
12. Crime and Violence

These identified community health needs are discussed in greater detail later in this report

Community Served by Good Shepherd

Good Shepherd is located in Longview, TX. Longview is approximately a two (2) hour drive from Dallas, TX.

Defined Community

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other types of health care providers, Good Shepherd is the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community.

Based on the patient origin of acute care inpatient and outpatient discharges from July 1, 2014, through June 30, 2015, management has identified the CHNA community to include Gregg, Harrison, Panola, Rusk and Upshur counties for Good Shepherd Medical Center as each county represents greater than 1% of the total discharges and in aggregate the five counties represent greater than 80% of the total discharges. These counties are listed in *Exhibit 1* (Community) with corresponding demographic information in the following exhibits.

Secondary data for certain counties included in the secondary service area has not been included in the CHNA report as discharges for each individual county is less than 1% of total discharges. The socioeconomic characteristics, physical environment, clinical care, health status and health outcomes for these counties are similar to those indicated in the data for the three counties identified as the CHNA community. Primary data was obtained for these counties through key stakeholder surveys with representatives from each county's health department.

County Health Rankings – Improvements and Opportunity Areas from 2013 to Present

The counties in the CHNA Defined Community, Gregg, Harrison, Panola, Rusk and Upshur, were measured on several factors. Their statistics were ranked in relation to the averages in the state of Texas. The criteria that counties are ranking on include Health Behaviors, Clinical Care, Social and Economic Factors, and Physical Environment. The Health Behaviors category includes statistics on physical habits (exercise, substance consumption, etc.) that affect an individual's physical condition. Clinical Care includes statistics on individual's access to medical professionals and preventative medicine procedures. The Social and Economic Factors statistics relate to the education level, income measures, and other conditions which affect a child's development and adult life. The final group, Physical Environment, identifies characteristics of the county's ecosystem and its conditions.

County Health Ranking Comparison from 2013 to 2016

Ranking Area	Gregg	Harrison	Panola	Rusk	Upshur
Health Behavior	Decline from 2013	Improved from 2013	Improved from 2013	Improved from 2013	Improved from 2013
Clinical Care	Improved from 2013	Improved from 2013	Decline from 2013	Improved from 2013	Decline from 2013
Social/Economic	Decline from 2013	Decline from 2013	Improved from 2013	Improved from 2013	Improved from 2013
Physical Environment	Decline from 2013	Improved from 2013	Improved from 2013	Decline from 2013	Decline from 2013

Gregg County's ranking position declined compared to 2013. This decline is attributed to an increase in smoking and a decrease in Primary Care Providers in the area. Greg County also experienced an increase in the rate of sexually transmitted infections.

Harrison County improved their position, compared to the county's position in 2013, in the statistical areas of physical inactivity, preventable hospital stays, and economic factors (such as percent of adults with post-secondary education, violent crime rate, etc.). While many economic factors in the county increased, the county population saw primary care physicians leave the county as the ratio of population to primary care physicians increased. The county experienced an increase in the rate of sexually transmitted infection as well.

Panola County improved their position, compared to the county's position in 2013, in population to primary care physician as the county population saw an increased number of primary care physicians. The rate of preventable hospital stays per 1,000 Medicare enrollees also decreased. Similar to the counties mentioned earlier, Panola County experienced a sharp increase in the rate of sexually transmitted infection among its population.

Rusk County improved their position, compared to the county's position in 2013, in the rate of sexually transmitted infection among the population. The rate of preventable hospital stays in the county also decreased. Adult obesity and access to primary care physicians decreased in the period studied in Rusk County.

Upshur County improved their position, compared to the county's position in 2013, in the rate of sexually transmitted infection among the population, access to primary care physicians, preventable hospital stays and violent crime rate per 10,000 population. However, Upshur declined from 2013 in Clinical care and Physical Environment.

The County Health Rankings for the primary service area indicate that while the population is making some improvements, the population is frequently below the state average on health rankings. This creates a significant impact to Good Shepherd since it is one of the few health care facilities in the area.

Exhibit 1
Good Shepherd Medical Center - Longview
Summary of Inpatient & Outpatient Discharges by Zip Code

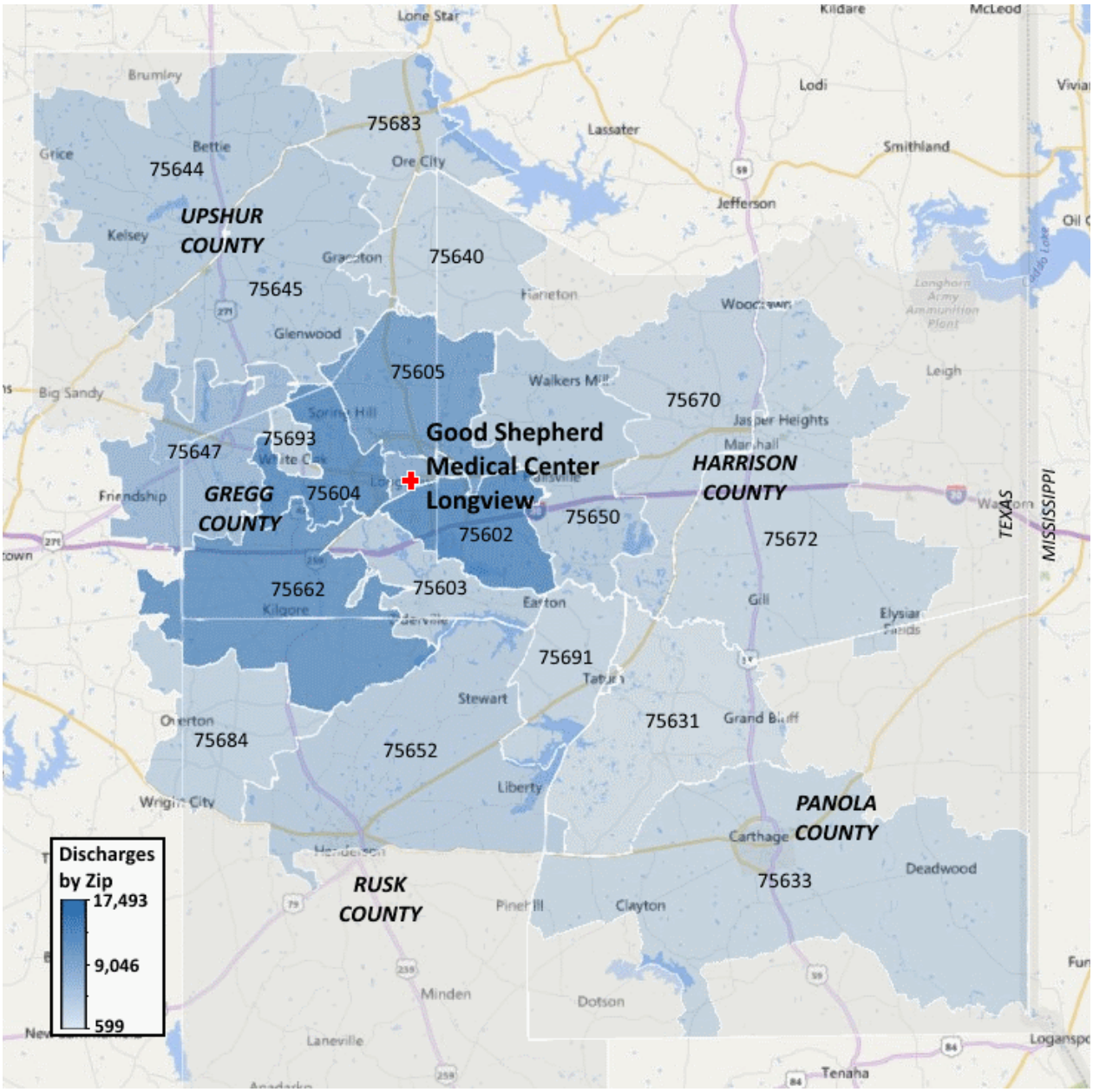
City	Zip Code	Discharges	Percent Discharges
Gregg County	**Total**	**89,652**	**73.4%**
Longview	75602	17,493	11.6%
Longview	75604	17,308	11.5%
Longview	75605	13,888	9.2%
Longview	75601	10,542	7.0%
Longview	75603	3,598	2.4%
Kilgore	75662	15,629	10.4%
Gladewater	75647	7,859	5.2%
White Oak	75693	3,335	2.2%
Upshur County	**Total**	**13,163**	**10.8%**
Gilmer	75644	4,251	2.8%
Gilmer	75645	4,254	2.8%
Ore City	75683	2,362	1.6%
Diana	75640	2,296	1.5%
Harrison County	**Total**	**8,934**	**7.3%**
Marshall	75670	2,650	1.8%
Marshall	75672	1,827	1.2%
Hallsville	75650	4,457	3.0%
Rusk County	**Total**	**8,550**	**7.0%**
Henderson	75652	3,926	2.6%
Overton	75684	2,539	1.7%
Tatum	75691	2,085	1.4%
Panola County	**Total**	**1,818**	**1.2%**
Carthage	75633	1,818	1.2%
	Total	122,117	

Note: Community zip codes were identified as key community zip codes based on the qualification that 1) 80% of the Hospital's discharge population was found in those zip codes, 2) the zip codes is a continuous county and 3) has greater than 1% of the discharges.

Community Details

Identification and Description of Geographical Community

The following map geographically illustrates Good Shepherd's community by showing the community zip codes shaded by number of inpatient discharges. The map below displays Good Shepherd's geographic relationship to the community, as well as significant roads and highways.



Community Population and Demographics

The U.S. Bureau of Census has compiled population and demographic data. *Exhibit 2* below shows the total population of the community. It also provides the breakout of the community between the male and female population, age distribution, race/ethnicity and the Hispanic population.

Exhibit 2
Demographic Snapshot
Good Shepherd Medical Center

DEMOGRAPHIC CHARACTERISTICS

	Total Population
Gregg County, TX	122,258
Harrison County, TX	66,467
Panola County, TX	23,877
Rusk County, TX	53,508
Upshur County, TX	39,640
Total Service Area	305,750
Texas	12,848,554
United States	311,536,591

	Gregg	Harrison	Panola	Rusk	Upshur
Total Male Population	59,922	32,555	11,560	28,268	19,590
Total Female Population	62,336	33,912	12,317	25,240	20,050
	122,258	66,467	23,877	53,508	39,640

POPULATION DISTRIBUTION

Age Distribution										
Age Group	Gregg	Harrison	Panola	Rusk	Upshur	Percent of Total Community	Texas	Percent of Total IL	United States	Percent of Total US
0 - 4	9,303	4,991	1,583	3,430	2,523	0	1,934,973	7.55%	20,052,112	6.44%
5 - 17	22,118	13,523	4,369	8,843	7,226	0	4,989,935	19.46%	53,825,364	17.28%
18 - 24	12,413	974	1,628	4,854	3,242	0	2,634,158	10.27%	31,071,264	9.97%
25 - 34	16,680	8,787	2,923	7,176	4,406	0	3,690,303	14.39%	41,711,276	13.39%
35 - 44	14,734	8,936	2,864	6,799	4,574	0	3,510,980	13.69%	40,874,160	13.12%
45 - 54	16,401	10,045	3,322	7,765	5,906	0	3,435,096	13.40%	44,506,268	14.29%
55 - 64	13,920	9,243	3,313	6,705	5,444	0	2,707,582	10.56%	37,645,104	12.08%
65+	16,689	9,968	3,875	7,936	6,319	0	2,736,346	10.67%	41,851,043	13.43%
Total	**122,258**	**66,467**	**23,877**	**53,508**	**39,640**	**100%**	**25,639,373**	**100%**	**311,536,591**	**100%**

RACE

Race Distribution						
Race	Gregg	Harrison	Panola	Rusk	Upshur	Percent of Total Community
White Non-Hispanic	91,844	49,701	18,852	43,096	34,897	77.97%
Black Non-Hispanic	25,187	15,257	4,237	9,618	3,506	18.91%
Asian and Pacific Island Non-Hispanic	1,610	342	70	274	212	0.82%
All Others	3,617	1,167	719	520	1,025	2.31%
Total	**122,258**	**66,467**	**23,877**	**53,508**	**39,640**	**100%**

HISPANIC POPULATION

	Gregg	Harrison	Panola	Rusk	Upshur	Percent of Total Community	Texas	Percent of Total TX	United States	Percent of Total US
Hispanic	20,593	7,602	2,013	7,926	2,725	13.36%	9,717,727	37.90%	51,786,592	16.62%
Non-Hispanic	101,665	58,865	21,864	45,582	36,915	86.64%	15,921,646	62.10%	259,750,000	83.38%
Total	**122,258**	**66,467**	**23,877**	**53,508**	**39,640**	**100%**	**25,639,373**	**100%**	**311,536,592**	**100%**

Source: Community Commons (ACS 2008-2012 data sets)

While the relative age of the community population can impact community health needs, so can the ethnicity and race of a population. The population of the community by race illustrates different categories of race, such as white, black, Asian, other and multiple races. White non-Hispanics make up 86.9% of the community.

Exhibit 3

Good Shepherd Medical Center

Inside/Outisde MSA Population

County	Percent Inside MSA	Percent Outside MSA
Gregg	86.64%	13.36%
Harrison	43.95%	56.05%
Panola	27.28%	72.72%
Rusk	34.13%	65.87%
Upshur	20.70%	79.30%
TEXAS	84.70%	15.30%
UNITED STATES	80.89%	19.11%

Source: Community Commons

Exhibit 3 reports the percentage of population living inside MSAs and outside MSAs. Inside MSA areas are identified using population density, count and size thresholds. Inside MSA areas also include territory with a high degree of impervious surface (development). Outside MSA areas are all areas that are not urban.

Socioeconomic Characteristics of the Community

The socioeconomic characteristics of a geographic area influence the way residents access health care services and perceive the need for health care services within society. The economic status of an area may be assessed by examining multiple variables within the community. The following exhibits are a compilation of data that includes household per capita income, employment rates, poverty, uninsured population and educational attainment for the community. These standard measures will be used to compare the socioeconomic status of the community to the state of Texas and the United States.

Income and Employment

Exhibit 4 presents the per capita income for the CHNA community. This 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 exhibit is the average (mean) income computed for every man, woman and child in the specified area. Panola is the only county that has a per capita income that is above the state of Texas.

Exhibit 4
Good Shepherd Medical Center
Per Capita Income

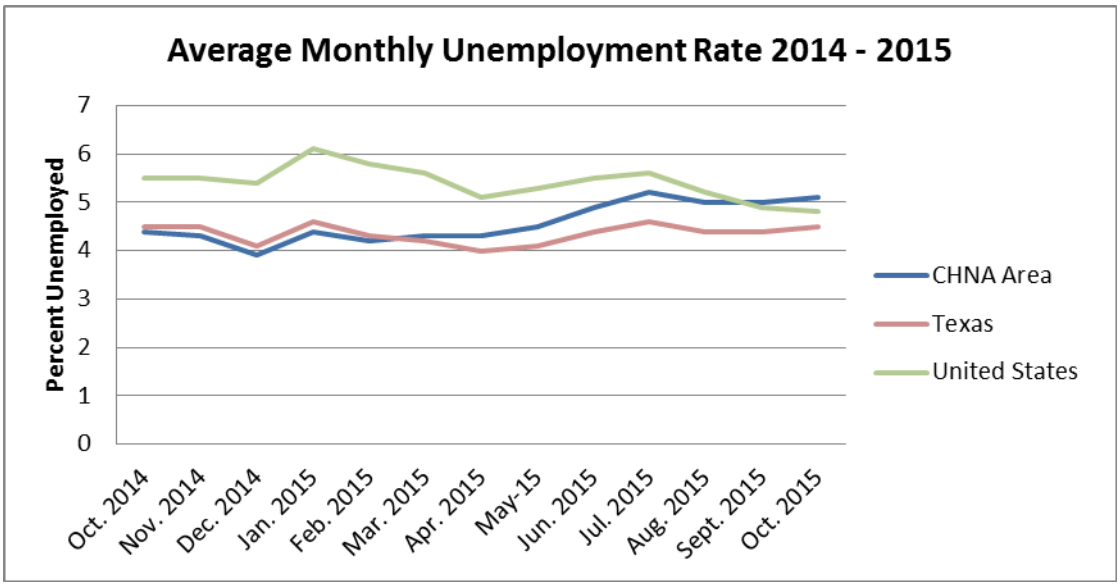
County	Total Adult Population	Total Income ($)	Per Capita Income ($)
Gregg	90,837	$2,941,978,368	$32,387
Harrison	47,953	$1,544,411,776	$32,207
Panola	17,925	$633,329,088	$35,332
Rusk	41,235	$1,157,914,752	$28,081
Upshur	29,891	$891,214,912	$29,815
Texas	25,639,372	$667,104,706,560	$26,019
UNITED STATES	237,659,115	$8,771,308,355,584	$36,907

Source: Community Commons

Unemployment Rate

Exhibit 5 presents the average annual unemployment rate from 2004 - 2013 for the community defined as the community, as well as the trend for Texas and the United States. On average, the unemployment rate for the community is on target with the United States and lower than the state of Texas.

Exhibit 5

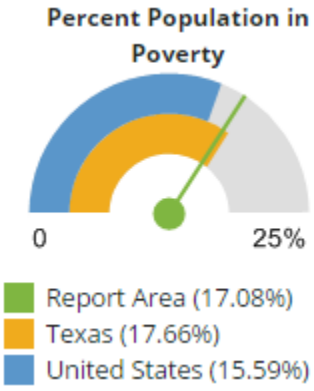


Poverty

Exhibit 6 presents the percentage of total population below 100% Federal Poverty Level (FPL). Poverty is a key driver of health status and is relevant because poverty creates barriers to access, including health services, healthy food choices and other factors that contribute to poor health.

Exhibit 6	Total Population	Population in Poverty	Percent Population in Poverty
Total CHNA Community	293,452	48,882	16.66%
Gregg County, TX	118,366	20,865	17.63%
Harrison County, TX	64,422	10,284	15.96%
Panola County, TX	23,272	2,955	12.7%
Rusk County, TX	48,455	8,644	17.84%
Upshur County, TX	38,937	6,134	15.75%
Texas	25,032,532	4,416,829	17.64%
United States	303,692,064	46,663,432	15.37%

Data Source: U.S. Census Bureau, American Community Survey. 2009-13.

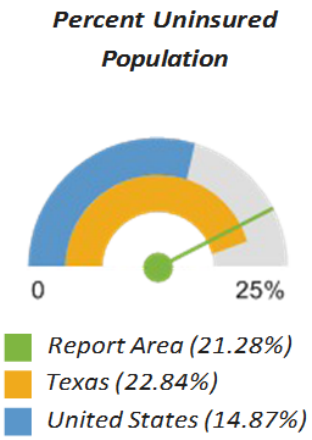


Uninsured

Exhibit 7 reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to health care access, including regular primary care, specialty care and other health services that contribute to poor health status. Over 63,000 persons are uninsured in the CHNA community. Harrison County has the highest uninsured rate of 22.15%.

Exhibit 7	Total Population (For Whom Insurance Status is Determined)	Total Uninsured Population	Percent Uninsured Population
Total CHNA Community	296,947	63,177	**21.28%**
Gregg County, TX	120,153	25,812	**21.48%**
Harrison County, TX	65,549	14,519	**22.15%**
Panola County, TX	23,573	4,053	**17.19%**
Rusk County, TX	48,610	10,605	**21.82%**
Upshur County, TX	39,062	8,188	**20.96%**
Texas	25,158,370	5,746,305	22.84%
United States	306,448,480	45,569,668	14.87%

Note: This indicator is compared with the state average.
Data Source: US Census Bureau, American Community Survey. 2009-13.

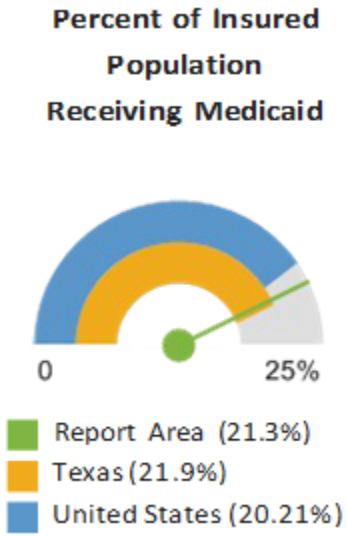


Medicaid

The Medicaid indicator reports the percentage of the population with insurance enrolled in Medicaid (or other means-tested public health insurance). This is relevant because it assesses vulnerable populations, which are more likely to have multiple health access, health status and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment. *Exhibit 8* shows Gregg County is the only county within the CHNA community to rank negatively compared to the state of Texas.

Exhibit 8	Total Population (For Whom Insurance Status is Determined)	Population with Any Health Insurance	Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid
Total CHNA Community	296,947	233,770	49,804	**21.3%**
Gregg County, TX	120,153	94,341	21,163	**22.43%**
Harrison County, TX	65,549	51,030	10,046	**19.69%**
Panola County, TX	23,573	19,520	3,766	**19.29%**
Rusk County, TX	48,610	38,005	8,112	**21.34%**
Upshur County, TX	39,062	30,874	6,717	**21.76%**
Texas	25,158,370	19,412,064	4,251,929	21.9%
United States	306,448,480	260,878,816	52,714,280	20.21%

Note: This indicator is compared with the state average.
Data Source: US Census Bureau, American Community Survey. 2009-13.



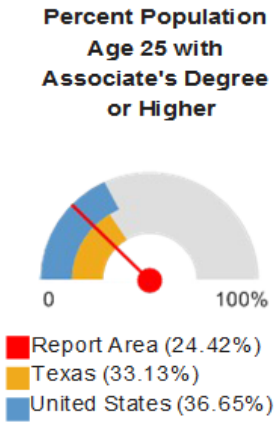
Education

Exhibit 9 presents the population with an Associate's level degree or higher in each county versus Texas and the United States.

Education levels obtained by community residents may impact the local economy. Higher levels of education generally lead to higher wages, less unemployment and job stability. These factors may indirectly influence community health. As noted in *Exhibit 9*, the percent of residents within the CHNA community obtaining an Associate's degree or higher is below the state percentage.

Exhibit 9	Total Population Age 25	Population Age 25 with Associate's Degree or Higher	Percent Population Age 25 with Associate's Degree or Higher
Total CHNA Community	200,105	48,865	**24.42%**
Gregg County, TX	78,188	22,127	**28.3%**
Harrison County, TX	42,948	11,081	**25.8%**
Panola County, TX	15,939	3,130	**19.64%**
Rusk County, TX	36,381	7,209	**19.82%**
Upshur County, TX	26,649	5,318	**19.96%**
Texas	16,080,307	5,327,302	33.13%
United States	206,587,856	75,718,936	36.65%

Note: This indicator is compared with the state average.
Data Source: US Census Bureau, American Community Survey. 2009-13. Source geography: Tract



Physical Environment of the Community

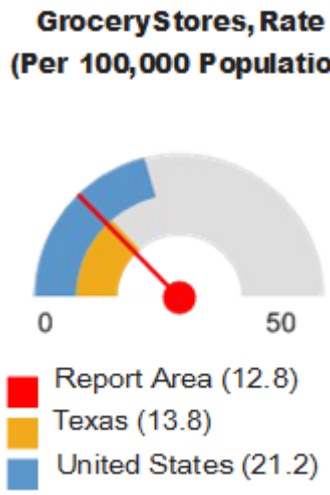
A community's health is also affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health. This section will touch on a few of the elements that relate to some needs mentioned throughout the report.

Grocery Store Access

Exhibit 10 reports the number of grocery stores per 100,000-population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods, fresh fruits and vegetables and fresh and prepared meats, fish and poultry. Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

Exhibit 10	Total Population	Number of Establishments	Establishments, Rate per 100,000 Population
Total CHNA Community	303,796	39	**12.8**
Gregg County, TX	121,730	15	**12.32**
Harrison County, TX	65,631	11	**16.76**
Panola County, TX	23,796	3	**12.61**
RuskCounty, TX	53,330	6	**11.25**
Upshur County, TX	39,309	4	**10.18**
Texas	25,145,561	3,473	13.8
United States	312,732,537	66,286	21.2

Note: This indicator is compared with the state average.
Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2013. Source geography: County

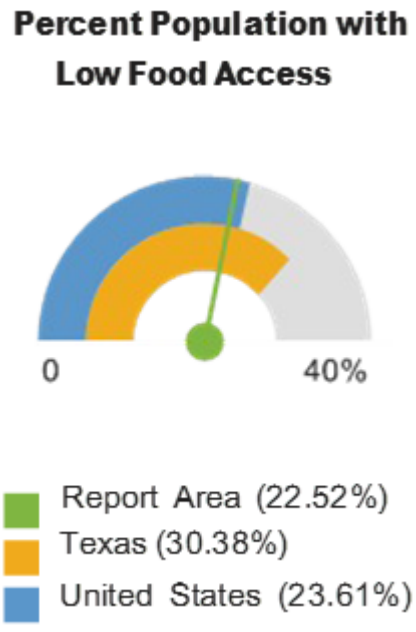


Food Access/Food Deserts

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 stores. The information in *Exhibit 11* below is relevant because it highlights populations and geographies facing food insecurity.

Exhibit 11	Total Population	Population with Low Food Access	Percent Population with Low Food Access
Total CHNA Community	303,796	68,421	**22.52%**
Gregg County, TX	121,730	31,024	**25.49%**
Harrison County, TX	65,631	11,749	**17.9%**
Panola County, TX	23,796	5,579	**23.45%**
Rusk County, TX	53,330	15,044	**28.21%**
Upshur County, TX	39,309	5,025	**12.78%**
Texas	25,145,561	7,639,114	30.38%
United States	308,745,538	72,905,540	23.61%

Note: This indicator is compared with the state average.
Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010.

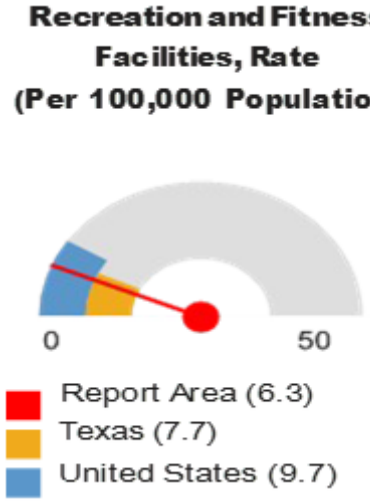


Recreation and Fitness Facility Access

This indicator reports the number per 100,000-population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940. It is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors. *Exhibit 12* shows that Panola County is the only county that does not have any fitness establishments available to the residents.

Exhibit 12	Total Population	Number of Establishments	Establishments, Rate per 100,000 Population
Total CHNA Community	303,796	19	**6.3**
Gregg County, TX	121,730	12	**9.86**
Harrison County, TX	65,631	4	**6.09**
Panola County, TX	23,796	0	**0**
Rusk County, TX	53,330	2	**3.75**
Upshur County, TX	39,309	1	**2.54**
Texas	25,145,561	1,932	7.7
United States	312,732,537	30,393	9.7

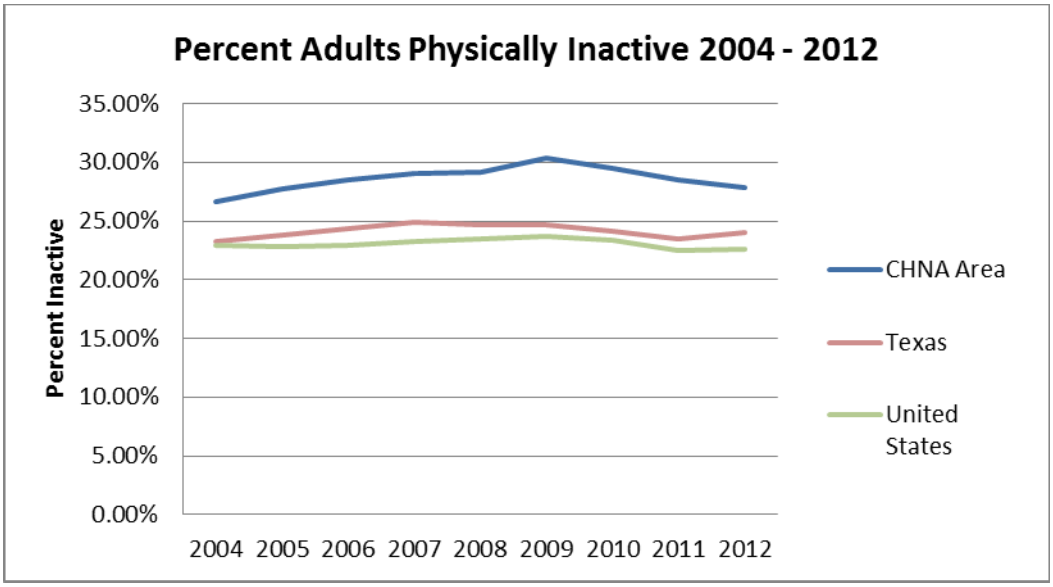
Note: This indicator is compared with the state average.
Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2013.



Physical Activity

The trend graph below (*Exhibit 13)* shows the percentage of adults who are physically inactive by year for the community and compared to Texas and the United States. Since 2004, the CHNA community has had a higher percentage of adults who are physically inactive compared to both the state of Texas and the United States. The trend saw an increase in 2009, the percentage of adults physically inactive within the community has slightly decreased between 2011 and 2012.

Exhibit 13



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.

Note: The Hospital used data from 2012 as this data represented the most recent information available on the subject.

Clinical Care of the Community

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of un-insurance, financial hardship, transportation barriers, cultural competency and coverage limitations affect access.

Rates of morbidity, mortality and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions

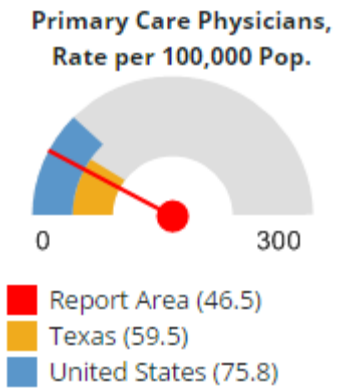
Access to Primary Care

Exhibit 14 shows the number of primary care physicians per 100,000-population. Doctors classified as "primary care physicians" by the American Medical Association include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contribute to access and health status issues.

Exhibit 14	Total Population, 2012	Primary Care Physicians, 2012	Primary Care Physicians, Rate per 100,000 Pop.
Total CHNA Community	308,149	143	46.4
Gregg County, TX	122,658	92	75
Harrison County, TX	67,450	18	26.7
Panola County, TX	24,020	10	41.6
Rusk County, TX	54,026	12	22.2
Upshur County, TX	39,995	11	27.5
Texas	26,059,203	15,254	58.5
United States	313,914,040	233,862	74.5

Data Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.

Note: The Hospital used data from 2012 as this data represented the most recent information available on the subject.



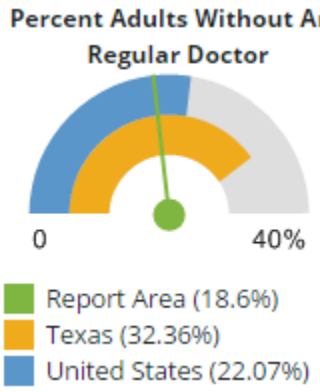
Lack of a Consistent Source of Primary Care

Exhibit 15 reports the percentage of adults aged 18 and older who self-report that they do not have at least one person who they think of as their personal doctor or health care provider. This indicator is relevant because access to regular primary care is important to preventing major health issues and emergency department visits.

Exhibit 15	Survey Population (Adults Age 18)	Total Adults Without Any Regular Doctor	Percent Adults Without Any Regular Doctor
Total CHNA Community	240,963	44,897	18.6%
Gregg County, TX	81,939	14,151	17.27%
Harrison County, TX	54,530	13,899	25.49%
Panola County, TX	27,762	3,660	13.18%
Rusk County, TX	39,678	11,040	27.82%
Upshur County, TX	37,054	2,147	5.79%
Texas	18,375,873	5,946,509	32.36%
United States	236,884,668	52,290,932	22.07%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.

Note: The Hospital used data from 2012 as this data represented the most recent information available on the subject.



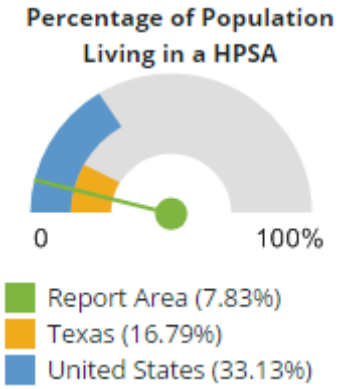
Population Living in a Health Professional Shortage Area

This indicator reports the percentage of the population that is living in a geographic area designated as a Health Professional Shortage Area (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. As *Exhibit 16* below shows, 100% of the residents from Harrison and Panola counties within the CHNA community are living in a health professional shortage area.

Exhibit 16	Total Area Population	Population Living in a HPSA	Percentage of Population Living in a HPSA
Total CHNA Community	303,796	97,886	32.22%
Gregg County, TX	121,730	0	0%
Harrison County, TX	65,631	0	0%
Panola County, TX	23,796	23,796	100%
Rusk County, TX	53,330	0	0%
Upshur County, TX	39,309	8,459	21.52%
Texas	25,145,561	6,121,607	24.34%
United States	308,745,538	105,203,742	34.07%

Note: 0% indicates that the county is not designated as an HPSA area, 100% indicates that the entire county is designated as an HPSA area

Data Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015. Source geography: HPSA

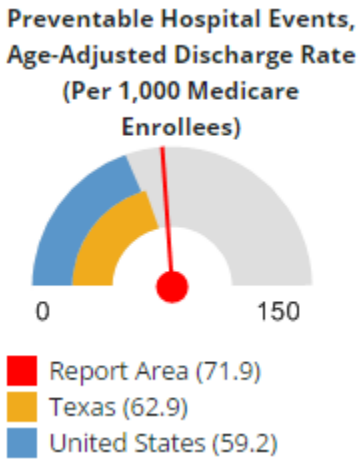


Preventable Hospital Events

Exhibit 17 reports the discharge rate (per 1,000 Medicare enrollees) for conditions that are ambulatory care sensitive (ACS). ACS conditions include pneumonia, dehydration, asthma, diabetes and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients. This indicator is relevant because analysis of ACS discharges allows demonstrating a possible "return on investment" from interventions that reduce admissions (for example, for uninsured or Medicaid patients) through better access to primary care resources.

Exhibit 17	Total Medicare Part A Enrollees	Ambulatory Care Sensitive Condition Hospital Discharges	Ambulatory Care Sensitive Condition Discharge Rate
Total CHNA Community	35,196	2,529	71.9
Gregg County, TX	16,334	1,073	65.7
Harrison County, TX	6,644	477	71.9
Panola County, TX	3,039	257	84.7
Rusk County, TX	5,224	431	82.5
Upshur County, TX	3,955	290	73.3
Texas	2,030,887	127,787	62.9
United States	58,209,898	3,448,111	59.2

Data Source: Dartmouth College Institute for Health Policy, Clinical Practice, Dartmouth Atlas of Health Care. 2012. Source geography: County



Health Status of the Community

This section of the assessment reviews the health status of Gregg, Harrison, Panola, Rusk and Upshur county residents. As in the previous section, comparisons are provided with the state of Texas and the United States. This in-depth assessment of the mortality and morbidity data, health outcomes, health factors and mental health indicators of the county residents that make up the CHNA community will enable Good Shepherd to identify priority health issues related to the health status of its residents.

Good health can be defined as a state of physical, mental and social well-being, rather than the absence of disease or infirmity. According to *Healthy People 2020*, the national health objectives released by the U.S. Department of Health and Human Services, individual health is closely linked to community health. Community health, which includes both the physical and social environment in which individuals live, work and play, is profoundly affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community. Healthy people are among a community's most essential resources.

Numerous factors have a significant impact on an individual's health status: lifestyle and behavior, human biology, environmental and socioeconomic conditions, as well as access to adequate and appropriate health care and medical services.

Studies by the American Society of Internal Medicine conclude that up to 70% of an individual's health status is directly attributable to personal lifestyle decisions and attitudes. Persons who do not smoke, drink in moderation (if at all), use automobile seat belts (car seats for infants and small children), maintain a nutritious low-fat, high-fiber diet, reduce excess stress in daily living and exercise regularly have a significantly greater potential of avoiding debilitating diseases, infirmities and premature death.

The interrelationship among lifestyle/behavior, personal health attitude and poor health status is gaining recognition and acceptance by both the general public and health care providers. Some examples of lifestyle/behavior and related health care problems include the following:

Lifestyle	Primary Disease Factor
Smoking	Lung cancer Cardiovascular disease Emphysema Chronic bronchitis
Alcohol/drug abuse	Cirrhosis of liver Motor vehicle crashes Unintentional injuries Malnutrition Suicide Homicide Mental illness
Poor nutrition	Obesity Digestive disease Depression

Lifestyle	Primary Disease Factor
Driving at excessive speeds	Trauma Motor vehicle crashes
Lack of exercise	Cardiovascular disease Depression
Overstressed	Mental illness Alcohol/drug abuse Cardiovascular disease

Health problems should be examined in terms of morbidity as well as mortality. Morbidity is defined as the incidence of illness or injury, and mortality is defined as the incidence of death. Such information provides useful indicators of health status trends and permits an assessment of the impact of changes in health services on a resident population during an established period of time. Community attention and health care resources may then be directed to those areas of greatest impact and concern.

Leading Causes of Death and Health Outcomes

Exhibit 18 reflects the leading causes of death for the community and compares the rates to the state of Texas and the United States.

Exhibit 18
Good Shepherd Medical Center
Selected Causes of Resident Deaths: Number and Crude Rate

	Gregg		Harrison		Texas		United States	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Cancer	258	210.70	129	195.20	37,243	145.30	577,313	185.4
Heart disease	295	240.96	143	215.12	38,738	151.17	600,899	192.95
Ischaemic heart disease	174	142.10	83	125.80	23,779	92.80	390,568	127.43
Lung disease	80	65.22	42	63.96	9,198	35.89	142,214	45.66
Stroke	62	50.50	33	50.10	9,194	35.90	131,470	42.90
Unintentional injury	56	45.44	37	55.82	9,336	36.43	125	40.05
Motor vehicle	24	19.80	18	26.90	3,356	13.10	34,139	11.00
Suicide	18	14.70	10	14.80	2,938	11.50	39,308	12.60

	Panola		Rusk		Texas		United States	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Cancer	55	229.40	108	202.60	37,243	145.30	577,313	185.4
Heart disease	55	229.44	152	284.07	38,738	151.17	600,899	192.95
Ischaemic heart disease	34	141.50	82	152.90	23,779	92.80	390,568	127.43
Lung disease	18	73.69	34	63.17	9,198	35.89	142,214	45.66
Stroke	12	51.10	23	42.20	9,194	35.90	131,470	42.90
Unintentional injury	17	69.50	33	62.42	9,336	36.43	125	40.05
Motor vehicle	10	43.50	16	30.30	3,356	13.10	34,139	11.00
Suicide	4	15.90	7	13.80	2,938	11.50	39,308	12.60

	Upshur		Texas		United States	
	Number	Rate	Number	Rate	Number	Rate
Cancer	92	231.7	37,243	145.30	577,313	185.4
Heart disease	115	290.77	38,738	151.17	600,899	192.95
Ischaemic heart disease	83	209.50	23,779	92.80	390,568	127.43
Lung disease	25	62.60	9,198	35.89	142,214	45.66
Stroke	20	50.00	9,194	35.90	131,470	42.90
Unintentional injury	21	53.51	9,336	36.43	125	40.05
Motor vehicle	10	25.20	3,356	13.10	34,139	11.00
Suicide	9	22.20	2,938	11.50	39,308	12.60

Source: Community Commons 2007-2011

The table above shows leading causes of death within each county as compared to the state of Texas and also to the United States. The crude rate is shown per 100,000 residents. The rates highlighted in yellow represent the county and corresponding leading cause of death that is greater than the state rate. As the table indicates, all of the county leading causes of death above are greater than the Texas rate.

Health Outcomes and Factors

An analysis of various health outcomes and factors for a particular community can, if improved, help make the community a healthier place to live, learn, work and play. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture and environment. This portion of the CHNA utilizes information from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

The County Health Rankings model is grounded in the belief that programs and policies implemented at the local, state and federal levels have an impact on the variety of factors that, in turn, determine the health outcomes for communities across the nation. The model provides a ranking method that ranks all 50 states and the counties within each state, based on the measurement of two types of health outcomes for each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by programs and policies at the local, state and federal levels.

Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, *e.g.*, 1 or 2, are considered to be the "healthiest." Counties are ranked relative to the health of other counties in the same state on the following summary measures:

- ✓ Health outcomes – rankings are based on an equal weighting of one length of life (mortality) measure and four quality of life (morbidity) measures.
- ✓ Health factors – rankings are based on weighted scores of four types of factors:
  - Health behaviors (nine measures)
  - Clinical care (seven measures)
  - Social and economic (nine measures)
  - Physical environment (five measures)

A more detailed discussion about the ranking system, data sources and measures, data quality and calculating scores and ranks can be found at the website for County Health Rankings (www.countyhealthrankings.org).

As seen in *Exhibits 19,* the relative health status of each county within the community will be compared to the state of Illinois as well as to a national benchmark. The current year information is compared to the health outcomes reported on the prior community health needs assessment and the change in measures is indicated. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture and environment.

Exhibit 19.1
Good Shepherd Medical Center
County Health Rankings – Health Outcomes

		Gregg County 2012	Gregg County 2015	Change	Texas 2015	Top U.S. Performers 2015
Mortality	*	181	** 189	↑		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		10,268	9,467	↓	6,650	5,200
Morbidity	*	145	** 133	↓		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		17%	19%	↑	18%	10%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		3.9	3.9		3.7	2.5
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		3.2	2.8	↓	3.3	2.3
Low birth weight – Percent of live births with low birth weight (<2500 grams)		9.3%	9.4%	↑	8.4%	5.9%

* Rank out of 221 Texas counties in 2010
** Rank out of 237 Texas counties in 2015

Note: N/A indicates unreliable or missing data

Source: Countyhealthrankings.org

Exhibit 19.2
Good Shepherd Medical Center
County Health Rankings – Health Outcomes

		Harrison County 2012	Harrison County 2015	Change	Texas 2015	Top U.S. Performers 2015
Mortality	*	185	** 173	↓		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		10,393	9,113	↓	6,650	5,200
Morbidity	*	167	** 155	↓		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		20%	18%	↓	18%	10%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		3.5	3.8	↑	3.7	2.5
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		4.2	4.8	↑	3.3	2.3
Low birth weight – Percent of live births with low birth weight (<2500 grams)		9.2%	9.6%	↑	8.4%	5.9%

* Rank out of 221 Texas counties in 2010
** Rank out of 237 Texas counties in 2015

Note: N/A indicates unreliable or missing data

Source: Countyhealthrankings.org

Exhibit 19.3
Good Shepherd Medical Center
County Health Rankings – Health Outcomes

		Panola County 2012	Panola County 2015	Change	Texas 2015	Top U.S. Performers 2015
Mortality	*	**156**	** **178**	↑		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		9,490	9,210	↓	6,650	5,200
Morbidity	*	**142**	** **99**	↓		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		16%	15%	↓	18%	10%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		5.3	4.8	↓	3.7	2.5
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		6.0	NA		3.3	2.3
Low birth weight – Percent of live births with low birth weight (<2500 grams)		7.3%	8.1%	↑	8.4%	5.9%

* Rank out of 221 Texas counties in 2010
** Rank out of 237 Texas counties in 2015

Note: N/A indicates unreliable or missing data

Source: Countyhealthrankings.org

Exhibit 19.4
Good Shepherd Medical Center
County Health Rankings – Health Outcomes

		Rusk County 2012	Rusk County 2015	Change	Texas 2015	Top U.S. Performers 2015
Mortality	*	164	** 175	↑		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		9,686	9,184	↓	6,650	5,200
Morbidity	*	96	** 112	↑		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		16%	15%	↓	18%	10%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		3.0	3.9	↑	3.7	2.5
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		3.2	4.3	↑	3.3	2.3
Low birth weight – Percent of live births with low birth weight (<2500 grams)		8.9%	8.4%	↓	8.4%	5.9%

* Rank out of 221 Texas counties in 2010
** Rank out of 237 Texas counties in 2015

Note: N/A indicates unreliable or missing data

Source: Countyhealthrankings.org

Exhibit 19.5
Good Shepherd Medical Center
County Health Rankings – Health Outcomes

		Upshur County 2012	Upshur County 2015	Change	Texas 2015	Top U.S. Performers 2015
Mortality	*	167	** 231	↑		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		9,982	11,364	↑	6,650	5,200
Morbidity	*	127	NA			
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		NA	NA		18%	10%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		3.5	NA		3.7	2.5
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		3.7	1.4	↓	3.3	2.3
Low birth weight – Percent of live births with low birth weight (<2500 grams)		7.8%	7.9%	↑	8.4%	5.9%

* Rank out of 221 Texas counties in 2010
** Rank out of 237 Texas counties in 2015

Note: N/A indicates unreliable or missing data

Source: Countyhealthrankings.org

The above tables show that mortality outcomes ratings have declined for all counties except Harrison County from the prior year. However, morbidity ranking have improved for all counties except Rusk County which declined from the prior year and Upshur County where there was not enough information.

A number of different health factors shape a community's health outcomes. The County Health Rankings model includes four types of health factors: health behaviors, clinical care, social and economic and the physical environment. The following summary shows some of the major improvements from prior year to current year and challenges faced by each county in Good Shepherd's community. The improvements/challenges shown below in *Exhibits 20* were determined using a process of comparing the rankings of each county's health outcomes in the current year to the rankings in 2012. If the current year rankings showed an improvement or decline of 4% or four points, they were included in the charts below. Please refer to Appendix D for the full list of health factor findings and comparisons between prior year information reported and current year information.

Exhibit 20

Gregg County

Improvements	Challenges
Preventable hospital stays hospitalization rate for ambulatory - care sensitive conditions per 1,000 Medicare decreased from 78 to 66	Sexually Transmitted Infections – chlamydia rate per 100,000 population increased 688 to 810
High school graduation - percent of ninth grade cohort that graduates in 4 years has increased from 87% to 91%	
Children in poverty under age 18 decreased from 30% to 25%	
Violent crime rate per 100,000 population (age-adjusted) has decreased from 771 to 504	

Harrison County

Improvements	Challenges
Physical inactivity - percent of adults age 20 and over reporting no leisure time physical activity decreased from 34% to 30%	Sexually Transmitted Infections – chlamydia rate per 100,000 population increased 289 to 482
Preventable hospital stays - hospitalization rate for ambulatory - care sensitive conditions per 1,000 Medicare decreased from 89 to 72	Primary care physicians - ratio of population to primary care physicians increased from 2,899 to 3,747:1
Percent of adults age 25-44 years with some post-secondary education increased from 47.9% to 52.2%	
Violent crime rate - violent crime rate per 100,000 population (age-adjusted) decreased from 456 to 405	

Panola County

Improvements	Challenges
Teen birth rate - per 1,000 female population, ages 15-19 decreased from 58 to 53	Sexually Transmitted Infections – chlamydia rate per 100,000 population increased 247 to 446
Preventable hospital stays - hospitalization rate for ambulatory - care sensitive conditions per 1,000 Medicare enrollees decreased from 107 to 85	
Primary care physicians - ratio of population to primary care physicians decreased from 3,312:1 to 2,402:1	

Rusk County

Improvements	Challenges
Sexually Transmitted Infections – chlamydia rate per 100,000 population decreased 286 to 267	Adult obesity - percent of adults that report a BMI > = 30 increased from 31% to 37%
Preventable hospital stays - hospitalization rate for ambulatory - care sensitive conditions per 1,000 Medicare decreased from 107 to 83	Primary care physicians - ratio of population to primary care physicians increased from 2,719:1 to 4,502:1
Violent crime rate - violent crime rate per 100,000 population (age-adjusted) decreased from 429 to 357.	Children in poverty - percent of children under age 18 in poverty increased from 24% to 28%
	Children in single - parent households - percent of children that live in household headed by single parent increased from 27% to 36%

Upshur County

Improvements	Challenges
Sexually Transmitted Infections – chlamydia rate per 100,000 population decreased 274 to 243	Adult smoking – percent of adults that report smoking at least 100 cigarettes and that they currently smoke (47%) is much higher than the Texas average (17%)
Primary care physicians - ratio of population to primary care physicians decreased from 3,788: 1 to 3,636:1	Adult obesity is higher (33%) than the Texas average (29%) and higher than in 2012 (31%)
Preventable hospital stays - hospitalization rate for ambulatory - care sensitive conditions per 1,000 Medicare decreased from 101 to 73	Access to exercise opportunities (30%) is significantly lower than the Texas average (84%)
Violent crime rate per 100,000 population (age-adjusted) decreased from 303 to 263	

Note: There is currently no health care facility in Upshur County

As can be seen from the summarized tables above, there are several areas of the community that have room for improvement when compared to the state statistics and prior years; however, there are also significant improvements made within each county from the prior year CHNA report.

The following exhibits show a more detailed view of certain health outcomes and factors. The percentages for each county and the community as a whole are compared to the state of Texas.

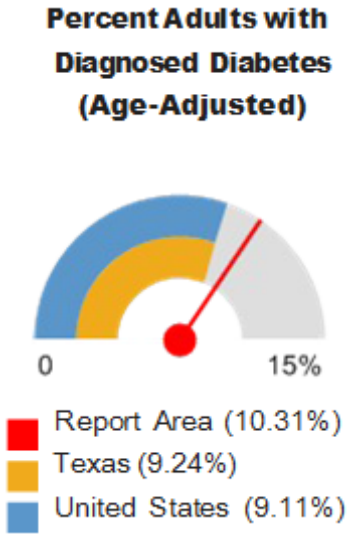
Diabetes (Adult)

Exhibit 21 reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Exhibit 21	Total Population Age 20	Population with Diagnosed Diabetes	Population with Diagnosed Diabetes, Crude Rate	Population with Diagnosed Diabetes, Age-Adjusted Rate
Total CHNA Community	222,779	25,514	11.45	**10.31%**
Gregg County, TX	87,491	9,624	11	**10.2%**
Harrison County, TX	48,181	5,589	11.6	**10.4%**
Panola County, TX	17,513	1,979	11.3	**9.7%**
Rusk County, TX	40,283	4,834	12	**10.9%**
Upshur County, TX	29,311	3,488	11.9	**10.1%**
Texas	18,357,669	1,698,171	9.25	9.24%

Note: This indicator is compared with the state average.
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County

Note: The Hospital used data from 2012 as this data represented the most recent information available on the subject.

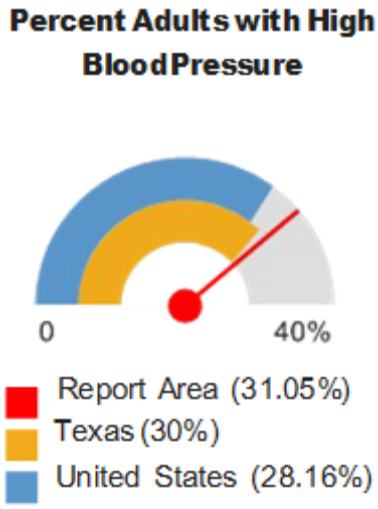


High Blood Pressure (Adult)

Per *Exhibit 22* below, 64,525 or 31.05% of adults aged 18 and older have ever been told by a doctor that they have high blood pressure or hypertension. The community percentage of high blood pressure among adults is higher than the percentage of Texas and the United States.

Exhibit 22	Total Population (Age 18)	Total Adults with High Blood Pressure	Percent Adults with High Blood Pressure
Total CHNA Community	225,657	64,525	**31.05%**
Gregg County, TX	89,785	31,066	**34.6%**
Harrison County, TX	48,183	11,949	**24.8%**
Panola County, TX	17,860	No data	No data
Rusk County, TX	40,379	12,881	**31.9%**
Upshur County, TX	29,450	8,629	**29.3%**
Texas	17,999,726	5,399,918	30%
United States	232,556,016	65,476,522	28.16%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data

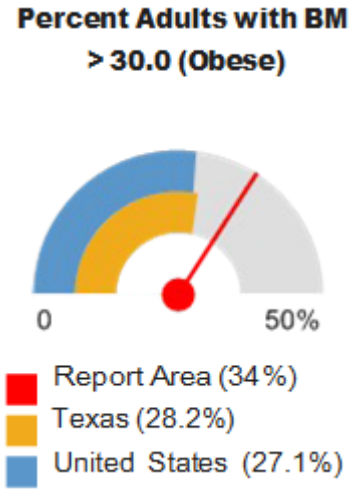


Obesity

Of adults aged 20 and older, 34% self-report that they have a body mass index (BMI) greater than 30.0 (obese) in the community per *Exhibit 23*. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. All five counties have a BMI percentage greater than the state rate.

Exhibit 23	Total Population Age 20	Adults with BMI > 30.0 (Obese)	Percent Adults with BMI > 30.0 (Obese)
Total CHNA Community	222,867	76,053	**34%**
Gregg County, TX	87,707	30,785	**35%**
Harrison County, TX	48,239	15,919	**32.8%**
Panola County, TX	17,529	5,662	**32.2%**
Rusk County, TX	40,133	14,207	**35.3%**
Upshur County, TX	29,259	9,480	**32.3%**
Texas	18,326,228	5,204,739	28.2%
United States	231,417,834	63,336,403	27.1%

Note: This indicator is compared with the state average.
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County

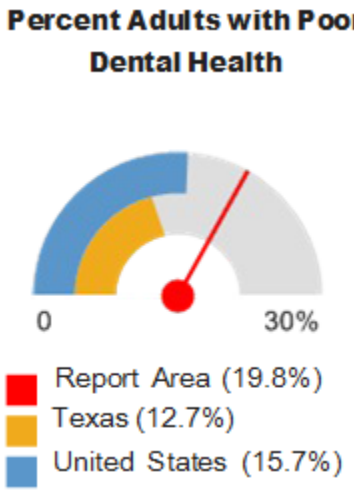


Poor Dental Health

This indicator is relevant because it indicates lack of access to dental care and/or social barriers to utilization of dental services. *Exhibit 24* shows that of the information available, all counties except for Panola County have higher rates of poor dental health than the state and national rates.

Exhibit 24	Total Population (Age 18)	Total Adults with Poor Dental Health	Percent Adults with Poor Dental Health
CHNA Community Area	223,344	44,324	**19.8%**
Gregg County, TX	88,770	15,235	**17.2%**
Harrison County, TX	47,876	10,152	**21.2%**
Panola County, TX	17,729	1,723	**9.7%**
Rusk County, TX	39,819	7,292	**18.3%**
Upshur County, TX	29,150	9,922	**34%**
Texas	17,999,726	2,279,845	12.7%
United States	235,375,690	36,842,620	15.7%

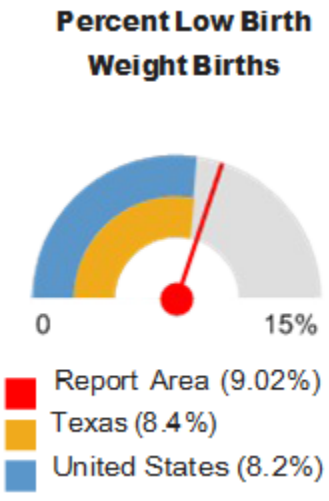
Note: This indicator is compared with the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10. Source geography: County



Low Birth Weight

Exhibit 25 reports the percentage of total births that are low birth weight (under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Exhibit 25	Total Live Births	Low Weight Births (Under 2500g)	Low Weight Births, Percent of Total
CHNA Community Area	29,946	2,701	**9.02%**
Gregg County, TX	13,692	1,287	**9.4%**
Harrison County, TX	6,062	582	**9.6%**
Panola County, TX	2,128	172	**8.1%**
Rusk County, TX	4,655	391	**8.4%**
Upshur County, TX	3,409	269	**7.9%**
Texas	2,759,442	231,793	8.4%
United States	29,300,495	2,402,641	8.2%
HP 2020 Target			**<= 7.8%**



Community Input – Key Stakeholder Surveys

Surveying key stakeholders (community members who represent the broad interest of the community, persons representing vulnerable populations or persons with knowledge of or expertise in public health) is a technique employed to assess public perceptions of the county's health status and unmet needs. These surveys are intended to ascertain opinions among individuals likely to be knowledgeable about the community and influential over the opinions of others about health concerns in the community.

Methodology

Surveys were distributed to 188 key stakeholders. Stakeholders were determined based on a) their specialized knowledge or expertise in public health, b) their affiliation with local government, schools and industry or c) their involvement with underserved and minority populations. We received 53 individual key stakeholder responses to our inquiries.

Participants provided comments on the following issues:

- ✓ Health and quality of life for residents of the primary community
- ✓ Underserved populations and communities of need
- ✓ Barriers to improving health and quality of life for residents of the community
- ✓ Opinions regarding the important health issues that affect community residents and the types of services that are important for addressing these issues

Feedback was also solicited regarding community improvements seen since Good Shepherd's previous Community Health Needs Assessment in 2013.

Survey questions were provided in narrative form and respondents provided free text responses. Please refer to *Appendix E* for a copy of the survey questions. This technique does not provide a quantitative analysis of the stakeholders' opinions but reveals community input for some of the factors affecting the views and sentiments about overall health and quality of life within the community.

Key Stakeholder Profiles

Key stakeholders from the community (see *Appendix E* for a list of key stakeholders) worked for the following types of organizations and agencies:

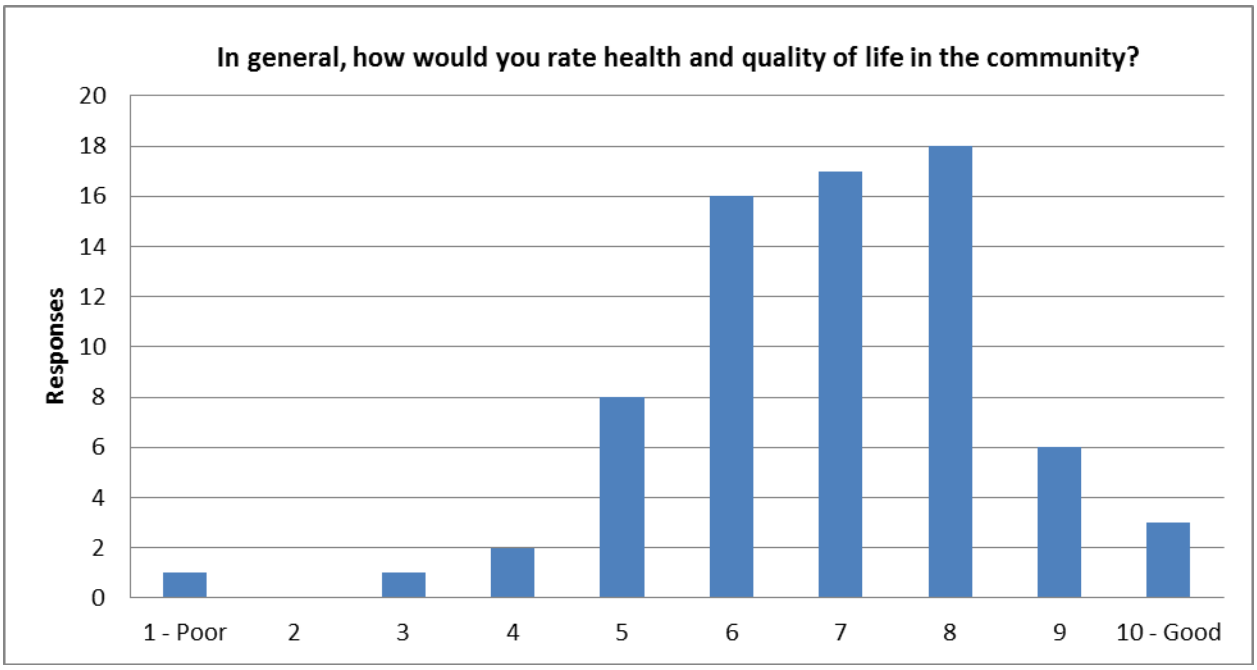
- ✓ Good Shepherd Medical Center
- ✓ Social service agencies
- ✓ Public service agencies (Emergency services, Fire services)
- ✓ Local government agencies
- ✓ Public health agencies
- ✓ Other medical providers
- ✓ Community centers

Key Stakeholder Survey Results

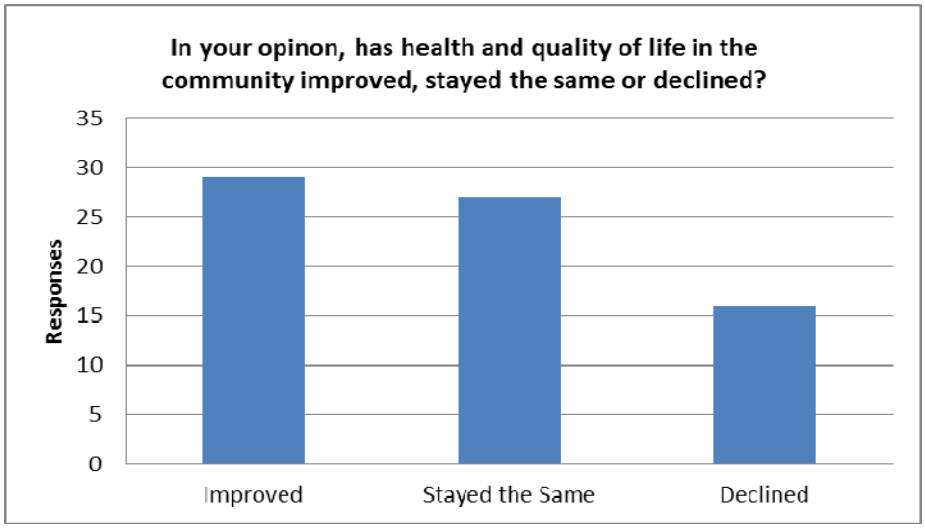
The questions on the survey are grouped into five major categories for discussion. The survey questions for each key stakeholder were identical. A summary of the stakeholders' responses by each of the categories follows. Paraphrased quotes are included to reflect some commonly held opinions and direct quotes are employed to emphasize strong feelings associated with the statements. This section of the report summarizes what the key stakeholders said without assessing the credibility of their comments.

1. General opinions regarding health and quality of life in the community

The key stakeholders were asked to rate the health and quality of life in their respective communities. They were also asked to provide their opinion whether the health and quality of life had improved, declined or stayed the same over the past few years. Lastly, key stakeholders were asked to provide support for their answers.



Key stakeholders were asked if health and quality of life in the community has improved, stayed the same or declined.



Respondents were then asked to explain why health and quality of life in the community has improved, stayed the same or declined, stakeholders note that improvements have occurred as a result of the community promoting healthier lifestyles through exercise and better eating habits, improvements to hospital facilities and recruiting and awareness of the importance of prevention in the community and with health care providers. Additionally, improvements have resulted from an attitude shift in the community toward improving quality of life and a healthy lifestyle. Respondents also notes that additional specialists have come to the community recently.

Stakeholders who felt health and quality of life had declined stated that many individuals have lost their jobs and health insurance due to the recent decline in the energy sector of the economy, the need for additional doctors in the community, crime rates in the community and little progression with providing mental health services. Respondents also noted that high rates of obesity and chronic diseases have negatively impacted the community's quality of life. The cost of health care and the lack of coverage by insurance was also noted as a challenge to the community especially with health plans with high deductibles and Medicaid coverage.

Lack of mental health services in the community was also attributed to negatively impacting the health and quality of life in the community. Many key stakeholders stated there was a severe shortage of mental health services in the community, specifically outpatient mental health services. While there are a few services available, many who need services lack education regarding behavioral health and resist treatment due to the stigma attached to mental health conditions.

2. Underserved populations and communities of need

Key stakeholders were asked to provide their opinions regarding specific populations or groups of people whose health or quality of life may not be as good as others. BKD also asked the key stakeholders to provide their opinions as to if these groups of people have a more difficult time obtaining necessary/preventive medical services.

Respondents noted that persons living with low-incomes or in poverty are most likely to be underserved due to lack of access to services. Lack of financial resources prevents persons with low-income from seeking medical care. Transportation was felt to be a major barrier for persons with few financial resources. The elderly was also identified as a population faced with challenges accessing care due to limited transportation, isolation and fixed incomes.

Stakeholders also commented that individuals with mental health concerns and substance abuse issues as well as the homeless population have a significantly difficult time accessing health services and typically have a lower quality of life. Additionally, several stakeholders noted that since Medicaid was not expanded in Texas as a part of the Affordable Care Act, many individuals do not have Medicaid coverage which would allow them to more easily access health care services.
Several of the key stakeholders noted there are language barriers and transportation barriers for the Hispanic population living in the community. The language barrier and lack of legal status for many of these immigrant workers limits the health care services they are able to access, particularly preventive services.

3. *Barriers*

The key stakeholders were asked what barriers or problems keep community residents from obtaining necessary health services and improving health in their community. The majority of the key stakeholders noted that affordability and financial barriers were primary barriers to accessing health care. Stakeholders indicated that this was due to the economic downturn in the energy sector and individuals losing their jobs and health insurance. Additionally, stakeholders indicated that for those who have insurance, it often provides insufficient coverage.
Insufficient primary care physicians in the community were also noted as a barrier to improved health and quality of life. Additionally, stakeholders noted that there is a lack of public awareness of existing community based health programs and services that are currently offered.

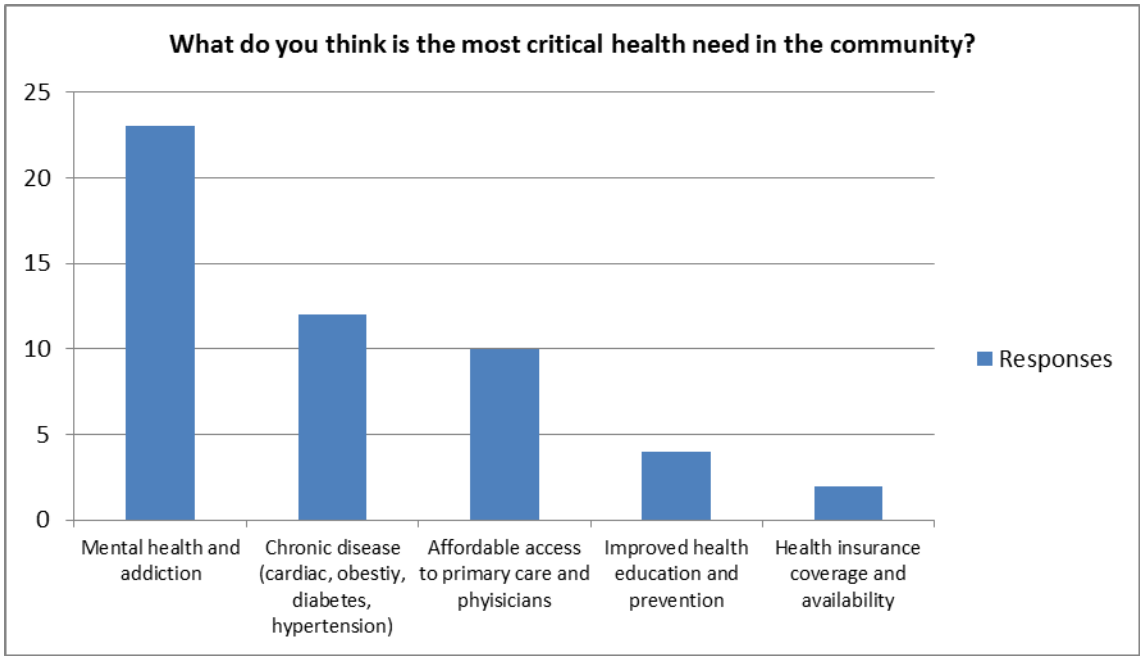
"The community is in need of family practitioners and specialty physicians. There is also too few mental health agencies, physicians, and facilities willing to take in these patients."

Lack of services and funding for mental health was also noted as a significant barrier to community health and quality of life.

4. *Most important health and quality of life issues*

Key stakeholders were asked to provide their opinion as to the most critical health and quality of life issues facing the county. The issues identified most frequently were:

- Mental/behavioral health services and addiction services;
- Chronic disease (cardiac, obesity, diabetes, hypertension);
- Affordable access to primary care and physicians;
- Improved health education and prevention; and
- Health insurance coverage and availability



Mental health was indicated as the most critical health need in the community by nearly half of the respondents.

"Many of our homeless population also struggle with mental illnesses. This makes their care needs more complex. While we are working on improving this care, we still have a lot of work to do."

The stakeholders were asked if there are any issues related to economic development, affordable housing, poverty, education, healthy nutrition, physical activity and drug and alcohol abuse that the hospital specifically should be addressing. Stakeholders responded that drug and alcohol abuse and general health education of the community including the importance of nutrition and physical activity

In order to address these most critical health issues in the community, stakeholders suggested a more focused effort on health education and community leaders increasing investments in community resources and population health.

"This burden cannot lie solely on the demands of the hospitals and physicians. We as health care providers do need to branch out of the four walls of the hospitals and be more visible in the community. Education and wellness needs to start earlier in life."

"As a community, we can come together to create ways to improve health such as assess safety in the community for individuals who like to walk; assess quality of sidewalks for walkers, assess restaurants' quality of foods and offer incentives for restaurants with menu items lower than 20g of fat, etc."

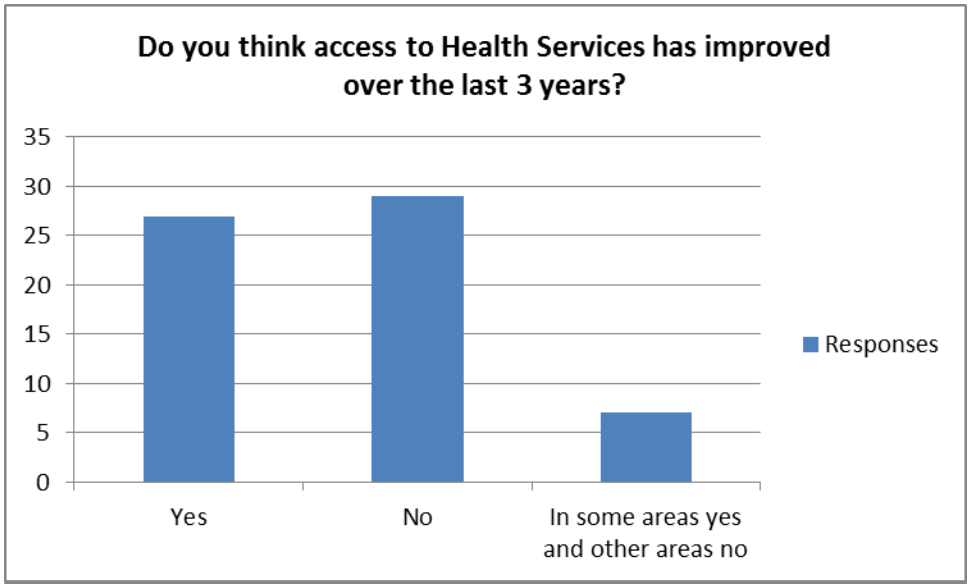
Additional comments focused on improving mental health services and increasing the number of mental health practitioners in the area by first recognizing the mental health issue in the area as well as provide education to the community on mental health issues.

5. ***Feedback on health improvements in the community since the prior Community Health Needs Assessment.***

In an effort to evaluate changes in health and health behavior since the 2013 Community Health Needs Assessment, several questions asked about additional significant health needs that were not identified in the 2013 Community Health Needs Assessment. The needs identified in the previous assessment included: uninsured/lack of access to services (cost), obesity, heart disease, lack of mental health services, lack of primary care physicians, physical inactivity, diabetes, poor nutrition, utilization of emergency room for episodic care, lack of health education. Additional needs that were identified by stakeholders in this year's survey included:

- Improving Medicaid funding and access to Medicaid;
- Additional health education;
- Substance abuse disorders;
- Homeless population;
- High deductible insurance plans causing health care to be too expensive;
- More hospital beds needed to provide for Mental Health patients.

During the 2013 Community Health Needs Assessment, a significant community need for access to health services emerged as a trend. As a part of this year's survey, stakeholders were asked if they thought health services have improved over the past three (3) years. The chart below shows the results:



Respondents who responded yes commented that there are more specialists and urgent care facilities available. Some respondents commented that there are more services available, but community members may not be taking advantage of those resources.

Those respondents who said that health services have not improved over the last three (3) years commented that poor economic trends have results in community members making poor decisions related to their health care, a lack of primary care physicians and a need for increased public awareness about how to access health services and programs that are free and highly subsidized.

Respondents were asked how they would rate the hospital's efforts in communicating how they are addressing the identified community health needs. The majority of respondents said that they had at least received communication on how the hospital is addressing needs and many respondents stated that they would rate the hospital's efforts as "good." Respondents stated that they appreciate the mailings and other communications of involvement in the community and new services. Respondents from the local health departments felt that the hospital is doing a good job communicating available resources. Some respondents noted that the hospital should help make the community more aware of newer services such as the NorthPark Medical Plaza and how to access these services.

Respondents were asked about the hospital's role in addressing the identified health needs of the community and they stated that the hospital should contribute to the message about the importance of preventive health care with the aid of media and schools. Additionally, they believe the hospital should be a leader in the community in responding to local health needs including health education, prevention and outreach services to the community.

Key Findings

A summary of themes and key findings provided by the key informants follow:

- In general, respondents thought the health and quality of life in the community is good and has either remained the same or improved in the past few years.
- The greatest health concern in the community is mental and behavioral health. 45 percent of respondents stated that mental health is the most critical health issue in the community.
- Chronic disease (heart disease, obesity, and hypertension) and affordable access to primary care physicians were the second and third highest ranked critical health issues in the community.
- Many respondents noted that the economic downturn in the energy sector has created unemployment and a loss of health insurance resulting in individuals not being able to access necessary health services.
- Respondents noted that the impact of high deductible and Health Insurance Exchange plans have resulted in many community members not being able to afford health care services. Additionally, respondents noted that the lack of Medicaid expansion in Texas has left many individuals uninsured.
- The addition of specialists in the community and new clinics were seen as positively impacting community health.
- There were mixed views on the health services offered in the community, among those respondents who were aware of community services they noted that the community offers adequate health services. Those respondents who may not be aware of community services noted that better communication of available services was needed.

- Many respondents noted a need for a long term investment in the community to promote healthier lifestyles including additional educational programs on nutrition and health, infrastructure that supports activity including parks, sidewalks and other facilities.
- Education on health issues, preventative care and nutritional information is limited. There is a significant need for community outreach programs aimed to educate patients and those within and around the community.

Health Issues of Vulnerable Populations

According to Dignity Health's Community Need Index (see Appendices), the Medical Center's community has a moderate level of need. The CNI score is an average of five different barrier scores that measure socioeconomic indicators of each community (income, cultural, education, insurance and housing. The zip codes that have the highest need in the community are 75602 (Longview) and 75670 (Marshall).

Certain key stakeholders were selected due to their positions working with low-income and uninsured populations. Several key stakeholders were selected due to their work with minority populations. Based on information obtained through key stakeholder surveys and the community health survey, the following populations are considered to be vulnerable or underserved in the community and the identified needs are listed:

- Uninsured/Working Poor Population
  - Lack of mental health services
  - Access to primary care physicians
  - High cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education
  - Access to food
- Elderly
  - Transportation
  - Lack of health knowledge regarding how to access services
  - Cost of prescriptions
- Immigrant Population
  - Language barriers
  - Transportation
  - Healthy living education

Information Gaps

This assessment was designed to provide a comprehensive and broad picture of the health in the overall community served by Good Shepherd; however, there may be a number of medical conditions that are not specifically addressed in this report due to various factors, including but not limited to, publically available information or limited community input.

In addition, certain population groups might not be identifiable or might not be represented in numbers sufficient for independent analysis. Examples include homeless, institutionalized persons, undocumented residents and members of certain ethnic groups who do not speak English or Spanish. Efforts were made to obtain input from these specific populations through key stakeholder surveys.

Prioritization of Identified Health Needs

Priority setting is a required step in the community benefit planning process. The IRS regulations indicate that the CHNA must provide a prioritized description of the community health needs identified through the CHNA and include a description of the process and criteria used in prioritizing the health needs.

Using findings obtained through the collection of primary and secondary data, Good Shepherd completed an analysis of these inputs (see *Appendices*) to identify community health needs. The following data was analyzed to identify health needs for the community:

Leading Causes of Death

Leading causes of death for the community and the death rates for the leading causes of death for each county within Good Shepherd's CHNA community were compared to U.S. adjusted death rates. Causes of death in which the county rate compared unfavorably to the U.S. adjusted death rate resulted in a health need for the Medical Center CHNA community.

Health Outcomes and Factors

An analysis of the County Health Rankings health outcomes and factors data was prepared for each county within Good Shepherd's CHNA community. County rates and measurements for health behaviors, clinical care, social and economic factors and the physical environment were compared to state benchmarks. County rankings in which the county rate compared unfavorably (by greater than 30% of the national benchmark) resulted in an identified health need.

Primary Data

Health needs identified through key informant surveys were included as health needs. Needs for vulnerable populations were separately reported on the analysis in order to facilitate the prioritization process.

Health Needs of Vulnerable Populations

Health needs of vulnerable populations were included for ranking purposes.

To facilitate prioritization of identified health needs, a ranking process was used. Health needs were ranked based on the following five factors. Each factor received a score between 0 and 5.

1) **How many people are affected by the issue or size of the issue?** For this factor, ratings were based on the percentage of the community who are impacted by the identified need. The following scale was utilized: >25% of the community= 5; >15% and <25%=4; >10% and <15%=3; >5% and <10%=2 and <5%=1.
2) **What are the consequences of not addressing this problem?** Identified health needs which have a high death rate or have a high impact on chronic diseases received a higher rating.
3) **The impact of the problem on vulnerable populations.** Needs identified which pertained to vulnerable populations were rated for this factor.
4) **How important the problem is to the community.** Needs identified through community surveys and/or focus groups were rated for this factor.
5) **Prevalence of common themes.** The rating for this factor was determined by how many sources of data (leading causes of death, primary causes for inpatient hospitalization, health outcomes and factors and primary data) identified the need.

Each need was ranked based on the five prioritization metrics. As a result, the following summary list of needs was identified:

- Mental and Behavioral Health and lack of mental health hospital beds and clinicians
- Obesity/Heart Disease/Diabetes and other Chronic Diseases
- Poor Nutrition/Limited Access to Healthy Food Options
- Healthy Behaviors/Lifestyle Choices
- Access to Exercise Opportunities
- Lack of Access to Services
- Substance Abuse
- Physical Inactivity
- Lack of Health Knowledge/Education
- Lack of Primary Care Physicians/Hours
- Uninsured/Limited Insurance
- Children in Poverty/Homelessness
- Diabetic Screen Rates
- Transportation
- Adult Smoking/Tobacco Use
- Sexually Transmitted Infections
- Language/ Cultural Barriers

Management's Prioritization Process

For the health needs prioritization process, Good Shepherd engaged a hospital leadership team to review the most significant health needs reported in the prior CHNA, as well as in *Exhibit 26*, using the following criteria:

- ✓ Current area of hospital focus
- ✓ Established relationships with community partners to address the health need
- ✓ Organizational capacity and existing infrastructure to address the health need

Based on the criteria outlined above, the leadership team ranked each of the health needs. (you can use a variety of methods – Hi/Lo Scale, discussion and debate, etc.) As a result of the priority setting process, there are identified priority areas that will be addressed through Good Shepherd's Implementation Strategy for fiscal years 2017-2019.

Good Shepherd's next steps include developing an implementation strategy to address these priority areas. The timeline for implementation of these priority areas is during the fiscal years 2017-2019.

Exhibit 26
Good Shepherd Medical Center
Prioritization of Health Needs

Behavior	How Many People Are Affected by the Issue?	What Are the Consequences of Not Addressing This Problem?	What is the Impact on Vulnerable Populations?	How Important is it to the Community?	How Many Sources Identified the Need?	Total Score *
Obesity/Heart Disease/Diabetes and other chronic disease	5	5	3	5	4	**22**
Lack of Mental Health Providers/Services	5	3	4	5	1	**18**
Poor Nutrition/Limited Access to Healthy Food Options	5	4	4	3	2	**18**
Healthy Behaviors/Lifestyle Choices	5	4	4	4	1	**18**
Access to Exercise Opportunities	5	3	3	4	3	**18**
Lack of Access to Services	5	3	4	5	1	**18**
Substance Abuse	3	4	2	5	2	**16**
Physical Inactivity	4	3	4	4	1	**16**
Lack of Health Knowledge/Education	5	1	4	4	1	**15**
Lack of Primary Care Physicians/Hours	4	2	3	5	1	**15**
Uninsured/Limited Insurance	4	1	4	4	2	**15**
Children in Poverty/Homelessness	3	2	5	2	3	**15**
Diabetic screen rates	4	2	5	2	1	**14**
Transportation	4	1	5	2	1	**13**
Adult Smoking/Tobacco Use	4	5	3	2	1	**15**
Sexually Transmitted Infections	2	5	3	1	2	**13**
Language/ Cultural barriers	2	1	4	3	2	**12**

The Medical Center's next steps include developing an implementation strategy to address these priority areas.

Resources Available to Address Significant Health Needs

Health Care Resources

The availability of health care resources is a critical component to the health of a county's residents and a measure of the soundness of the area's health care delivery system. An adequate number of health care facilities and health care providers are vital for sustaining a community's health status. Fewer health care facilities and health care providers can impact the timely delivery of services. A limited supply of health resources, especially providers, results in the limited capacity of the health care delivery system to absorb charity and indigent care as there are fewer providers upon which to distribute the burden of indigent care.

Hospitals

Good Shepherd Medical Center has 425 acute beds and is one of the few hospital facilities located within the CHNA community. Residents of the community also take advantage of services provided by hospitals in neighboring counties, as well as services offered by other facilities and providers.

Exhibit 27 summarizes hospitals available to the residents of the four counties in which the community resides.

Exhibit 27
Good Shepherd Health System
Summary of Area Hospitals and Health Centers

Facility	Address	County
Select Specialty Hospital of Longview	700 E Marshall Ave, Longview, TX 75601	Gregg
Longview Regional Medical Center	2901 N Fourth St, Longview, TX 75605	Gregg
Oceans Behavioral Hospital of Longview	615 Clinic Dr, Longview, TX 75605	Gregg
Behavioral Hospital of Longview	22 Bermuda Ln, Longview, TX 75605	Gregg
Allegiance Specialty Hospital of Kilgore	1612 S Henderson Blvd, Kilgore, TX 75662	Gregg
ETMC Henderson	300 Wilson St, Henderson, TX 75652	Rusk
ETMC Carthage	409 Cottage Rd, Carthage, TX 75633	Panola

Other Health Care Facilities

Short-term acute care hospital services are not the only health services available to members of Good Shepherd's community. *Exhibit 28* provides a listing of community health centers and rural health clinics within the Medical Center's community.

Exhibit 28
Good Shepherd Health System
Summary of Rural Health Centers & FQHCs

Facility	Facility Type	Address	County
East Texas Medical Center Henderson Family Health	Rural Health Clinic	300 Wilson Street 2E, Henderson, TX 75652	Rusk
Trinity Clinic Henderson	Rural Health Clinic	511 N High, Henderson, TX 75652	Rusk
East Texas Med Center Carthage Health Center	Rural Health Clinic	409 Cottage Road Suite A, Carthage, TX 75633	Panola
ETMC First Physicians Clinic	Rural Health Clinic	702 Davis St, Carthage, TX 75633	Panola
East Texas Pediatrics	Rural Health Clinic	618 S Grove Ste 100, Marshall, TX75670	Harrison
Marshall Health Clinic	Rural Health Clinic	805 Linsey, Marshall, TX 75670	Harrison
Marshall Pediatric Clinic	Rural Health Clinic	707 S Grove St, Marshall, TX 75670	Harrison
Med Plaza	Federally Qualified Health Center	703 E Marshall Ave, Longview, TX 75601	Gregg
Jim Meyers Comprehensive Health Center	Federally Qualified Health Center	410 N 4th St, Longview, TX 75601	Gregg
Wellness Point - Longview	Federally Qualified Health Center	1107 E Marshall Ave, Longview, TX 75601	Gregg
Genesis Primecare	Federally Qualified Health Center	2131 S Mobberly Ave, Longview, TX 75602	Gregg
Wellness Pointe - Longview North	Federally Qualified Health Center	805 Medical Dr Ste A, Longview, TX 75602	Gregg
Wellness Point - Longview South	Federally Qualified Health Center	2430 S High St, Longview, TX 75602	Gregg
Wellness Pointe Kilgore	Federally Qualified Health Center	1711 S Henderson Blvd Ste 400, Kilgore, TX 75662	Gregg
Wellness Pointe Gilmer	Federally Qualified Health Center	602 Titus St Ste 130, Gilmer, TX 75644	Upshur
Genesis Primecare Marshall 2	Federally Qualified Health Center	401 N Grove St Ste A, Marshall, TX 75670	Harrison
Genesis Primecare Marshall	Federally Qualified Health Center	811 S Washington Ave, Marshall, TX 75670	Harrison
Genesis Primacare	Federally Qualified Health Center	502 E Rusk St, Marshall, TX 75670	Harrison

Source: CMS.gov, Heath Resources & Services Administration (HRSA)

The Medical Center's CHNA community also has a number of clinics inside various retail facilities, including Walgreens and CVS. These clinics are expanding past providing only flu shots to providing checkups and treatments to a growing list of ailments.

APPENDICES

APPENDIX A

ANALYSIS OF DATA

Good Shepherd Health System
Analysis of CHNA Data

Analysis of Health Status-Leading Causes of Death

		(A)		(B)	
	U.S. Crude Rates	10% of U.S. Crude Rate	County Rate	County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Gregg County:					
Cancer	185.8	18.6	210.7	24.9	Health Need
Heart Disease	197.5	19.8	241.0	43.5	Health Need
Lung Disease	44.9	4.5	65.2	20.4	Health Need
Stroke	42.9	4.3	50.5	7.6	Health Need
Unintentional Injury	39.9	4.0	45.4	5.6	Health Need
Harrison County:					
Cancer	185.8	18.6	195.2	9.4	
Heart Disease	197.5	19.8	215.1	17.6	
Lung Disease	44.9	4.5	64.0	19.1	Health Need
Stroke	42.9	4.3	50.1	7.2	Health Need
Unintentional Injury	39.9	4.0	55.8	16.0	Health Need
Panola County:					
Cancer	185.8	18.6	229.4	43.6	Health Need
Heart Disease	197.5	19.8	229.4	31.9	Health Need
Lung Disease	44.9	4.5	73.7	28.8	Health Need
Stroke	42.9	4.3	51.1	8.2	Health Need
Unintentional Injury	39.9	4.0	69.5	29.6	Health Need
Rusk County					
Cancer	185.8	18.6	202.6	16.8	
Heart Disease	197.5	19.8	284.1	86.6	Health Need
Lung Disease	44.9	4.5	63.2	18.3	Health Need
Stroke	42.9	4.3	42.2	-0.7	
Unintentional Injury	39.9	4.0	62.4	22.6	Health Need
Upshur County					
Cancer	185.8	18.6	231.7	45.9	Health Need
Heart Disease	197.5	19.8	290.8	93.3	Health Need
Lung Disease	44.9	4.5	62.6	17.7	Health Need
Stroke	42.9	4.3	50.0	7.1	Health Need
Unintentional Injury	39.9	4.0	53.5	13.6	Health Need

Analysis of Health Outcomes and Factors

	National Benchmark	(A) 30% of National Benchmark	County Rate	(B) County Rate Less National Benchmark	If (B)>(A), then "Health Need"
Gregg County:					
Adult Smoking	14.0%	4.2%	17.0%	3.0%	
Adult Obesity	25.0%	7.5%	34.0%	9.0%	Health Need
Food Environment Index	8.4	3	N/A	N/A	N/A
Physical Inactivity	20.0%	6.0%	28.0%	8.0%	Health Need
Access to Exercise Opportunities	92.0%	27.6%	71.0%	21.0%	
Excessive Drinking	10.0%	3.0%	14.0%	4.0%	Health Need
Alcohol-Impaired Driving Deaths	14.0%	4.2%	36.0%	22%	Health Need
Sexually Transmitted Infections	138	41	810	672	Health Need
Teen Birth Rate	20	6	73	53	Health Need
Uninsured	11.0%	3.3%	25.0%	14.0%	Health Need
Primary Care Physicians	1045	314	1333	288	
Dentists	1377	413	1218	-159	
Mental Health Providers	386	116	764	378	Health Need
Preventable Hospital Stays	41	12	66	25	Health Need
Diabetic Screen Rate	90.0%	27.0%	85.0%	5.0%	
Mammography Screening	70.7%	21.2%	63.8%	6.9%	
Violent Crime Rate	59	18	504	445	Health Need
Children in Poverty	13.0%	3.9%	25.0%	12.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	38.0%	18.0%	Health Need
Harrison County:					
Adult Smoking	14.0%	4.2%	23.0%		
Adult Obesity	25.0%	7.5%	32.0%	7.0%	
Food Environment Index	8.4	3	6.2	2	
Physical Inactivity	20.0%	6.0%	30.0%	10.0%	Health Need
Access to Exercise Opportunities	92.0%	27.6%	56.0%	36.0%	Health Need
Excessive Drinking	10.0%	3.0%	17.0%		
Alcohol-Impaired Driving Deaths	14.0%	4.2%	37.0%	23%	Health Need
Sexually Transmitted Infections	138	41	482	344	Health Need
Teen Birth Rate	20	6	57	37	Health Need
Uninsured	11.0%	3.3%	24.0%	13.0%	Health Need
Primary Care Physicians	1045	314	3747	2702	Health Need
Dentists	1377	413	3934	2557	Health Need
Mental Health Providers	386	116	2735	2349	Health Need
Preventable Hospital Stays	41	12	72	31	Health Need
Diabetic Screen Rate	90.0%	27.0%	85.0%	5.0%	
Mammography Screening	70.7%	21.2%	59.0%	11.7%	
Violent Crime Rate	59	18	405	346	Health Need
Children in Poverty	13.0%	3.9%	26.0%	13.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	38.0%	18.0%	Health Need

Analysis of Health Outcomes and Factors

	National Benchmark	(A) 30% of National Benchmark	County Rate	(B) County Rate Less National Benchmark	If (B)>(A), then "Health Need"
Panola County:					
Adult Smoking	14.0%	4.2%	29.0%	15.0%	Health Need
Adult Obesity	25.0%	7.5%	32.0%	7.0%	
Food Environment Index	8.4	3	6.6	2	
Physical Inactivity	20.0%	6.0%	30.0%	10.0%	Health Need
Access to Exercise Opportunities	92.0%	27.6%	27.0%	65.0%	Health Need
Excessive Drinking	10.0%	3.0%	N/A		
Alcohol-Impaired Driving Deaths	14.0%	4.2%	22.0%	8%	Health Need
Sexually Transmitted Infections	138	41	446	308	Health Need
Teen Birth Rate	20	6	53	33	Health Need
Uninsured	11.0%	3.3%	22.0%	11.0%	Health Need
Primary Care Physicians	1045	314	2402	1357	Health Need
Dentists	1377	413	3978	2601	Health Need
Mental Health Providers	386	116	23870	23484	Health Need
Preventable Hospital Stays	41	12	85	44	Health Need
Diabetic Screen Rate	90.0%	27.0%	86.0%	4.0%	
Mammography Screening	70.7%	21.2%	52.5%	18.2%	
Violent Crime Rate	59	18	266	207	Health Need
Children in Poverty	13.0%	3.9%	20.0%	7.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	32.0%	12.0%	Health Need
Rusk County:					
Adult Smoking	14.0%	4.2%	17.0%	3.0%	
Adult Obesity	25.0%	7.5%	37.0%	12.0%	Health Need
Food Environment Index	8.4	3	6.4	2	
Physical Inactivity	20.0%	6.0%	27.0%	7.0%	Health Need
Access to Exercise Opportunities	92.0%	27.6%	41.0%	51.0%	Health Need
Excessive Drinking	10.0%	3.0%	N/A		
Alcohol-Impaired Driving Deaths	14.0%	4.2%	34.0%	20%	Health Need
Sexually Transmitted Infections	138	41	267	129	Health Need
Teen Birth Rate	20	6	65	45	Health Need
Uninsured	11.0%	3.3%	25.0%	14.0%	Health Need
Primary Care Physicians	1045	314	4502	3457	Health Need
Dentists	1377	413	4125	2748	Health Need
Mental Health Providers	386	116	4875	4489	Health Need
Preventable Hospital Stays	41	12	83	42	Health Need
Diabetic Screen Rate	90.0%	27.0%	81.0%	9.0%	
Mammography Screening	70.7%	21.2%	61.9%	8.8%	
Violent Crime Rate	59	18	357	298	Health Need
Children in Poverty	13.0%	3.9%	28.0%	15.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	36.0%	16.0%	Health Need

Analysis of Health Outcomes and Factors

	National Benchmark	(A) 30% of National Benchmark	County Rate	(B) County Rate Less National Benchmark	If (B)>(A), then "Health Need"
Upshur County:					
Adult Smoking	14.0%	4.2%	47.0%	33.0%	Health Need
Adult Obesity	25.0%	7.5%	33.0%	8.0%	Health Need
Food Environment Index	8.4	3	6.8	2	
Physical Inactivity	20.0%	6.0%	33.0%	13.0%	Health Need
Access to Exercise Opportunities	92.0%	27.6%	41.0%	51.0%	Health Need
Excessive Drinking	10.0%	3.0%	N/A		
Alcohol-Impaired Driving Deaths	14.0%	4.2%	17.0%	3%	
Sexually Transmitted Infections	138	41	243	105	Health Need
Teen Birth Rate	20	6	54	34	Health Need
Uninsured	11.0%	3.3%	24.0%	13.0%	Health Need
Primary Care Physicians	1045	314	3636	2591	Health Need
Dentists	1377	413	9971	8594	Health Need
Mental Health Providers	386	116	2849	2463	Health Need
Preventable Hospital Stays	41	12	73	32	Health Need
Diabetic Screen Rate	90.0%	27.0%	84.0%	6.0%	
Mammography Screening	70.7%	21.2%	55.4%	15.3%	
Violent Crime Rate	59	18	263	204	Health Need
Children in Poverty	13.0%	3.9%	26.0%	13.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	29.0%	9.0%	Health Need

Analysis of Primary Data – Key Informant Interviews

Poverty
Lack of Convenient Ambulatory Care
Lack of Health Knowledge/Education
Healthy Behaviors/Lifestyle Choices
Lack of Mental Health Services
Substance Abuse
Obesity
Heart Disease
Poor Nutrition/Lack of Healthy Food Options
Transportation
Shortage of Adult Dental Services
Pre-Natal Care
Uninsured
Lack of Physicians
Cost of Health Care
Good Employment Opportunities

Issues of Uninsured Persons, Low-Income Persons and Minority/Vulnerable Populations

Population	Issues
Uninsured/Working Poor Population	Transportation Access to primary care physicians High cost of health care prevents needs from being met Healthy lifestyle and health nutrition education Access to food Lack of mental health services Lack of adult dental services
Elderly	Transportation Lack of health knowledge regarding how to access services Cost of prescriptions Lack of adult dental services
Immigrant Population	Language barriers Transportation Healthy living education

APPENDIX B

SOURCES

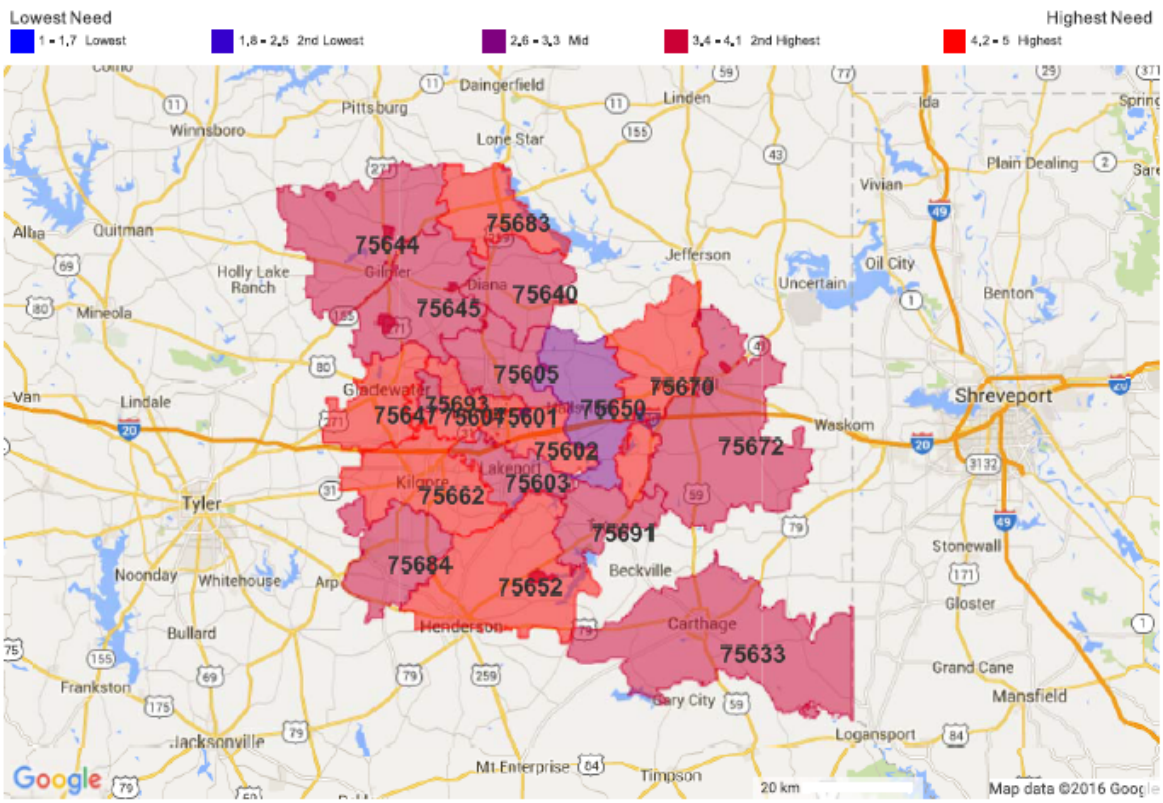
DATA TYPE	SOURCE	YEAR(S)
Discharges by Zip Code	Hospital	FY 2015
Population Estimates	The Nielson Company	2015
Demographics - Race/Ethnicity	Community Commons via American Community Survey http://www.communitycommons.org/	2015
Demographics - Income	Community Commons via American Community Survey http://www.communitycommons.org/	2009 - 2013
Unemployment	Community Commons via US Department of Labor http://www.communitycommons.org/	2015
Poverty	Community Commons via US Census Bureau, Small Areas Estimates Branch http://www.census.gov	2009 - 2013
Uninsured Status	Community Commons via US Census Bureau, Small area Helath Insurance Estimates http://www.communitycommons.org/	2009 - 2013
Medicaid	Community Commons via American Community Survey http://www.communitycommons.org/	2009 - 2013
Education	Community Commons via American Community Survey http://www.communitycommons.org/	2009 - 2013
Physical Environment - Grocery Store Access	Community Commons via US Cenus Bureau, County Business Patterns http://www.communitycommons.org/	2013
Physical Environment - Food Access/Food Deserts	Community Commons via US Department of Agriculture http://www.communitycommons.org/	2010
Physical Environment - Recreation and Fitness Facilities	Community Commons via US Cenus Bureau, County Business Patterns http://www.communitycommons.org/	2013
Physical Environment - Physically Inactive	Community Commons via US Centers for Disease control and Prevention http://www.communitycommons.org/	2012
Clinical Care - Access to Primary Care	Community Commons via US Department of Health & Human Services http://www.communitycommons.org/	2012
Clinical Care - Lack of a Consistent Source of Primary Care	Community Commons via US Department of Health & Human Services http://www.communitycommons.org/	2011 - 2012
Clinical Care - Population Living in a Health Professional Shortage Area	Community Commons via US Department of Health & Human Services http://www.communitycommons.org/	2015
Clinical Care - Preventable Hospital Events	Community Commons via Dartmouth College Institute for Health Policy & Clinical Practice http://www.communitycommons.org/	2012
Leading Causes of Death	Community Commons via CDC national Bital Statistics System http://www.communitycommons.org/	2007 - 2011
Health Outcomes and Factors	County Health Rankings http://www.countyhealthrankings.org/ & Community Commons http://www.communitycommons.org/	2015 & 2006 - 2012
Health Care Resources	Community Commons, CMS.gov, HRSA	

APPENDIX C

DIGNITY HEALTH COMMUNITY NEED INDEX

(CNI) REPORT

Map of Community Needs Index Scores for CHNA Community Based on Dignity Health's Community Need Index (CNI)



Mean(zipcode): 4 / Mean(person): 4.1 CNI Score Median: 4 CNI Score Mode: 3.8

Zip Code	CNI Score	Population	City	County	State
75601	4.6	16118	Longview	Gregg	Texas
75602	4.8	23694	Longview	Gregg	Texas
75603	3.8	5986	Longview	Gregg	Texas
75604	4.2	31193	Longview	Gregg	Texas
75605	4	29628	Longview	Gregg	Texas
75647	4.2	13423	Gladewater	Gregg	Texas
75662	4.2	25853	Kilgore	Gregg	Texas
75693	4	6910	White Oak	Gregg	Texas
75633	3.8	14242	Carthage	Panola	Texas
75640	3.4	4922	Diana	Upshur	Texas
75644	3.8	11520	Gilmer	Upshur	Texas
75645	3.4	10366	Gilmer	Upshur	Texas
75650	3	9036	Hallsville	Harrison	Texas
75652	4.4	17489	Henderson	Rusk	Texas
75670	4.8	18231	Marshall	Harrison	Texas
75672	3.8	17132	Marshall	Harrison	Texas
75683	4.2	4208	Ore City	Upshur	Texas
75684	3.8	7510	Overton	Rusk	Texas
75691	3.8	4038	Tatum	Rusk	Texas

Source: http://cni.chw-interactive.org

APPENDIX D

COUNTY HEALTH RANKINGS

Good Shepherd Medical Center
County Health Rankings – Health Factors

		Gregg County 2012	Gregg County 2015	Change	Texas 2015	Top Performers 2015**
Health Behaviors	*	207	189	↓		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		18.0%	17.0%	↓	17.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		32.0%	34.0%	↑	29.0%	25.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		N/A	6.0		6.4	8.4
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		30.0%	28.0%	↓	23.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		N/A	71.0%		84.0%	92.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		14.0%	14.0%		16.0%	10.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		N/A	36.0%		33.0%	14.0%
Sexually transmitted infections – Chlamydia rate per 100K population		688.0	810.0	↑	488.0	138.0
Teen birth rate – Per 1,000 female population, ages 15-19		78.0	73.0	↓	55.0	20.0
Clinical Care	*	25	27	↑		
Uninsured adults – Percent of population under age 65 without health insurance		25.0%	25.0%		25.0%	11%
Primary care physicians – Ratio of population to primary care physicians		1,131:1	1,333:1	↑	1,708:1	1,045:1
Dentists – Ratio of population to dentists		N/A	1,218:1		1,940:1	1,377:1
Mental health providers – Ratio of population to mental health providers		N/A	764:1		1,034:1	386:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		78.0	66.0	↓	63.0	41
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		85.0%	85.0%		83.0%	90%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		65.8%	63.8%	↓	58.9%	70.7%

County Health Rankings – Health Factors
Gregg County, continued

Social and Economic Factors	*	161	112	↓		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		87.0%	91.0%	↑	88.0%	N/A
Some college – Percent of adults aged 25-44 years with some post-secondary education		55.4%	54.9%	↓	58.6%	71.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		7.2%	5.5%	↓	6.3%	4.0%
Children in poverty – Percent of children under age 18 in poverty		30.0%	25.0%	↓	25.0%	13.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		N/A	4.8		4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		37.0%	38.0%	↑	33.0%	20%
Social associations – Number of membership associations per 10,000 population		N/A	14.7		7.8	22.0
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		771.0	504.0	↓	422.0	59.0
Injury deaths – Number of deaths due to injury per 100,000 population		N/A	70.0		55.0	50.0
Physical Environment	*	200	188	↓		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		NA	10.1		9.6	9.5
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		N/A	N/A		7.0%	0%
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities		N/A	16.0%		18.0%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		N/A	83.0%		80.0%	71%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes		N/A	20.0%		35.0%	15%

* Rank out of 221 Texas counties in 2010, rank out of 237 Texas counties in 2015
** 90th percentile, i.e., only 10% are better

Note: N/A indicates unreliable or missing data
Source: Countyhealthrankings.org

Good Shepherd Medical Center
County Health Rankings – Health Factors

		Harrison County 2012	Harrison County 2015	Change	Texas 2015	Top Performers 2015**
Health Behaviors	*	186	189	↑		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		22.0%	23.0%	↑	17.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		34.0%	32.0%	↓	29.0%	25.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		N/A	6.2		6.4	8.4
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		34.0%	30.0%	↓	23.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		N/A	56.0%		84.0%	92.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		N/A	17.0%		16.0%	10.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		N/A	37.0%		33.0%	14.0%
Sexually transmitted infections – Chlamydia rate per 100K population		289.0	482.0	↑	488.0	138.0
Teen birth rate – Per 1,000 female population, ages 15-19		54.0	57.0	↑	55.0	20.0
Clinical Care	*	68	75	↑		
Uninsured adults – Percent of population under age 65 without health insurance		25.0%	24.0%	↓	25.0%	11%
Primary care physicians – Ratio of population to primary care physicians		2,899:1	3,747:1	↑	1,708:1	1,045:1
Dentists – Ratio of population to dentists		N/A	5,145:1		1,940:1	1,377:1
Mental health providers – Ratio of population to mental health providers		N/A	3,934:1		1,034:1	386:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		89.0	72.0	↓	63.0	41
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		86.0%	85.0%	↓	83.0%	90%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		61.5%	59.0%	↓	58.9%	70.7%

County Health Rankings – Health Factors
Harrison County, continued

Social and Economic Factors	*	**146**	**129**	↓		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		90.0%	93.0%	↑	88.0%	N/A
Some college – Percent of adults age 25-44 years with some post-secondary education		47.9%	52.2%	↑	58.6%	71.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		8.8%	6.4%	↓	6.3%	4.0%
Children in poverty – Percent of children under age 18 in poverty		26.0%	26.0%		25.0%	13.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		N/A	5.1		4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		35.0%	38.0%	↑	33.0%	20%
Social associations – Number of membership associations per 10,000 population		N/A	12.8		7.8	22.0
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		456.0	405.0	↓	422.0	59.0
Injury deaths – Number of deaths due to injury per 100,000 population		N/A	77.0		55.0	50.0
Physical Environment	*	**139**	**224**	↑		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		N/A	10.3		9.6	9.5
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		N/A	29%		7%	-
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities		N/A	13%		18%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		N/A	84%		80%	71%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes		N/A	28%		35%	15%

* Rank out of 221 Texas counties in 2010, rank out of 237 Texas counties in 2015
** 90th percentile, i.e., only 10% are better

Note: N/A indicates unreliable or missing data
Source: *Countyhealthrankings.org*

Good Shepherd Medical Center
County Health Rankings – Health Factors

		Panola County 2012	Panola County 2015	Change	Texas 2015	Top Performers 2015**
Health Behaviors	*	146	152	↑		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		N/A	29.0%		17.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		30.0%	32.0%	↑	29.0%	25.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		N/A	6.6		6.4	8.4
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		27.0%	30.0%	↑	23.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		N/A	27.0%		84.0%	92.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		N/A	N/A		16.0%	10.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		N/A	22.0%		33.0%	14.0%
Sexually transmitted infections – Chlamydia rate per 100K population		247.0	446.0	↑	488.0	138.0
Teen birth rate – Per 1,000 female population, ages 15-19		58.0	53.0	↓	55.0	20.0
Clinical Care	*	92	84	↓		
Uninsured adults – Percent of population under age 65 without health insurance		23.0%	22.0%	↓	25.0%	11%
Primary care physicians – Ratio of population to primary care physicians		3,312:1	2,402:1	↓	1,708:1	1,045:1
Dentists – Ratio of population to dentists		N/A	3,978:1		1,940:1	1,377:1
Mental health providers – Ratio of population to mental health providers		N/A	23,870:1		1,034:1	386:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		107.0	85.0	↓	63.0	41
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		84.0%	86.0%	↑	83.0%	90%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		56.0%	52.5%	↓	58.9%	70.7%

County Health Rankings – Health Factors
Panola County, continued

Social and Economic Factors	*	75	111	↑		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		85.0%	86.0%	↑	88.0%	N/A
Some college – Percent of adults age 25-44 years with some post-secondary education		49.7%	50.9%	↑	58.6%	71.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		7.3%	5.1%	↓	6.3%	4.0%
Children in poverty – Percent of children under age 18 in poverty		21.0%	20.0%	↓	25.0%	13.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		N/A	4.9		4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		31.0%	32.0%	↑	33.0%	20%
Social associations – Number of membership associations per 10,000 population		N/A	10.4		7.8	22.0
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		266.0	266.0		422.0	59.0
Injury deaths – Number of deaths due to injury per 100,000 population		N/A	92.0		55.0	50.0
Physical Environment	*	138	162	↑		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		N/A	10.0	↓	9.6	9.5
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		N/A	3.0%		7.0%	-
Severe housing problems – Percentage of household with at least 1 of 4 housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities		N/A	10.0%		18.0%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		N/A	85.0%		80.0%	71%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes		N/A	38.0%		35.0%	15%

* Rank out of 221 Texas counties in 2010, rank out of 237 Texas counties in 2015
** 90th percentile, i.e., only 10% are better

Note: N/A indicates unreliable or missing data
Source: *Countyhealthrankings.org*

Good Shepherd Medical Center
County Health Rankings – Health Factors

		Rusk County 2012	Rusk County 2015	Change	Texas 2015	Top Performers 2015**
Health Behaviors	*	157	200	↑		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		17.0%	17.0%		17.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		31.0%	37.0%	↑	29.0%	25.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		N/A	6.4		6.4	8.4
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		28.0%	27.0%	↓	23.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		N/A	41.0%		84.0%	92.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		N/A	N/A		16.0%	10.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		N/A	34.0%		33.0%	14.0%
Sexually transmitted infections – Chlamydia rate per 100K population		286.0	267.0	↓	488.0	138.0
Teen birth rate – Per 1,000 female population, ages 15-19		64.0	65.0	↑	55.0	20.0
Clinical Care	*	99	138	↑		
Uninsured adults – Percent of population under age 65 without health insurance		25.0%	25.0%		25.0%	11%
Primary care physicians – Ratio of population to primary care physicians		2,719:1	4,502:1	↑	1,708:1	1,045:1
Dentists – Ratio of population to dentists		N/A	4,125:1		1,940:1	1,377:1
Mental health providers – Ratio of population to mental health providers		N/A	4,875:1		1,034:1	386:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		107.0	83.0	↓	63.0	41
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		82.0%	81.0%	↓	83.0%	90%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		63.2%	61.9%	↓	58.9%	70.7%

County Health Rankings – Health Factors
Rusk County, continued

Social and Economic Factors	*	**89**	**149**	↑		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		94.0%	91.0%	↓	88.0%	N/A
Some college – Percent of adults age 25-44 years with some post-secondary education		44.2%	45.8%	↑	58.6%	71.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		7.6%	6.1%	↓	6.3%	4.0%
Children in poverty – Percent of children under age 18 in poverty		24.0%	28.0%	↑	25.0%	13.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		N/A	4.7		4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		27.0%	36.0%	↑	33.0%	20%
Social associations – Number of membership associations per 10,000 population		N/A	13.0		7.8	22.0
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		429.0	357.0	↓	422.0	59.0
Injury deaths – Number of deaths due to injury per 100,000 population		N/A	82.0		55.0	50.0
Physical Environment	*	**173**	**168**	↓		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		N/A	9.8		9.6	9.5
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		N/A	6%		7.0%	-
Severe housing problems – Percentage of household with at least 1 of 4 housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities		N/A	11%		18%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		N/A	87%		80%	71%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30		N/A	34%		35%	15%

* Rank out of 221 Texas counties in 2010, rank out of 237 Texas counties in 2015
** 90th percentile, i.e., only 10% are better

Note: N/A indicates unreliable or missing data
Source: *Countyhealthrankings.org*

Good Shepherd Medical Center
County Health Rankings – Health Factors

		Upshur County 2012	Upshur County 2015	Change	Texas 2015	Top Performers 2015**
Health Behaviors	*	178	236	↑		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		N/A	47.0%		17.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		31.0%	33.0%	↑	29.0%	25.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		N/A	6.8		6.4	8.4
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		36.0%	33.0%	↓	23.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		N/A	30.0%		84.0%	92.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		N/A	N/A		16.0%	10.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		N/A	17.0%		33.0%	14.0%
Sexually transmitted infections – Chlamydia rate per 100K population		274.0	243.0	↓	488.0	138.0
Teen birth rate – Per 1,000 female population, ages 15-19		58.0	54.0	↓	55.0	20.0
Clinical Care	*	103	98	↓		
Uninsured adults – Percent of population under age 65 without health insurance		25.0%	24.0%	↓	25.0%	11%
Primary care physicians – Ratio of population to primary care physicians		3,788:1	3,636:1	↓	1,708:1	1,045:1
Dentists – Ratio of population to dentists		N/A	9,971:1		1,940:1	1,377:1
Mental health providers – Ratio of population to mental health providers		N/A	2,849:1		1,034:1	386:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		101.0	73.0	↓	63.0	41
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		82.0%	84.0%	↑	83.0%	90%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		58.9%	55.4%	↓	58.9%	70.7%

County Health Rankings – Health Factors
Upshur County, continued

Social and Economic Factors	*	**80**	**86**	↑		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		94.0%	96.0%	↑	88.0%	N/A
Some college – Percent of adults age 25-44 years with some post-secondary education		51.1%	52.9%	↑	58.6%	71.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		7.8%	5.7%	↓	6.3%	4.0%
Children in poverty – Percent of children under age 18 in poverty		26.0%	26.0%		25.0%	13.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		N/A	4.5		4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		32.0%	29.0%	↓	33.0%	20%
Social associations – Number of membership associations per 10,000 population		N/A	8.5		7.8	22.0
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		303.0	263.0	↓	422.0	59.0
Injury deaths – Number of deaths due to injury per 100,000 population		N/A	86.0		55.0	50.0
Physical Environment	*	**197**	**166**	↓		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		N/A	10.2	↓	9.6	9.5
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		N/A	0%		7.0%	-
Severe housing problems – Percentage of household with at least 1 of 4 housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities		N/A	13.0%		18.0%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		N/A	80.0%		80.0%	71%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30		N/A	42.0%		35.0%	15%

* Rank out of 221 Texas counties in 2010, rank out of 237 Texas counties in 2015
** 90th percentile, i.e., only 10% are better

Note: N/A indicates unreliable or missing data
Source: *Countyhealthrankings.org*

APPENDIX E

KEY STAKEHOLDER SURVEY PROTOCOL

& ACKNOWLEDGEMENTS

SURVEY QUESTIONS

1. In general, how would you rate health and quality of life in the community? (Scale from 1 to 10)
2. In your opinion, has health and quality of life in the community improved, stayed the same or declined?
    a. Improved
    b. Stayed the same
    c. Declined
3. Why do you think it has (based on answer from previous question: improved, declined, or stayed the same)?
4. What other factors have contributed to the (based on answer to question 2: improvement, decline or to health and quality of life staying the same)
5. What barriers, if any, exist to improving health and quality of life in the community?
6. In your opinion, what are the most critical health and quality of life issues in the community?
7. What needs to be done to address these issues?
8. The prior CHNA indicated the following as the most significant health needs. Is there anything that is not on the list that should be? (Uninsured / Lack of access to services (cost), Obesity, Heart Disease, Lack of mental health services, Lack of primary care physicians, Physical inactivity, Diabetes, Poor nutrition, Utilization of emergency room for episodic care, Lack of health education)
9. What do you think is most critical health need of the community?
10. In your opinion, are any the following areas in which the hospital should be addressing? Why or why not? (Economic Development, Affordable Housing, Poverty, Education, Healthy Nutrition, Physical Activity, Drug and Alcohol Abuse)
11. Do you think access to Health Services has improved over the last 3 years? Why or why not? What needs to be done to improve access to health services in the community?
12. Are there people or groups of people in the community whose health or quality of life may not be as good as others? Who are these persons or groups?
13. Are there people or groups of people who have a more difficult time obtaining necessary/preventive medical services? If so, who are these persons or groups? Why do you think they have a more difficult time? What can be done to improve the situation?
14. How would you rate the hospital's efforts on communicating how they are addressing the identified health needs? How have you received communication regarding the hospital's efforts?
15. What do you think is the hospital's role in addressing the identified health needs of the community?

Key Stakeholders

Thank you to the following individuals who participated in our key informant survey process:

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Bill Torres, *Good Shepherd Medical Center*
Brad Osburg, *Good Shepherd Medical Center Longview*
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Charly Rowland, *Good Shepherd Health System*
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Jennifer Ware, *Good Shepherd Medical Center*
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John Jaskiewicz, *Good Shepherd Medical Center*
John McDonald, *Good Shepherd Medical Center*
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Kasha Williams, *Council District 3, Longview*
Keith Creel, *Good Shepherd Medical Center*
Keith Kirbow, *Good Shepherd Medical Center*
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Kim Smith, *Marshall-Harrison County Health District*

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