LITTLE COLORADO MEDICAL CENTER'S 2020 COMMUNITY HEALTH NEEDS ASSESSMENT

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In Collaboration with Little Colorado Medical Center and its Community Partners

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Executive Summary

Introduction

Little Colorado Medical Center (LCMC) is a 25-bed critical access hospital in Winslow, Arizona. The hospital serves the health needs of a culturally and geographically diverse patient population. LCMC is committed to increasing access to high-quality health care. In its previous assessments, LCMC prioritized the delivery of efficient and effective care to reduce costs. While these remain priorities for LCMC, there is also an emphasis on creating a community that is resilient to the ongoing socioeconomic and health care changes in the region.

The COVID-19 pandemic has required LCMC to emphasize its work with community partners in order to identify and strategize around this health crisis and keep their community safe. While COVID-19 has presented a new challenge, LCMC is committed to responding to community priorities such as preventing or reducing heart disease, substance use disorder, diabetes and poor nutrition.

Overview

2020 Community Involvement
68 Phone Bank Surveys
71 community stakeholders & healthcare providers interviewed
Weekly Videoconference Meetings

This is the third Community Health Needs Assessment (CHNA or Assessment) conducted by LCMC since the Affordable Care Act's regulatory mandate. The foundation of this Assessment is built on the work performed in the two previous assessments—2014 and 2017, respectively. This Assessment has taken on a unique character as the COVID-19 pandemic has required adjustments and a new investigative focus. The pandemic disrupted traditional, in-person data gathering methods such as in-person interviews and focus groups. That said, new, creative methods were employed that actually increased the interactive data incorporated into this Assessment. Weekly videoconference meetings brought diverse voices into the fold and have made for a richer analysis.

The goals of the 2020 CHNA were:

1. Identify the health needs, assets and forces of change in LCMC's service areas;
2. Monitor changes and trends to community health since 2017;
3. Engage community stakeholders and healthcare providers through a multifaceted telecommunication approach;
4. Implement new strategies for addressing community health needs.

Key Findings

- While LCMC has pushed policy to curb drug and alcohol use disorder, it remains a significant concern in the community as people still grapple with disproportionately high poverty rates.

- Chronic health provider shortages still interfere with the efficient delivery of healthcare. LCMC has worked closely with its local community college, Northland Pioneer College, to create an intracommunity pipeline of nurses and technicians. Furthermore, transportation options improved, which help ferry individuals to specialists outside of LCMC's service area. Still, LCMC is in need of physicians and specialists. A lack of ready access to providers is a major cause of delayed care.
- Major chronic health issues cited in the last assessment remain a concern for the community. Specifically, heart disease and diabetes, which were among the most frequently mentioned chronic health issues among Assessment participants.
- Socio-economic conditions such as poverty, lack of access to healthy food and clean water are also at the forefront of community concerns. These are major factors contributing to the chronic and acute health conditions discussed in more detail in this Assessment.
- COVID-19 became a stress test for the community and highlighted some of the weaknesses in a healthcare system that deals with high rates of chronic disease and poverty; however, COVID-19 also demonstrated the inherent strength of LCMC's healthcare providers and the community they serve.

Priority Solutions

- Build on the community collaborations that have been fostered during the COVID-19 pandemic. Increase resource sharing among healthcare providers. Increase communication with community stakeholders and medical providers to forge new and creative solutions for addressing community health needs.
- Improve upon timely and efficient health care services in the Primary Service Area (PSA) by working with the local community college to provide staff and recruiting out-of-area providers to come work for LCMC.
- Push health care services out into the community as a means of reducing patient isolation and reducing patient reliance on LCMC's emergency department.
- Continue educating community members on hygiene, exercise, and healthy eating habits as a low-cost, upstream approach to preventative medicine.
- Support local non-profits to increase the availability of community food deliveries and health education.

Community Health Needs Assessment

I. Assessment Process

CHNA guidelines require diverse community participation with the goal of identifying health priorities and developing strategic implementation plans. LCMC conducted its first CHNA in 2014. What followed was an intensive process with community advisory committee input and primary data collection. LCMC built on what it learned in 2014 to produce its 2017 Assessment. Primary data, key findings and community priorities were updated from LCMC's 2014 and 2017 assessments to determine goals met and areas requiring improvement and intervention in 2020 and beyond.

The COVID-19 pandemic of 2020 presented new challenges in terms of gathering community input. Still, community engagement is critical to LCMC's continued success as the area's leading healthcare provider. Adjusting to these new challenges, LCMC created a weekly videoconference meeting where local and regional healthcare providers, government agencies, and community stakeholders collaborated to resolve common issues. The 2020 CHNA is built on this type of active, community-oriented engagement. Enthusiastic participants volunteered diverse perspectives through focus groups, one-on-one interviews, and surveys.

Primary data collection consisted of the administration of the Community Advisory Board Questionnaire, the 2020 Community Needs Survey (the Survey), focus groups, interviews, and a review of available public health and hospital data.

2020 CHNA Timetable	
Windshield Survey of the Winslow and Navajo Communities	August 2019
Conference with LCMC Administrative Staff about the 2020 Assessment	March 2020
Winslow Community Update Meetings and Focus Groups Involving Community Stakeholders	March to September 2020
Interviews with Community Stakeholders and Medical Providers	June to September 2020
Community Advisory Board Questionnaire Community Needs Surveys	August to September 2020
Quantitative Analysis of Public Health Data Qualitative Analysis of Focus Group, Community Advisory Board, and Interview Data	September to October 2020
Implementation Strategy Development	January 2021

LCMC looks forward to a return to face-to-face data gathering as it continues to assess the health needs of the community it serves. Face-to-face meetings also have the advantage of generating consistent participation whereas one challenge in this Assessment was maintaining a level of participation that was present in the 2017 CHNA. That said, many people wanted to help make this Assessment a success. Participants acknowledged the importance of identifying health

needs in their community and had insights on how they believe LCMC can help improve upon what it is already doing in the community.

A significant advantage to the weekly community updates was having ongoing input from the Community Advisory Board as to how they perceived challenges facing the community and how best to address those challenges. From those weekly meetings, an organic strategic plan began to form wherein healthcare providers and community stakeholders alike identified shortfalls in their resources, where to focus their efforts to address a community need, and what interventions are producing the best results in the community. This may have been the most dramatic change since 2017 where the Community Advisory Board thought prospectively on what could be done relative to the data gathered through the assessment process. Here, data was used in real-time as a means to implement innovative policy and drive action to mitigate not only the effects of COVID-19 but a host of other community health issues.

II. Methodology

1. Community Advisory Committee Participation and Contribution

Input from the 2014 committee and the 2017 CHNA guided the assessment process. The 2020 Community Advisory Committee was convened via multiple videoconferences and was instrumental in 1) identifying and prioritizing community health needs; 2) identifying community assets to address community health needs; 3) assessing local, state and national policy changes that affect community health; and 4) evaluating and suggesting implementation strategies. The committee provided unique points-of-view and supplemented existing data with their insights.

2. Community Advisory Board Questionnaire

This qualitative survey was sent out to local and regional healthcare providers, public health organizations, government agencies, business leaders, faith leaders, school boards, and other community stakeholders. The questionnaire prompted participants to discuss public health issues facing the community, major health trends since 2017, and recommend any changes to LCMC's health care delivery that would improve community health.

3. Winslow Community Update

This was a weekly focus group whose members were local and regional stakeholders. Originally this update was designated to discuss the COVID-19 pandemic. This meeting between providers and community stakeholders was aimed at identifying shortcomings in addressing the COVID-19 crisis at a local level and determining what resources could be leveraged to best improve community response. The Community Update quickly evolved into a general collaboration between community stakeholders to improve the health outcomes of the community at-large. Some of the key topics addressed were school closures, healthcare provider staffing levels, equipment shortages, and infection rates.

4. Public Health Data

Public health data was gathered from the U.S. Census, U.S. Department of Agriculture, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Arizona Department of Health Services, and the University of Arizona Center for Rural Health.

5. Community Needs Survey

This survey was conducted over a two month period where participants were cold-called using publicly available phone numbers. The survey was modeled off of CDC public health surveys, the survey conducted in the 2017 CHNA, and the survey produced by Northern Arizona Healthcare in 2015. The survey took approximately 10 minutes to complete. Each participant was asked a series of demographic and health needs related questions. Those that participated seemed to appreciate that their input was being considered and often offered additional information during the survey. Any additional information yielded during the survey was noted so that it may be included in the qualitative analysis. The data gathered directly from the questions were tallied and analyzed as a quantitative data.

III. Limitations

The 2020 LCMC CHNA presented new challenges as the entire country adjusted to the COVID-19 pandemic. The initial strategy was to build on methodology utilized in the 2017 Assessment. However, the same interpersonal interactions that were central to the 2017 CHNA could not be replicated in the locked down world of COVID-19. With the advent of lockdowns, and out of an abundance of caution to limit the spread of COVID-19, new methods were employed to gather necessary data. In-person focus groups and interviews moved into the virtual space, which limited participants to those with stable internet and phone connections.

Another major change came in the form of forgoing the distribution of the Community Health Survey at large public gatherings. Instead, a similar survey was conducted by calling members of the public within LCMC's service area. This method was time consuming and limited the amount of survey data. Furthermore, cellular and landline coverage in the region is lower than metropolitan areas in Arizona. Many of the survey participants tended to be older and white than what is reflected in U.S. census data. Generating consistent participation in this survey was difficult. Many people either didn't want to participate or did not have working numbers.

Both the Community Advisory Board Questionnaire and Community Needs Survey attempted to strike a balance between the time necessary to gather important data and not exhausting survey participants by burdening them with too many questions. This methodology was utilized to increase survey participation and lower the risk of surveyor and participant burnout. The tradeoff is that the survey data was limited in scope. Interviews, focus groups and weekly meetings were used to supplement the Survey.

Demographic Characteristics of the Little Colorado Medical Center Service Area

I. Service Area

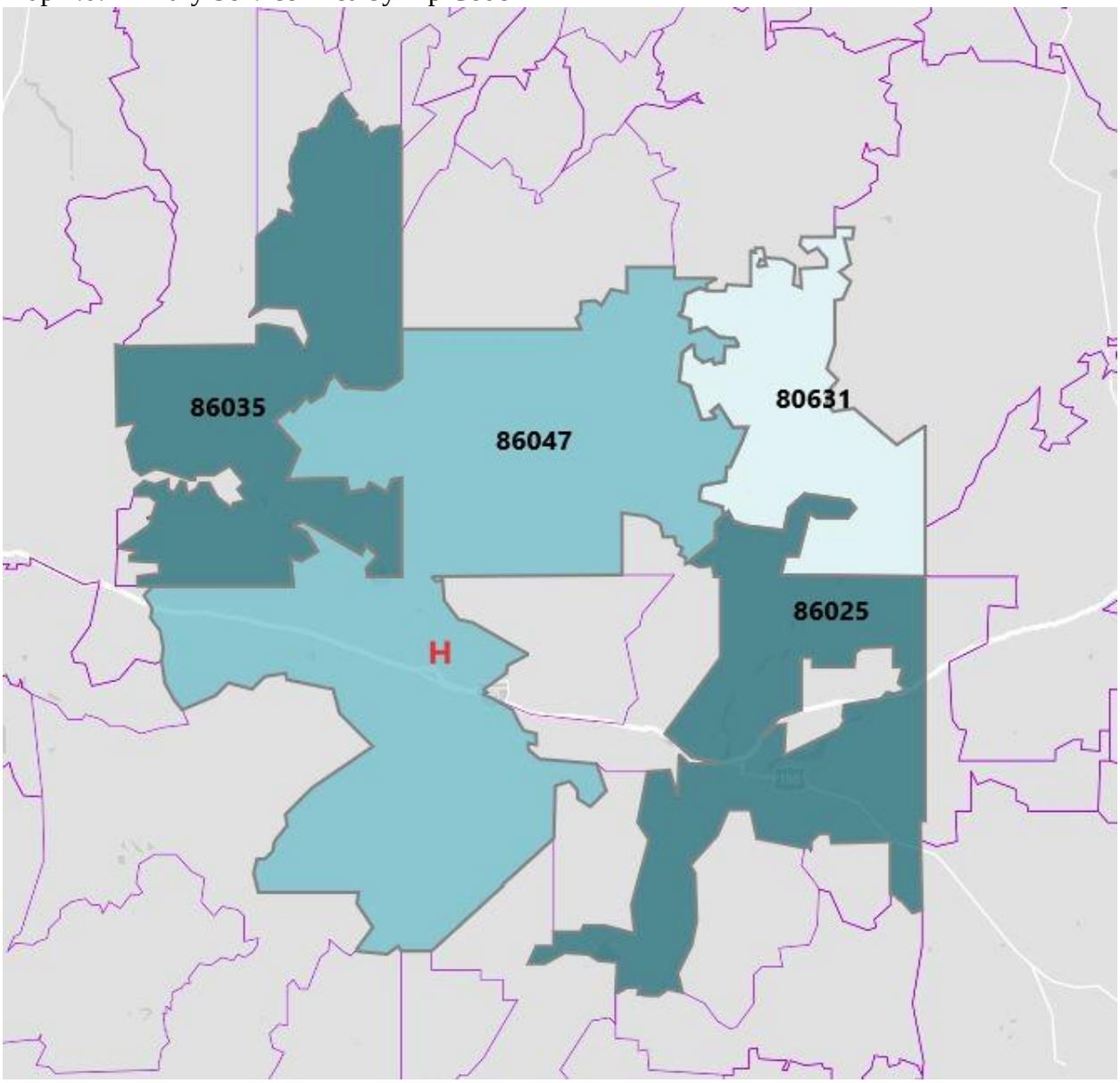
The primary service area or PSA was established pursuant to LCMC's discharge data reported to CMS. Based on its 2019 report, approximately 77% of LCMC's patients originated from four zip codes: 86047, 86035, 86031 and 86025. The four zip codes comprising the PSA are primarily located in Navajo County with a small portion overflowing into eastern Coconino County. Although this Assessment attempted to use only zip code level data for its PSA analysis, at certain points, data restrictions forced the use of census tracts, which overlapped the PSA.

Because the majority of the PSA is in Navajo County, data for the secondary service region is comprised Navajo County statistics.

As discussed in the 2017 assessment, LCMC serves a vast, sparsely populated region.[i] LCMC's emergency department draws patients travelling through Arizona because of the hospital's proximity to Interstate 40. The hospital's rural location causes it to balance between the need to push its health care resources out into the greater service region and pulling people into the Hospital by developing services locally in Winslow. A mix of both approaches has been employed over the years. Increased collaboration with other institutions and patient education efforts have helped increase LCMC's reach into the broader community.

The Community Needs Survey was conducted in the aforementioned zip codes to gather data directly from persons who are likely using, or may in the future use, LCMC's medical services. In any case, the people surveyed stand to benefit from LCMC's services and it was important to survey individuals and families that reside in LCMC's community.

Map 1.0: Primary Service Area by Zip Code

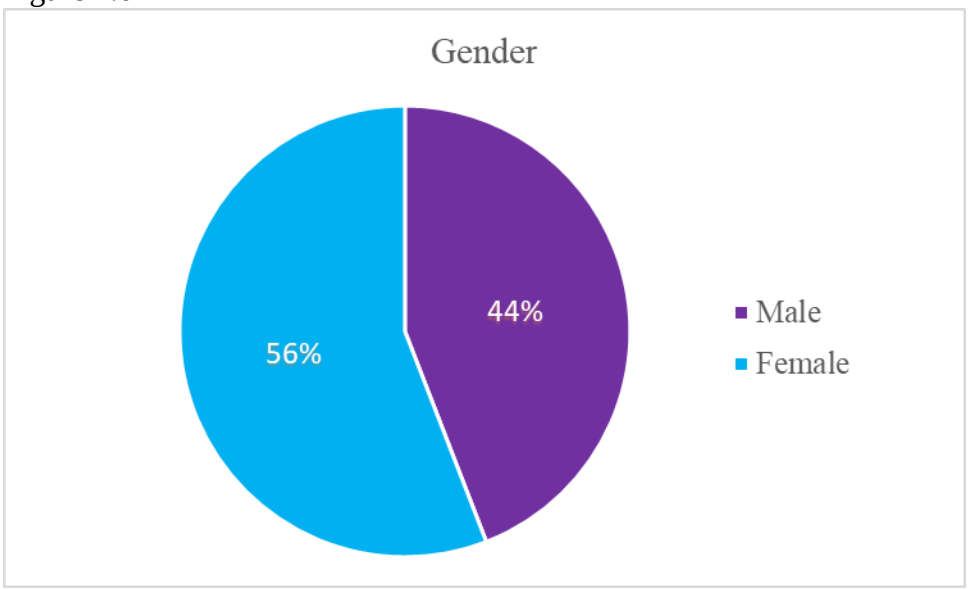


Source: U.S. Census Bureau

II. Gender

In Navajo County, the split between the male and female populace is fairly even at 50.2% and 49.8%, respectively, according to 2018 U.S. Census estimates. Community Needs Survey results favored female respondents over their male counterparts. Gender remains a key category in community health because of the different ways men and women experience health and socio-economic issues. A clear and significant difference between men and women is the ability to bear children and the appurtenant health issues that come with pregnancy and post-pregnancy. Another key consideration is that women still tend to earn less than their male counterparts, which depresses household incomes. Furthermore, women suffer domestic violence at a disproportionate rate. These, and a host of other factors, are cause for focus as LCMC and its community partners attempt to mitigate the differential health outcomes for each gender.

Figure 1.0



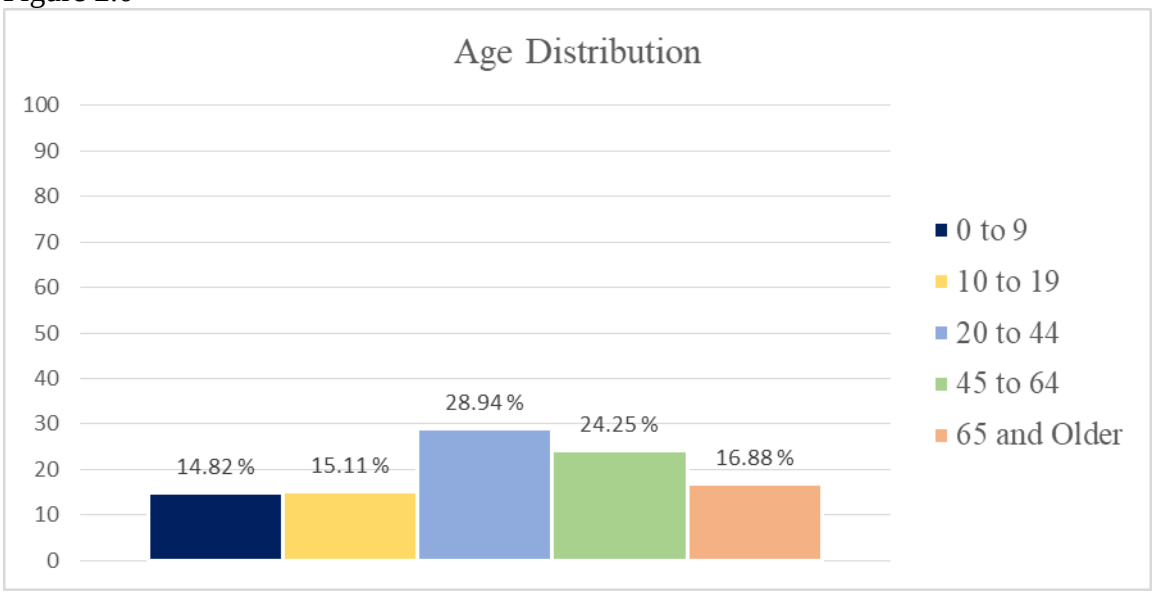
N 68
Source: Community Needs Survey

III. Age Distribution

As indicated in the 2017 Assessment, age distribution in the PSA and general service region skews toward middle aged and elderly demographics. LCMC has taken proactive measures since its 2017 Assessment by focusing resources toward preventative care and educating its aging patient population. LCMC has also increased its collaboration with local organizations and medical providers that tend to elderly needs.

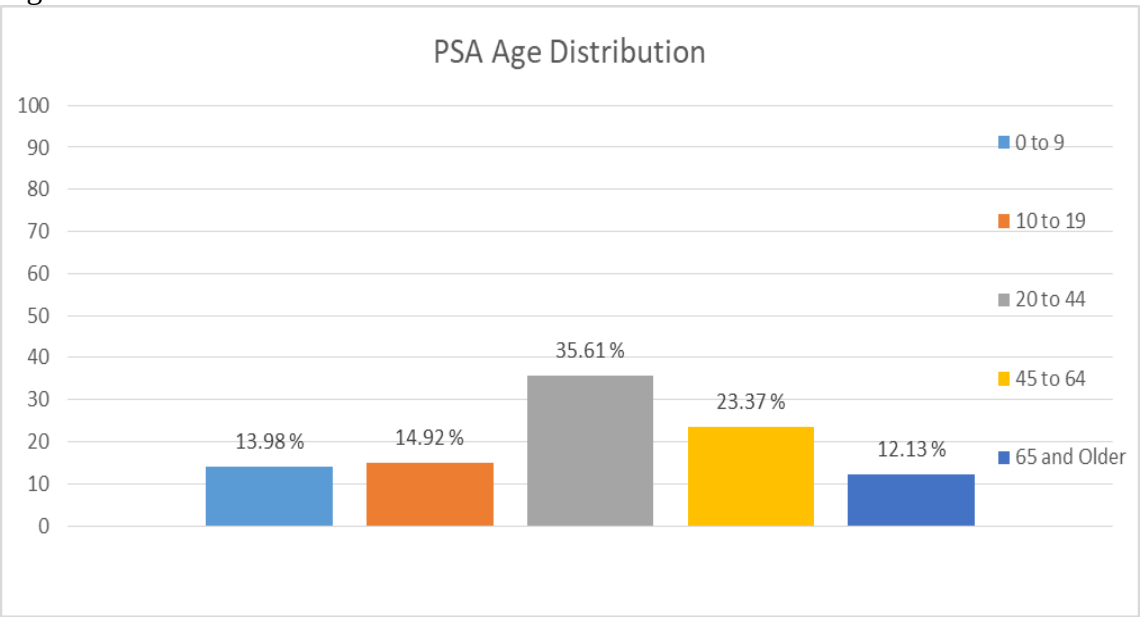
That said, participants in this Assessment continue to express concern over the elderly's access to care in two major areas: (1) affordability of care and (2) availability of medical care in the service area. Many older patients, especially those requiring specialized medical services such as orthopedics and cardiology, feel as if they are unable to readily access the care they need. Because elderly persons have significant representation in the service region. An entire section of this Assessment is dedicated to evaluating their particular health needs.

Figure 2.0



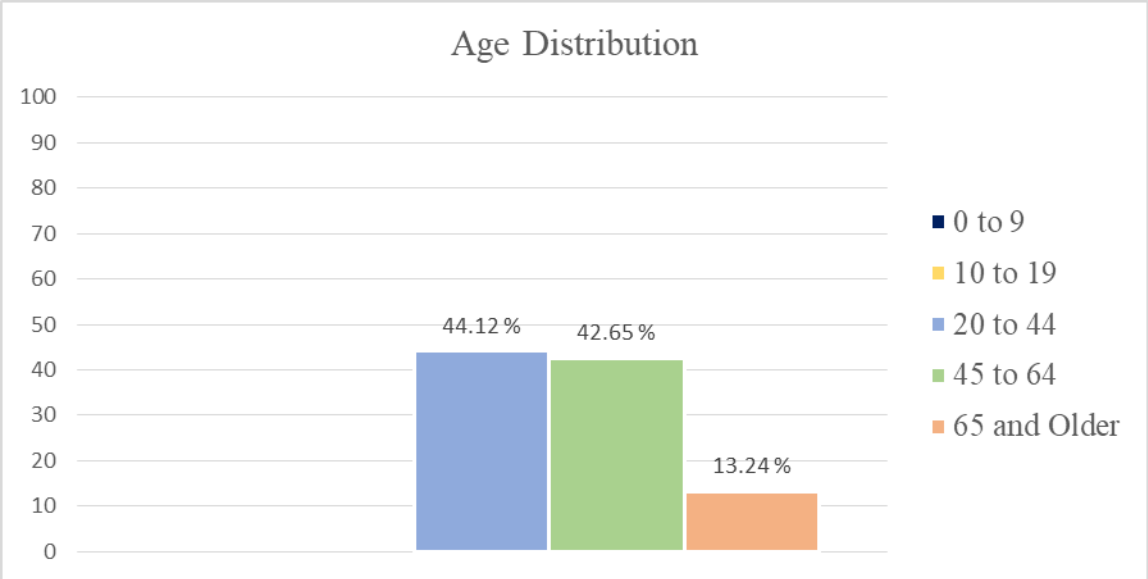
Source: U.S. Census, Navajo County, 2018 Estimates

Figure 2.1



Source: U.S. Census, Primary Service Area, 2018 Estimates

Figure 2.2



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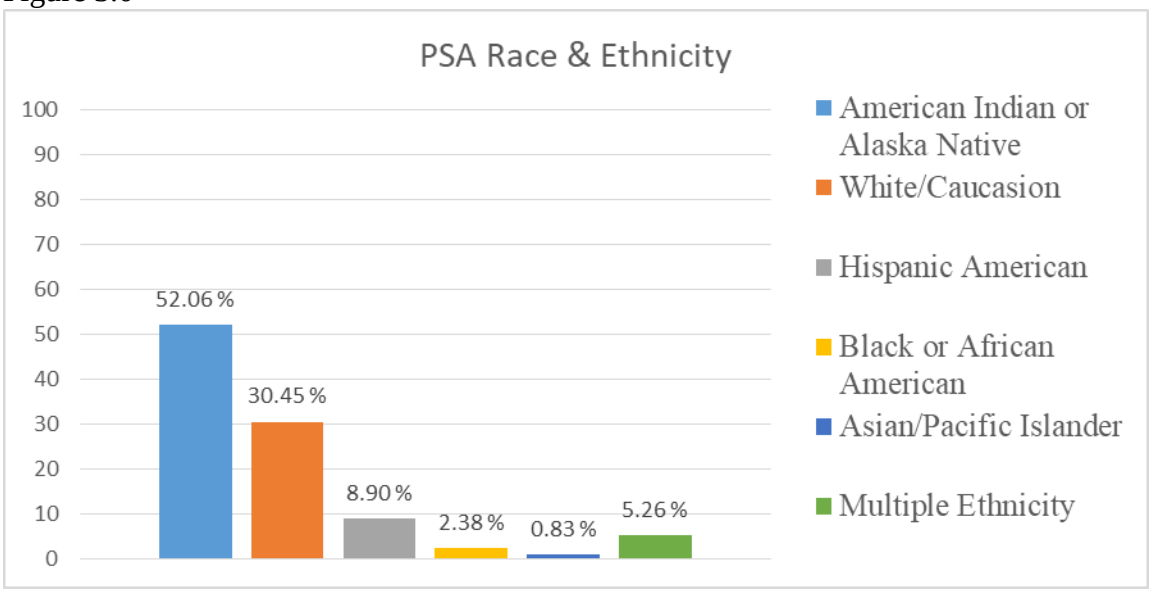
Source: Community Needs Survey

IV. Race & Ethnicity

LCMC's community is predominantly American Indian, due in large part to its geographic proximity to the sovereign territories of the Hopi and Navajo. The Hospital has strong relations with local and regional Indian healthcare providers. No more important were these relations than when the COVID-19 pandemic struck the region. Like a wildfire, the pandemic burned through the Navajo and Hopi territories and disproportionately affected the people within. As the sovereign governments devised mitigation strategies, such as curfews and shutdowns, local providers banded together in weekly meetings to collaborate on health care delivery plans. These weekly COVID meetings became the bedrock of addressing the pandemic as new cases flooded the region.

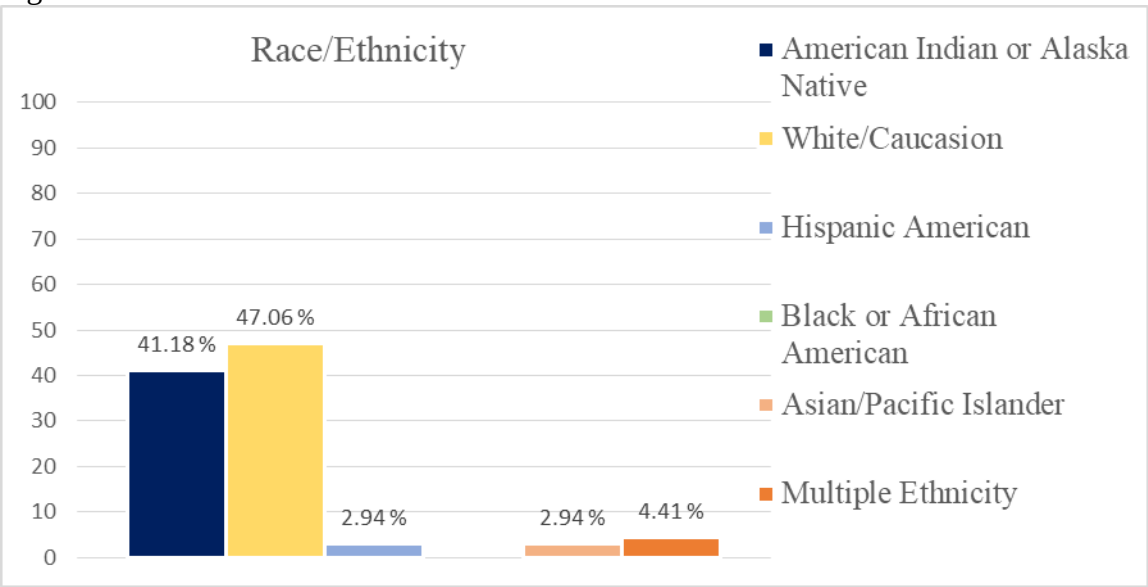
Aside from the COVID-19 pandemic, race remains a major factor in health outcomes. The Navajo and Hopi are sicker and poorer compared to their white counterparts. There are intransigent issues such as higher reported levels of substance use disorder and domestic violence among American Indians. Addressing these health issues will take more than the humble resources of LCMC, as we look to untangle chronic economic depression, poor health outcomes, and historical traumas.

Figure 3.0



Source: U.S. Census, Primary Service Area, 2018 Estimates

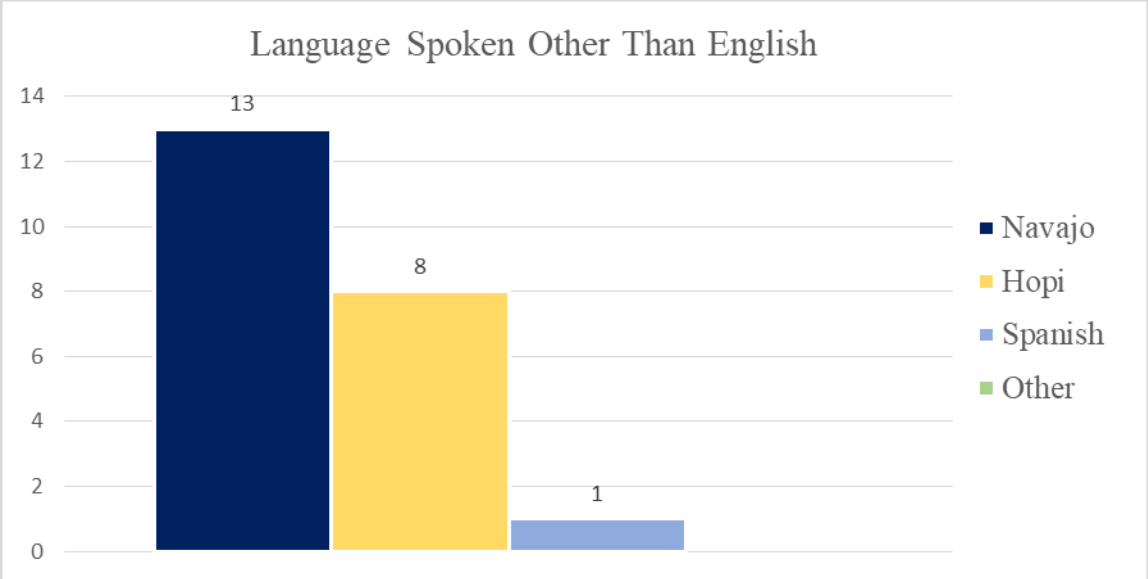
Figure 3.1



N 68
Source: Community Needs Survey

Another significant point of focus is the cultural and linguistic diversity of LCMC's service area. Survey participants reported languages, other than English, that were spoken at their home.

Figure 3.2



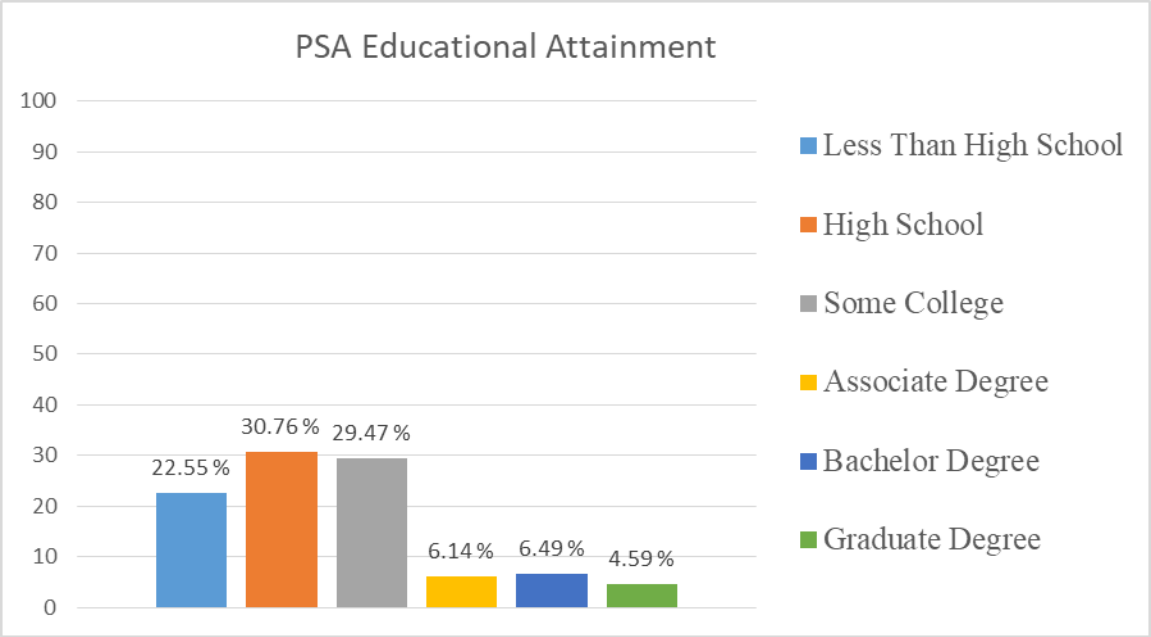
N 68
Source: Community Needs Survey

V. Education

Another social determinant of health is education, which continues to be an area where the PSA and general medical service region lag behind the rest of Arizona. The percentage of the Navajo County population (82.8%), ages 25 and over, that have graduated from high school is lower than the State average of 86.8%. There were also significantly lower rates of reported bachelor degree holders, 9.3%, than the State's reported 18%.[1]

The 2017 Assessment went into detail about why educational attainment is an important factor in health outcomes. The conclusion reached in that CHNA was that higher education attainment is correlated with lower mortality rates.

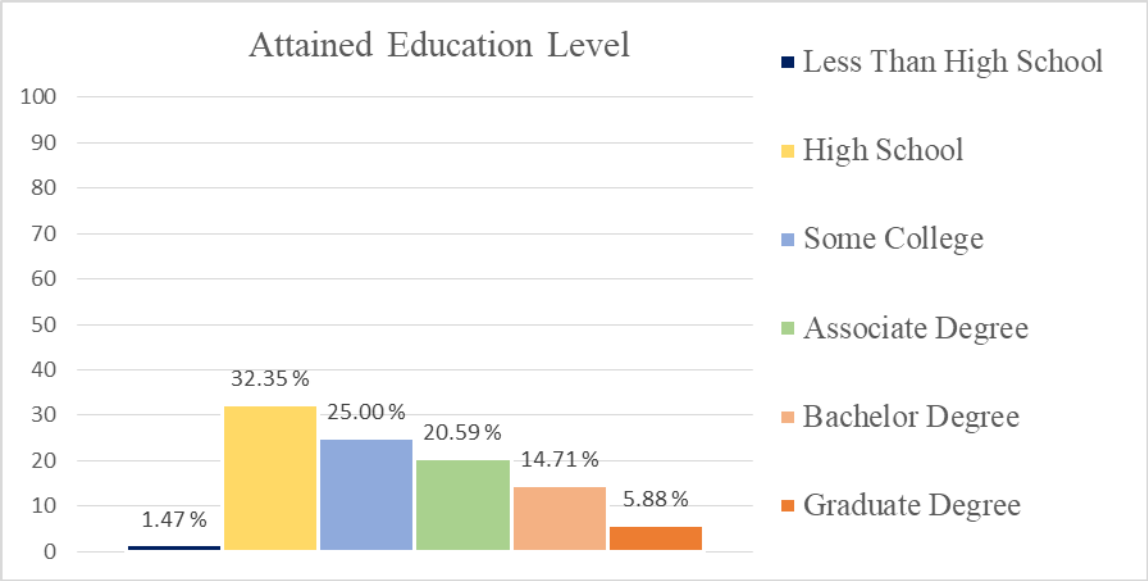
Figure 4.0



Source: U.S. Census, Primary Service Area, 2018 Estimates

[1] Based on 2018 U.S. Census Estimates

Figure 4.1



N 68

Source: Community Needs Survey

VI. Income & Poverty

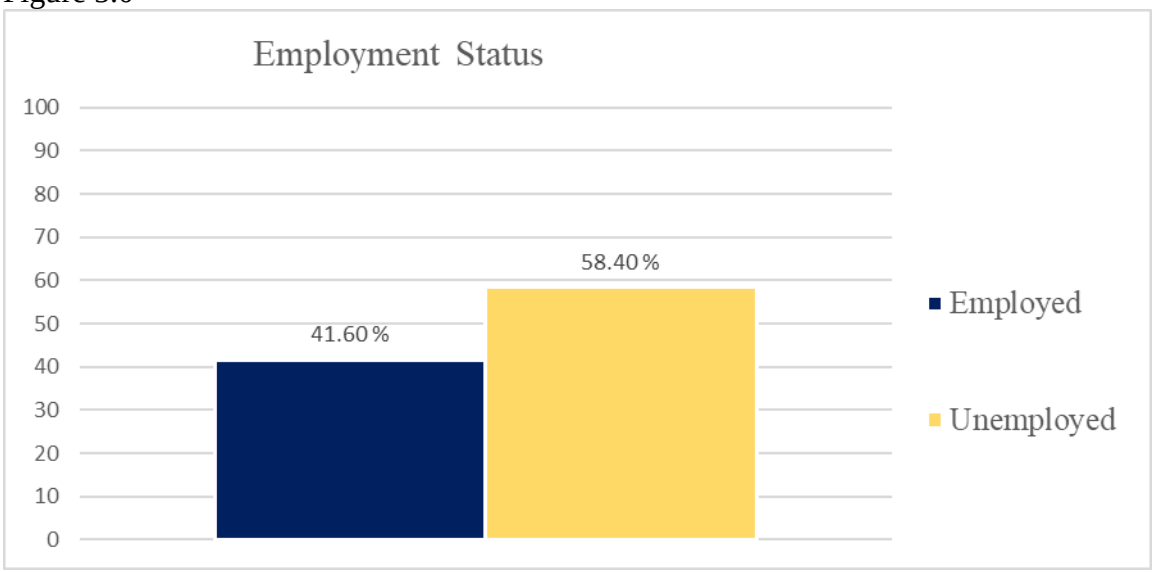
According to 2018 estimates, the median income for the primary service area was $38,313. Navajo County was slightly higher at $40,054 in 2018. Both were below the Arizona median, which came in at a reported $56,213. The 2020 National Poverty Level for a household of 3 in 2018 was $20,780. Approximately 35% of households in the PSA make at or below $24,999. Over 36% of children in Navajo County live at or below the national poverty line.[ii]

Of the estimated 6,899 households in the PSA, 2,114, or approximately 30%, are reliant on publicly funded food assistance programs.

Many interviewed and surveyed for this Assessment cited poverty as a major issue. Indeed, Navajo County is one of, if not the most, impoverished counties in the United States. Poverty is a major social determinant of adverse health outcomes.

As discussed in the previous Assessment, unemployment rates remain disproportionately high in the PSA when compared to State and national unemployment rates. The COVID-19 pandemic exacerbated the impact of chronic unemployment within the community. Assessing qualitative data gathered from interviews and surveys, the community feels that the economic disruption caused by the COVID-19 pandemic has only deepened an ongoing economic depression in the region. The lack of support from State and federal authorities has only deepened the financial crisis that has long plagued the area. Some community members feel more financially insecure now than they felt during the 2008 recession. There is an anxiety that without some leadership and support, the economic depression felt throughout the service area will be irreversible.

Figure 5.0



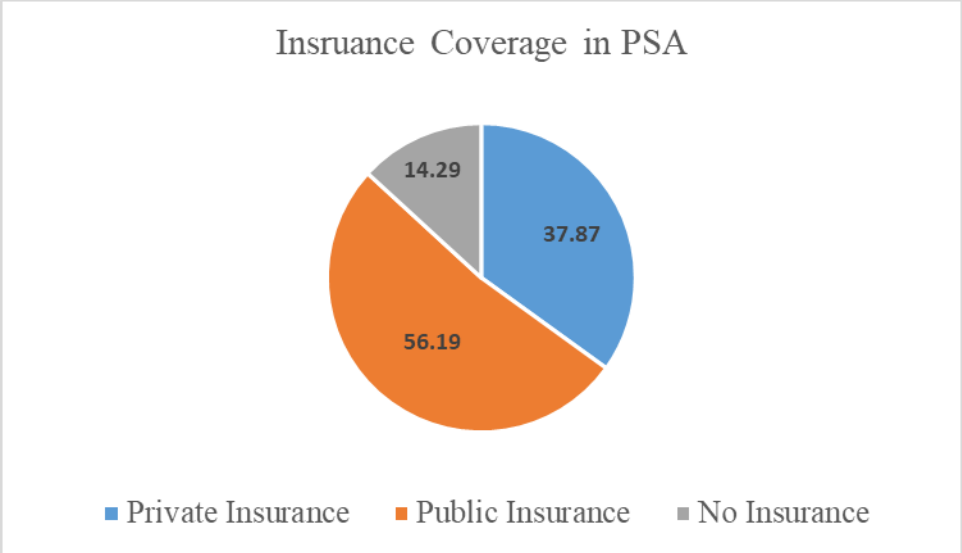
Source: U.S. Census, Primary Service Area, 2018 Estimates for Work Eligible Persons 16 Years and Over

VII. The Uninsured

Arizona's overall uninsured rate continues to fall since Medicaid expansion was passed. The State's overall uninsured rate hovers around 10%. However, note that the aforementioned estimate was pre-pandemic. The employer-based private health insurance system, which so many people rely upon, has experienced major disruption since the pandemic. People have either lost their employer-based insurance plan since being laid off, or their job is at risk because of ongoing cuts to the labor force.

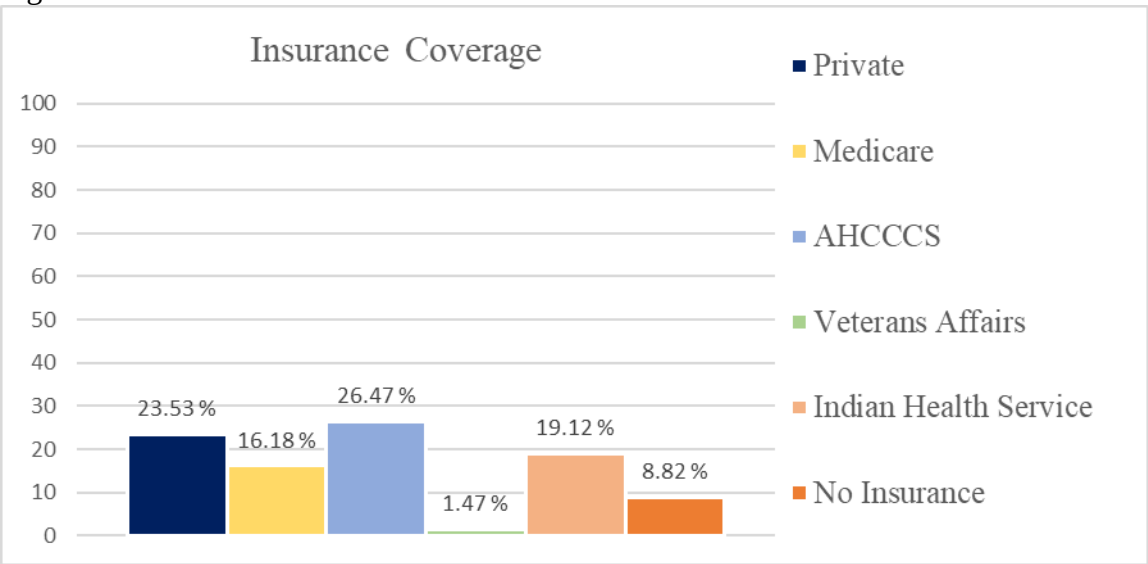
Furthermore, insurance does not guarantee that patients will have a primary care physician or that they will have visited a physician in the past year. Less than half of those surveyed for this Assessment have a primary care provider.

Figure 6.0



Source: U.S. Census, Primary Service Area, 2018 Estimates

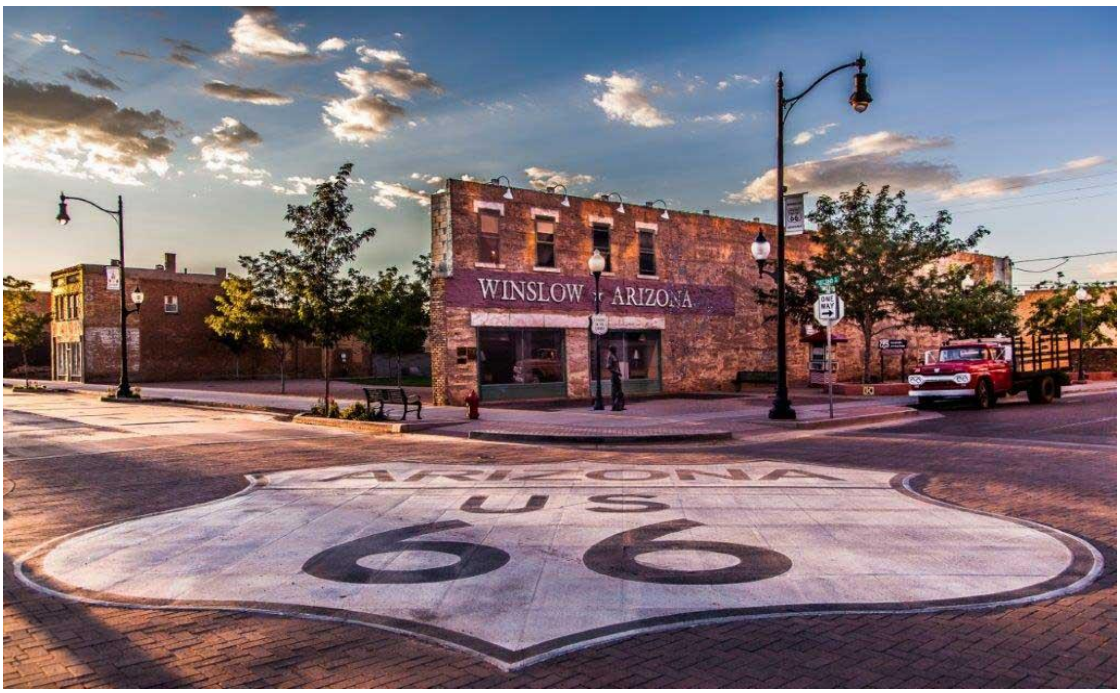
Figure 6.1



N 68

Source: Community Needs Survey

Because so much of the U.S. private insurance system is tied to employer-sponsored insurance, the COVID-19 pandemic presents a major disruption to that system. During the interview and survey phase of this Assessment, participants commented that they either experienced a disruption to their employer-sponsored insurance or that they knew someone who had experienced a disruption to their insurance. It was commented in the last assessment that lack of insurance leads to infrequent and delayed use in health care services. Simply put, an uninsured populace is an unhealthy one.



Source: Winslow Chamber of Commerce

Community Health Priorities

I. Characteristics of a Healthy Community

Figure 7.0

Health Indicator	Navajo County	Arizona	Healthy People 2020 Target
% (age 18-65) With Health Insurance	76.5	81.5	100
% (age <18) with Health Insurance	86.5	90	100
Cervical Cancer Incidence Rate	5.9	6.8	7.1
Colorectal Cancer (Age-Adjusted Death Rate)	28.8	35.4	39.9
Workers Commuting by Public Transportation	1.4	2	5.5
Coronary Heart Disease (Age-Adjusted Death Rate)	98	110	103.4
Tuberculosis Incidence per 100,000	2.8	2.8	1
Firearm-Related Deaths (Age-Adjusted Death Rate)	15.1	14.1	9.3
%Preterm Births	8.8	9	11.4
% Mothers who Received Early Prenatal Care	70.5	81.3	77.9
% of Low Birthweight Births	8.4	6.9	7.8
Infant Death Rate	4.5	5.3	6
% "Fair/Poor" Mental Health	4.6	3.6	
Suicide (Age-Adjusted Death Rate)	23.2	17	10.2
Salmonella Infection Incidence Rate	34	15.3	11.4
% Obese	31	28.9	

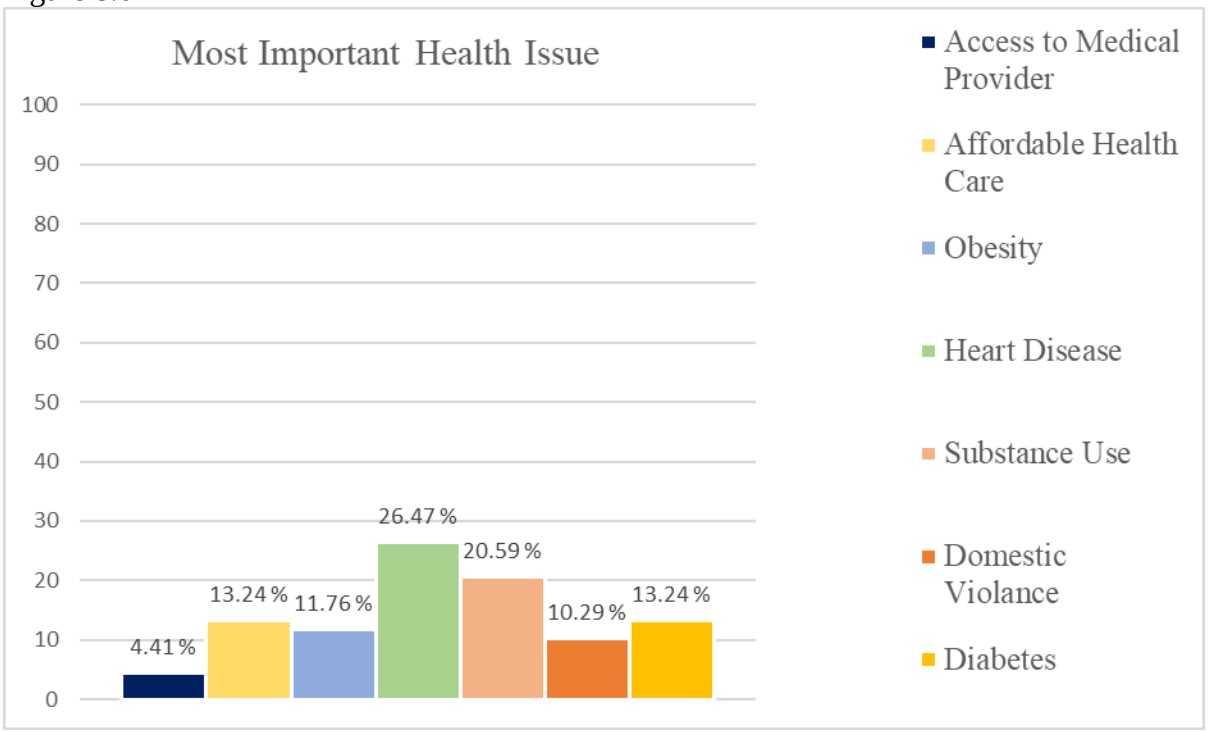
Source: Arizona Department of Health Services – 2017 Values

II. Criteria for Identifying Community Priorities

Primary and updated secondary data was used to determine progress from the 2017 CHNA and identify emerging health needs.

As with the previous Assessment, priorities were based on 1) community need; 2) potential for impact; 3) community interest, will and readiness; and 4) resources.

Figure 8.0



N 68

Source: Community Needs Survey

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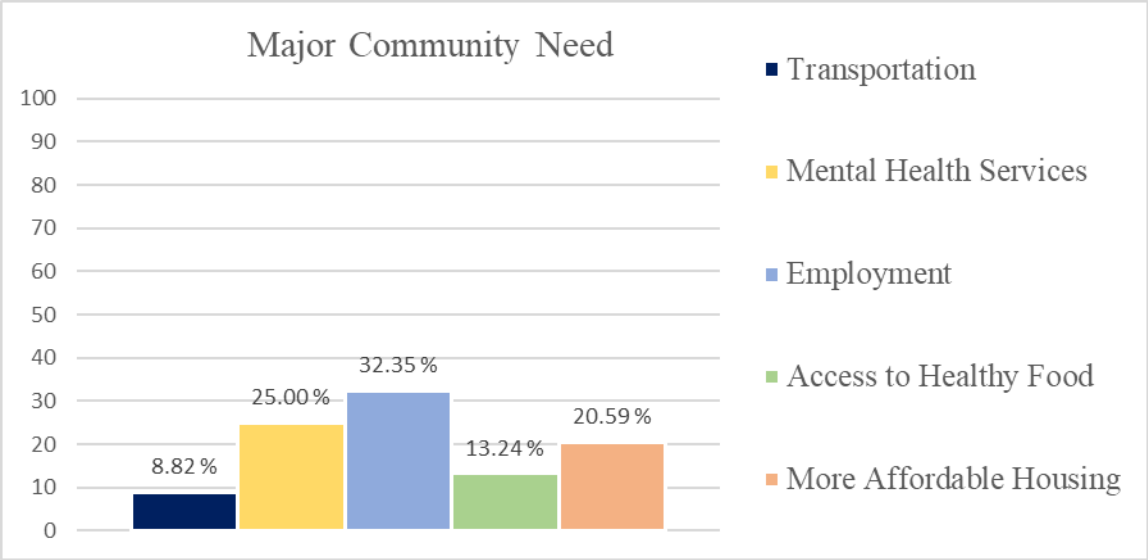

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Source: Community Needs Survey

The Arizona Department of Health Services publishes a series of community profiles showing health outcomes. While the primary care area, shown below, does not precisely align with the PSA described in this Assessment, it is a valuable indicator of what is occurring in the PSA.

Red indicates categories where the PSA is performing worse than Navajo County and the State of Arizona. Yellow indicates where the PSA is performing marginally worse than the County or the State, or both. Green indicates where the PSA is performing better than the County and State. No color indicates a category where there is no significant difference between the PSA and its counterparts.

Figure 8.2 – Mortality Per 100,000

	Primary Care Area - Winslow	Navajo County	Arizona
Cancer	162.5	136.1	138.8
Lung Cancer	26.3	27	31.4
Alzheimer's Disease	32.3	31.6	36.4
Homicide	4.6	15.8	6.4
Chronic Liver Disease	44.7	33	14.3
Chronic Lower Respiratory Disease	67.6	51.2	44
Diabetes	63.8	38.4	24.1
Heart Disease	142.3	128.4	145.2
Hypertension	6.5	9.1	12
Influenza and Pneumonia	17.5	14.3	10.2
Nephritis	17	13.4	6.4
Parkinson's Disease	6.7	10.8	9
Stroke	47.5	44.1	31.5
Suicide	10.7	44.8	18
Drug-Induced Death	16.8	20.5	23.2
Opiates/Opioids	6.1	2.1	12.1
All Accidents	83.3	106.6	55.6

Source: Arizona Department of Health Services – 2017 Values

III. Community Defined Priorities

A. Low Income and Poverty

In 2017, approximately 25% of Navajo County lived at or below the federal poverty level. In 2018, those numbers got worse, with an estimated 28.5% of the county population living at or below the federal poverty level. The PSA has even higher poverty rates at 29.4%.[iii]

As discussed in this Assessment, and the previous Assessment, income and poverty are major social determinants of health. The disproportionately low-incomes and relatively high poverty rates in the service region are reflected in poor health outcomes.

The life expectancy in Navajo County is 76.5 years, which is two years below the State average life expectancy. Navajo County consistently ranks in the bottom in terms of health outcomes. In 2019, the Robert Woods Foundation ranked Navajo County 14 out of 15 counties in terms of health outcomes.

Figure 8.2, above, shows that the Winslow Care Area underperforms in a number of major health categories. There are only 5 categories out of 17 where the Winslow community has better health outcomes than the State or County.

While LCMC remains a major employer in the area—and the local community college provides training and education to motivated, job-seeking individuals—many in the PSA express that there are few economic opportunities. Community members felt that individuals migrate out of the community to find stable jobs and livable wages.

From the evidence gathered for this Assessment, the COVID-19 pandemic has exacerbated chronic economic stress affecting the community. Many have cited loss of health insurance or unstable wages as reasons for delaying or forgoing medical care.

Therefore, it serves as little surprise that over 13% of Survey respondents listed affordable housing as a major community health issue, and over 20% cited it as a community need. Other major economic indicators, like employment and access to healthy food, accounted for over 45% of the responses in the Survey.

B. Mental and Behavioral Health

With 25% of Survey participants citing mental health services as a major community need, it remains a major topic in this Assessment. Between 2017 and 2018, Navajo County saw a rise in emergency room visits for mental disorders. In 2017, 8,728 individuals received emergency room care for a mental disorder. In 2018 that number increased to 10,598.[iv]

The increase in mental health cases has spurred increased action on LCMC's part. Since 2017, LCMC's nursing administration and social work team collaborated on a patient specific basis with a local behavioral health provider, adult protective services and Social Security. LCMC is also developing a clinically supported transportation model. The Hospital actively communicates with the local prison and Department of Corrections staff regarding safe and effective care of inmates with behavioral health issues. It also participates in State and Health Choice Integrated Care, ASU Behavioral Health Center, and Planned Assistance Network of Arizona to improve the quality of behavioral health and integrated medical care.

The Behavioral Health Unit has implemented the following elements into its comprehensive strategy to address behavioral health issues:

- Meeting quarterly with ChangePoint including the leadership team from Winslow, Holbrook and the inpatient Behavioral Health facility in Show Low;
- Meeting monthly with the WIHCC Care Coordinators and Social Work Director;
- Our Care Coordination team is developing relationships with Behavioral Health facilities across Arizona to assure appropriate placement of patients in need;
- Planning training for our Social Workers to do Behavioral Health intake assessments in coordination with ChangePoint; and,
- Looking into offering Telehealth Behavioral Counseling in the clinic.

A series of suicides in the community highlighted the significant consequences of poor mental health and the need to address the same. The deep and lasting effect of suicide on a close-knit community is something that cannot be adequately described in raw data. LCMC continues to focus its attention on connecting people with appropriate services and resources.

C. Substance Use Disorder

As with the previous Assessment, substance use disorder remains a major community health concern. Over 20% of Survey respondents pointed to substance use as a major community issue. The numbers in Figure 8.2 indicate that the Winslow community mortality rates are close to or below those reported at the county or State level. Still, the general service region has high substance use disorder rates, which adversely affect other health outcomes such as chronic liver, lung, kidney and heart disease.

Similar to the increase seen in mental health related visits, substance use related visits were also shown to be on the rise between 2017 and 2018. In 2017 there were 693 inpatient discharges related to substance use in Navajo County. In 2018 that number increased to 1,026.[v]

And, again, similar to other health outcomes, alcohol abuse continues to rise. In 2017 there were 420 total emergency room visits for alcohol abuse. In 2018 that number rose to 730. Admissions for alcohol use was particularly high among male admittees where in 2018 over 79% of emergency room visitors for alcohol abuse were men.[vi]

LCMC continues to work with City of Winslow and tribal authorities to work together to address this longstanding local issue. The Hospital has made the following strategic choices to address substance use disorder in the community:

- Direct delivery of Narcan kits to the emergency department;
- Members of the Hospital's Care Coordination team have gone to conferences to learn more on how to address the opioid issue and reported back with new ideas; and,
- Chronic pain patients that were being seen in the Hospital's clinic have been referred to Pain Management Specialist Providers for specialized care.

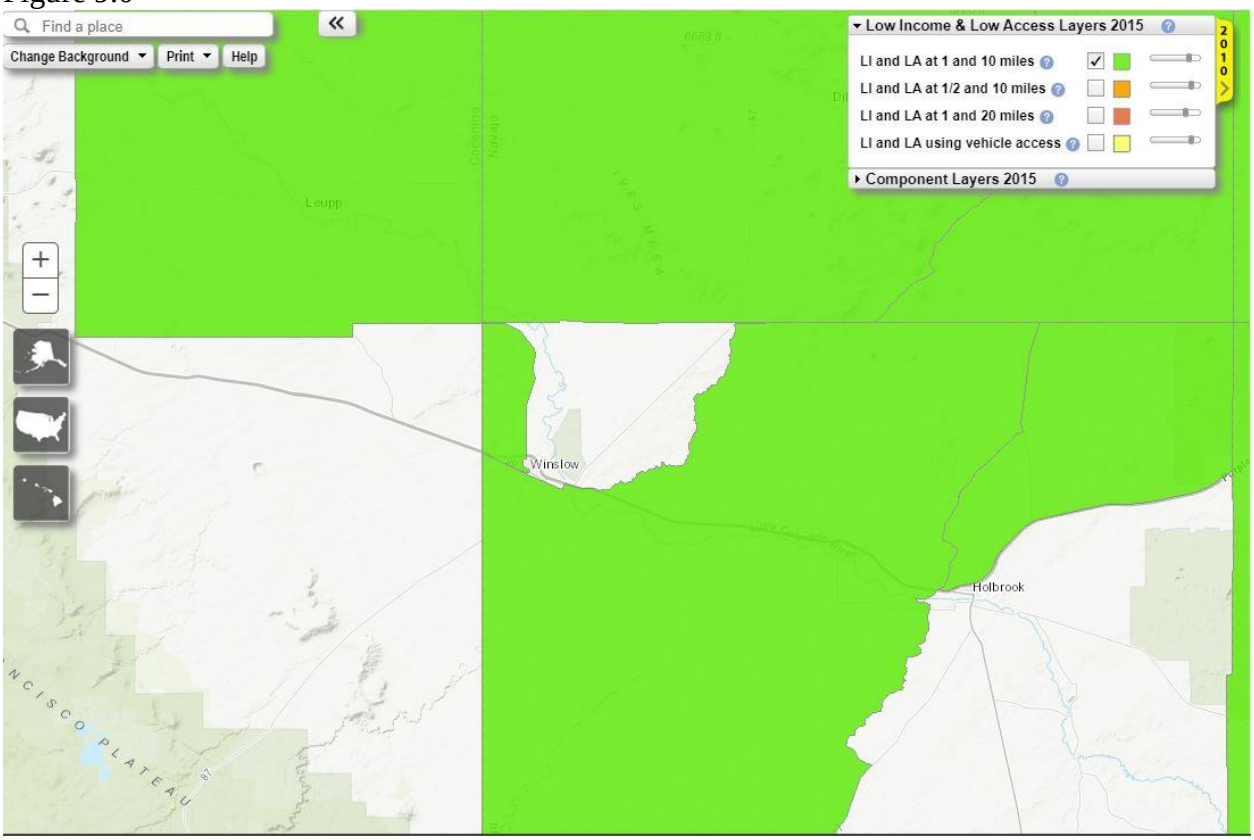
D. Senior Health Care

The previous Assessment highlighted themes related to access to care, financial insecurity, and food insecurity.

Food insecurity remains a major concern among community members. Seniors in particular noted that they worry about simply accessing food. The USDA's study of the area shows that food insecurity is prevalent. A major contributing factor being lack of transportation. In some surrounding census tracts, lack of vehicle ownership is as high as 34%. Thus, seniors feel they are isolated if they do not have ready means to transportation. Meals On Wheels and transportation programs do help to mitigate senior isolation.

Figure 9.0, below, shows the high prevalence of low income and low access to food in the PSA.

Figure 9.0



Source: US Department of Agriculture

Isolation also brings up another significant risk to the senior community, falls. Although not as a dramatic as some of the increases seen in this Assessment, there was a slight increase in falls in persons 65 and older between the years 2017 and 2018. According inpatient discharge data, individuals 65 and older reported 161 falls in Navajo County in 2017. That number increased to 198 in 2018.[vii]

LCMC provides information to its patients on the services offered by the Senior Center. Another need for seniors is Physical Therapy and rehabilitation. Although Winslow has an excellent Physical Therapy practice, it is not able to keep up with the increasing needs of the aging population. LCMC is actively working to expand its services to include Physical Therapy to meet the increased need within the community.

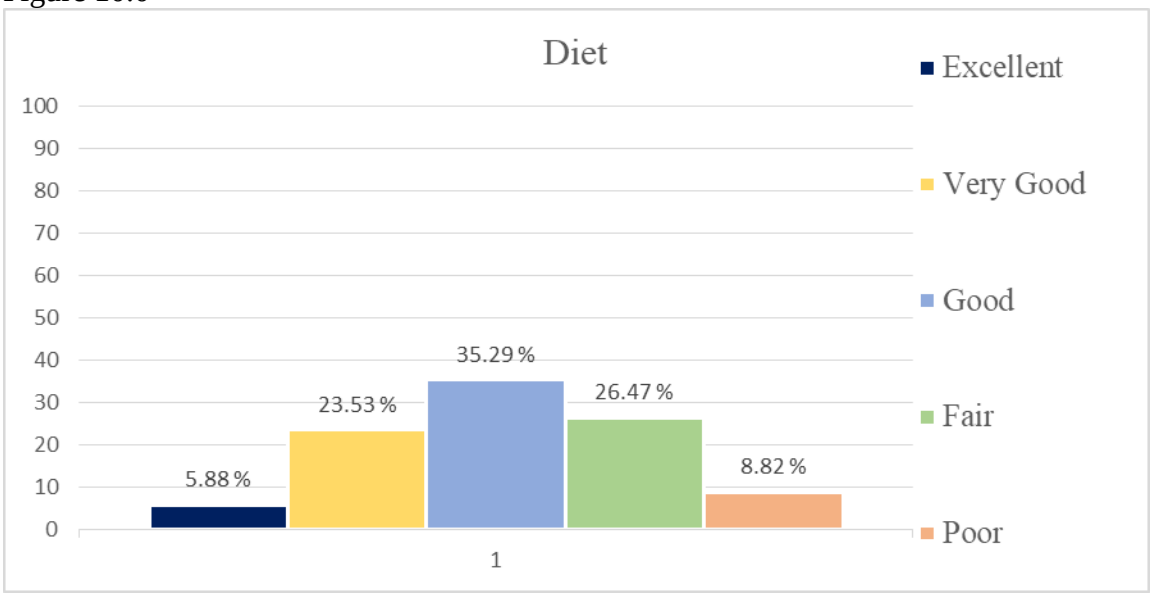
There is further need for outpatient treatments for local patients, such as wound care and intravenous antibiotics. LCMC recently expanded its wound care clinic on the hospital campus. LCMC's emergency department has expanded its infusion therapy for many antibiotics and certain other infusions. Many of the patients currently using these services were previously traveling to Flagstaff or were required to stay in a nursing home for treatment.

E. Obesity and Diabetes

Obesity and diabetes continue to be major community concerns, despite Survey data showing that community members have relatively good diets and exercise between 2 to 4 times a week.

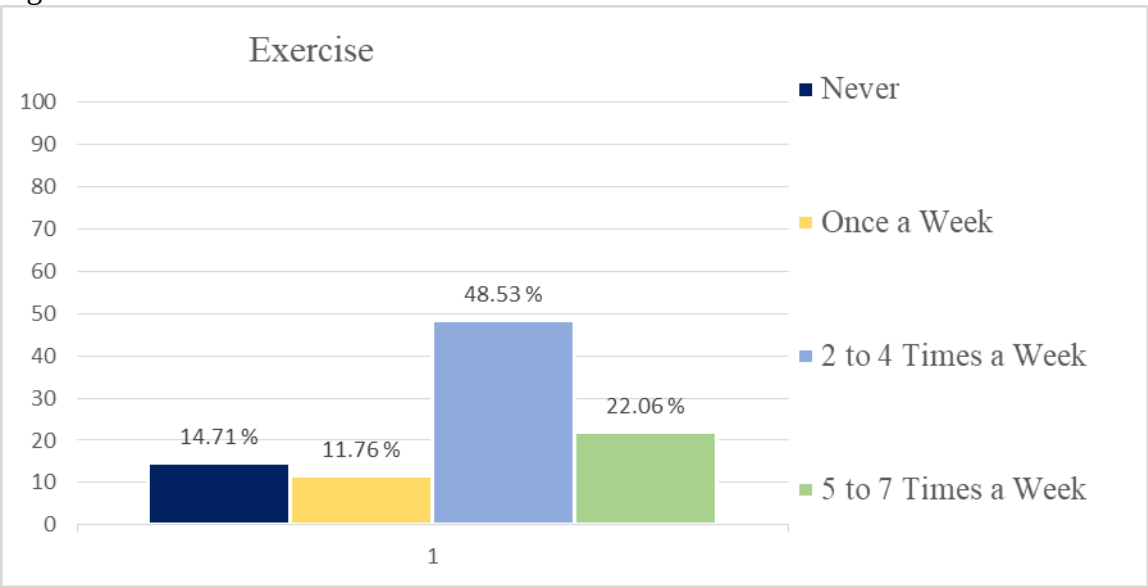
As shown in figure 8.2, the Winslow community suffers a disproportionately high rate of diabetes. LCMC continues to provide hot, nutritious meals on hospital premises and to facilitate delivery of nutritious meals to home bound seniors.

Figure 10.0



N 68
Source: Community Needs Survey

Figure 10.1



N 68
Source: Community Needs Survey

F. Health Provider Shortage

Statewide, Arizona only meets 41.7% of its primary care physician (PCP) needs. This chronic shortage is further exacerbated by the uneven distribution of providers throughout the state where underserved, rural populations are at an increased disadvantage. Between 26-50% of people living within LCMC's primary and secondary service areas are in a health provider shortage area (HPSA). When examining PCP shortages relative to tribal nations, the figures are much worse. As discussed above, Winslow borders the Navajo Nation, in addition to being in close proximity to the Hopi Tribe. The Navajo and Hopi are disproportionately affected by PCP shortages where between 76-100% of Navajo live in a HPSA and between 51-75% of Hopi live in a HPSA.[viii]

Similar to the analysis presented in LCMC's 2017 CHNA, common themes re-emerge in 2020 with providers reporting difficulty in recruiting and retaining mid and upper-level health care workers. Since 2017, LCMC and tribal entities have used a mix of recruiting methods with some success. Still, many positions remain open. Retention of health care workers remains an ongoing issue, which has been exacerbated by the retirement of older health care workers. As a stopgap measure, LCMC has re-enlisted retired physicians to provide expertise and clinical care. This stopgap measure was especially useful during the initial height of the COVID-19 pandemic where the entire health system was creating contingency strategies for the influx of patients.

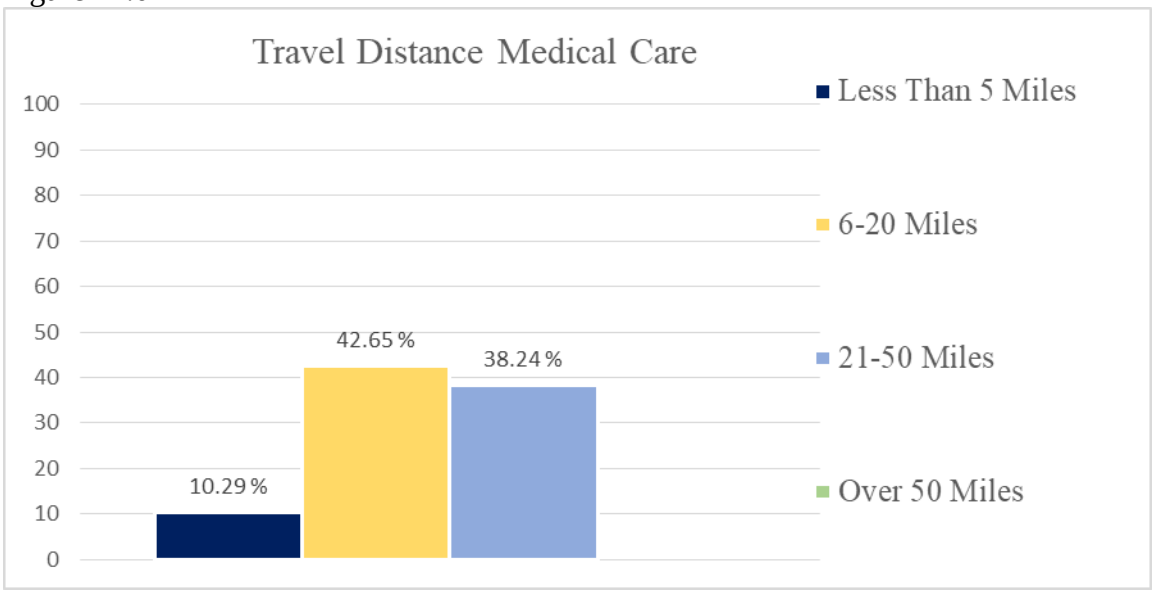
Health care workers at LCMC, and throughout the service area, continue to report high-volume workloads, stress, and burnout. Outside of LCMC, health care workers within the region cite having to take on multiple health care and administrative roles to make up for reduced staff. This creates a bottleneck in the healthcare delivery system. The squeeze on provider resources means that they cannot treat the number of patients requiring their medical services. This causes

(1) delays in patients receiving or seeking health care, which leads to more acute or critical cases and (2) patients being diverted to LCMC or another facility. In either of the aforementioned scenarios, LCMC, as the sole 24/7 emergency room in its primary service area, takes on a significant patient volume while having similar staffing issues as other providers in the region.

Bypass to other facilities has been a way around some of the provider shortage issues facing those living in LCMC's service area. Pre-COVID-19, community members reported improvements to non-emergent medical transportation since 2017. The primary reason patients sought to bypass LCMC was to see specialists that were only available at other healthcare facilities. Orthopedic and cardiovascular specialists were the most cited specialists sought by community members surveyed for this Assessment.

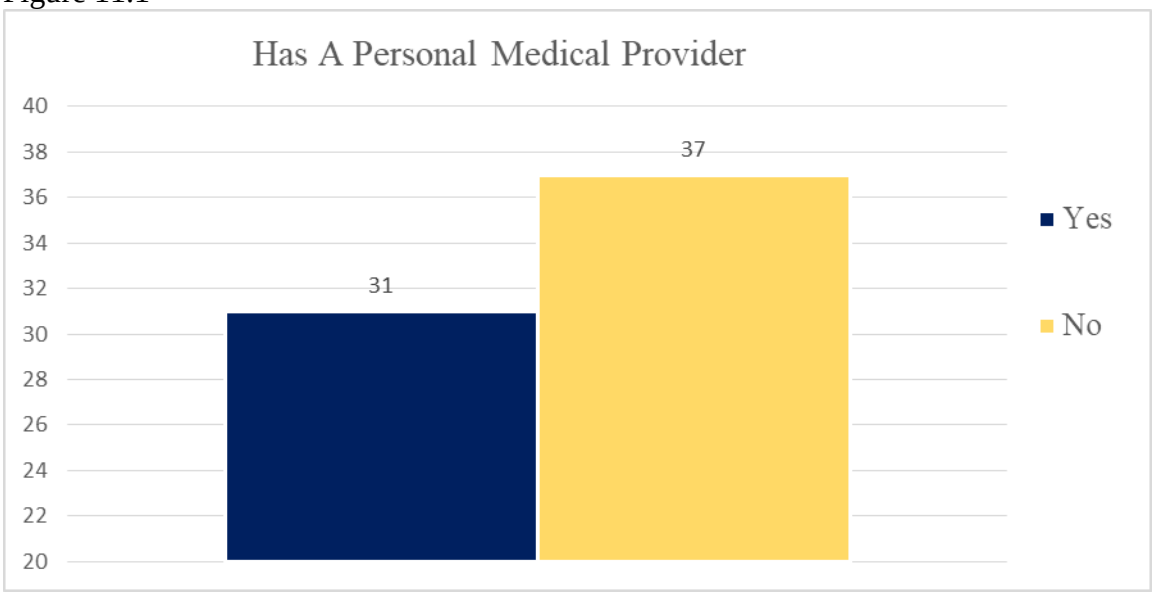
LCMC has effectively worked with the Human Resources and Services Administration to obtain LCMC's HPSA status in order to facilitate provider recruitment and retention, including loan repayment qualification. LCMC has recruited a new emergency medicine group, including several new providers delivering care to LCMC patients. LCMC has also recruited three primary care providers to its clinic. Furthermore, the hospital performs outreach to the local school district and community college to introduce and support students in health care fields. Community based recruitment and training is vitally important in creating and maintaining a pipeline of local people who want to stay in Winslow and help grow the community.

Figure 11.0



N 68
Source: Community Needs Survey

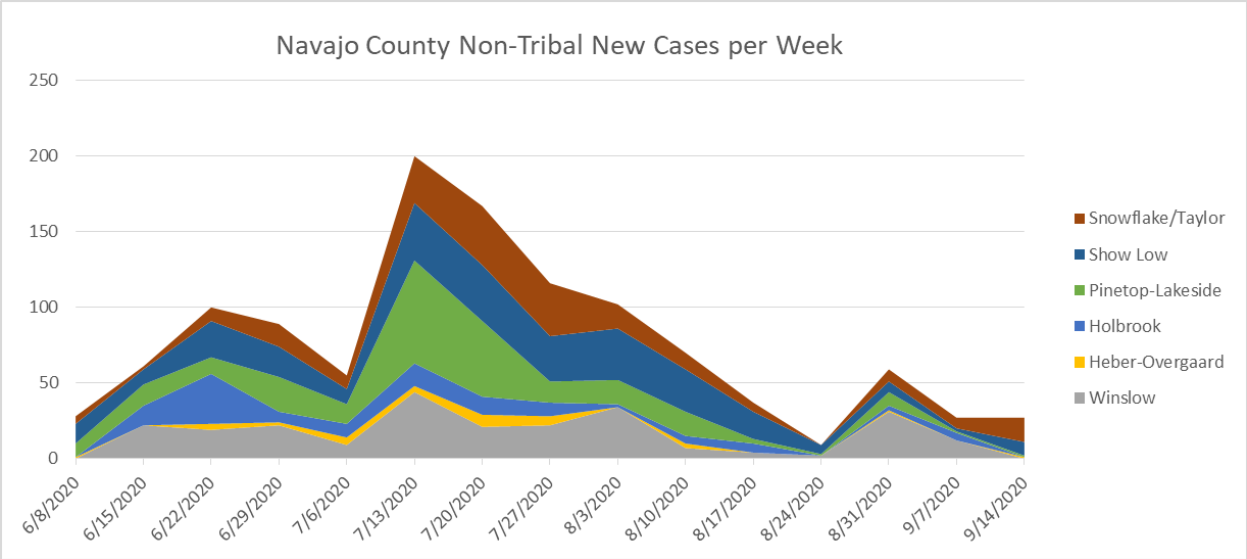
Figure 11.1

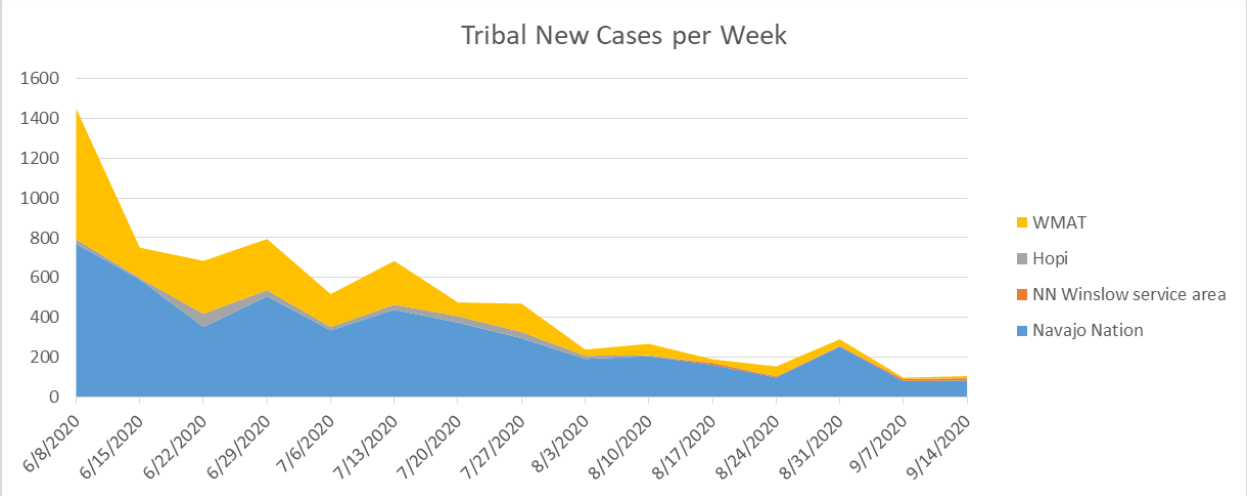


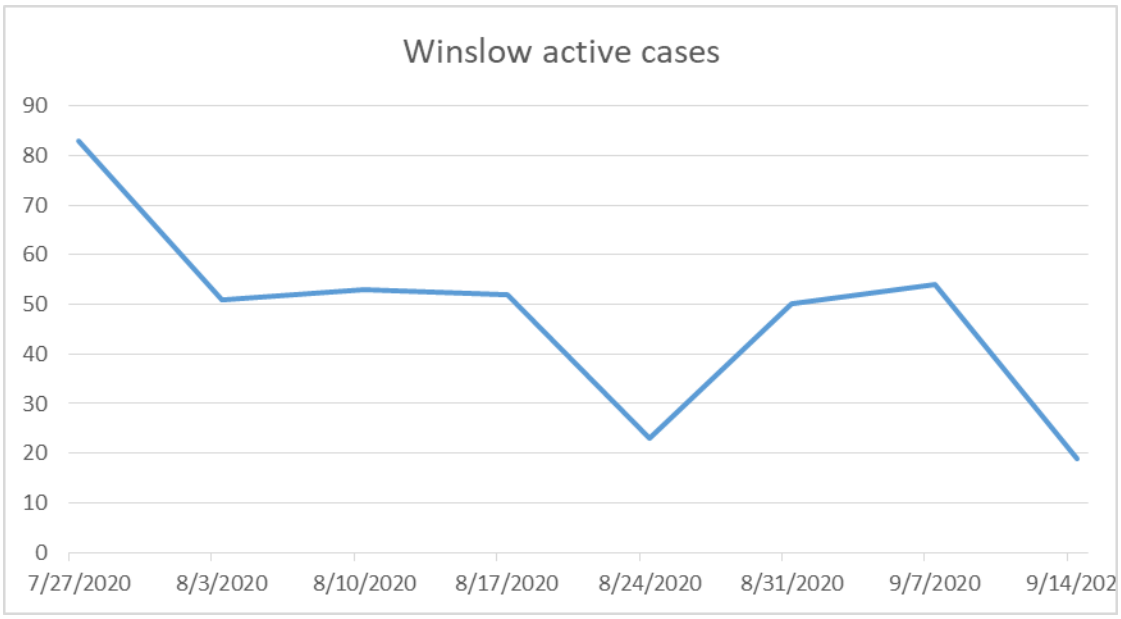
N 68
Source: Community Needs Survey

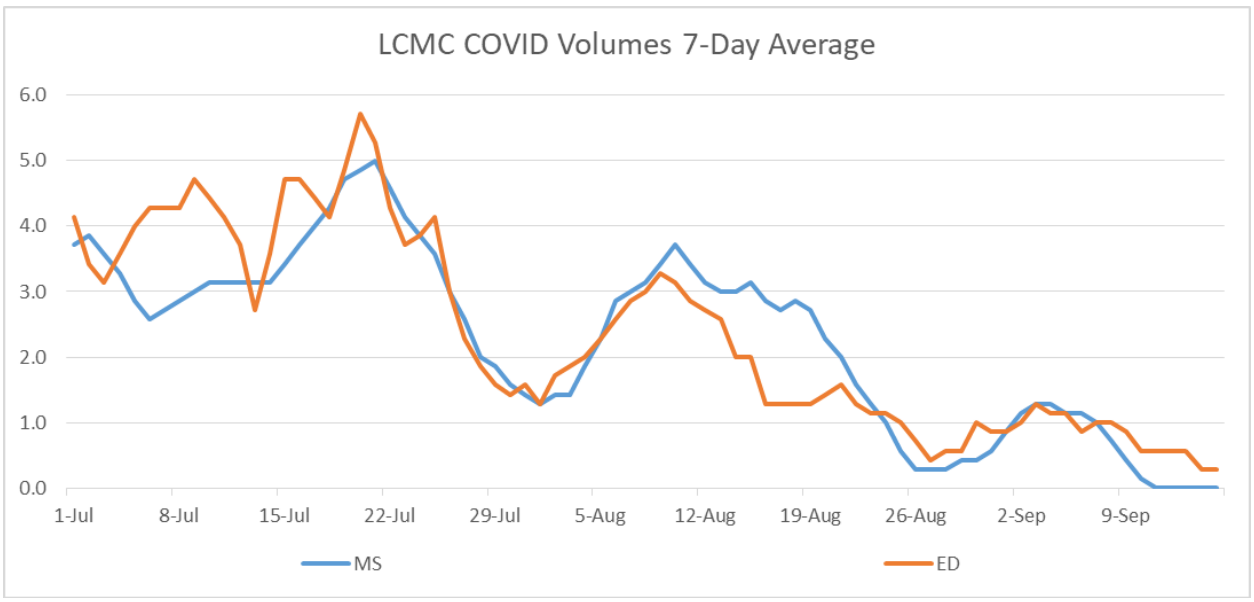
COVID-19

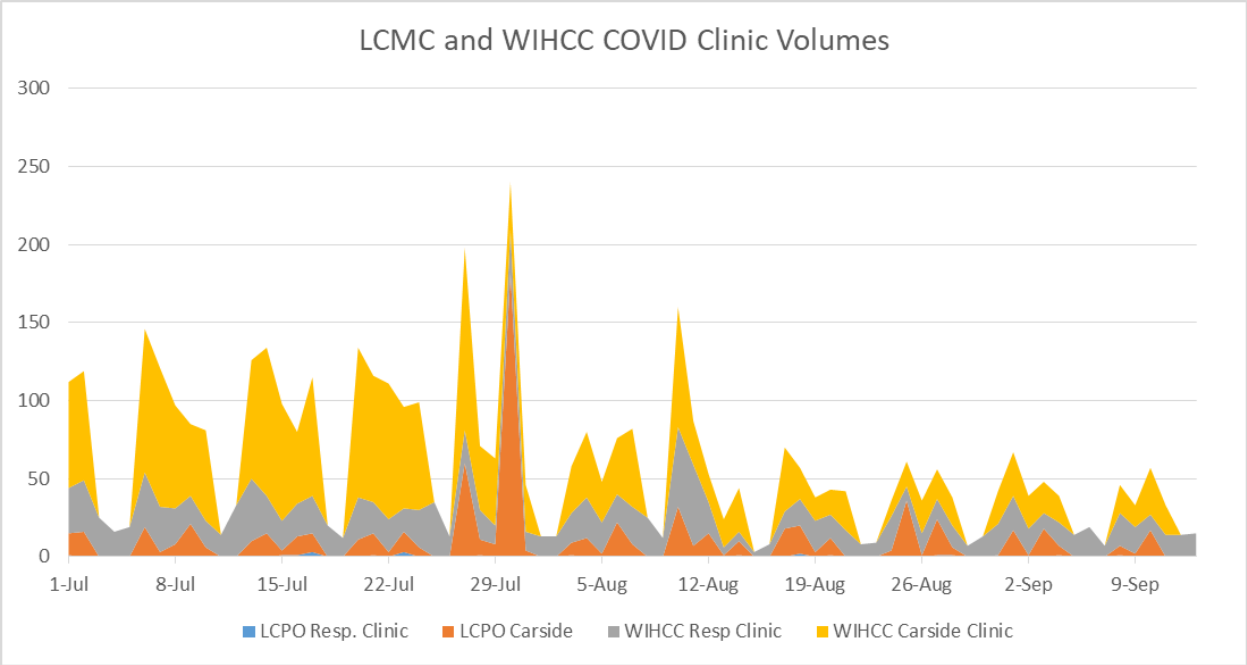
Below are a series of graphs, which were updated weekly, from the Winslow Community Update meetings. The data shared in this section is a testament to the ongoing dedication of LCMC staff and their community partners. Through their tireless effort, resources were shared, gaps in care identified, and improvements in health care delivery were achieved. This grassroots effort was instrumental in the mitigation of a raging pandemic when outside assistance was lacking or non-existent. Note, that the data shared here is only updated to September 2020. By the time this data was incorporated into the Assessment, new data began to emerge of a new outbreak in the service region.

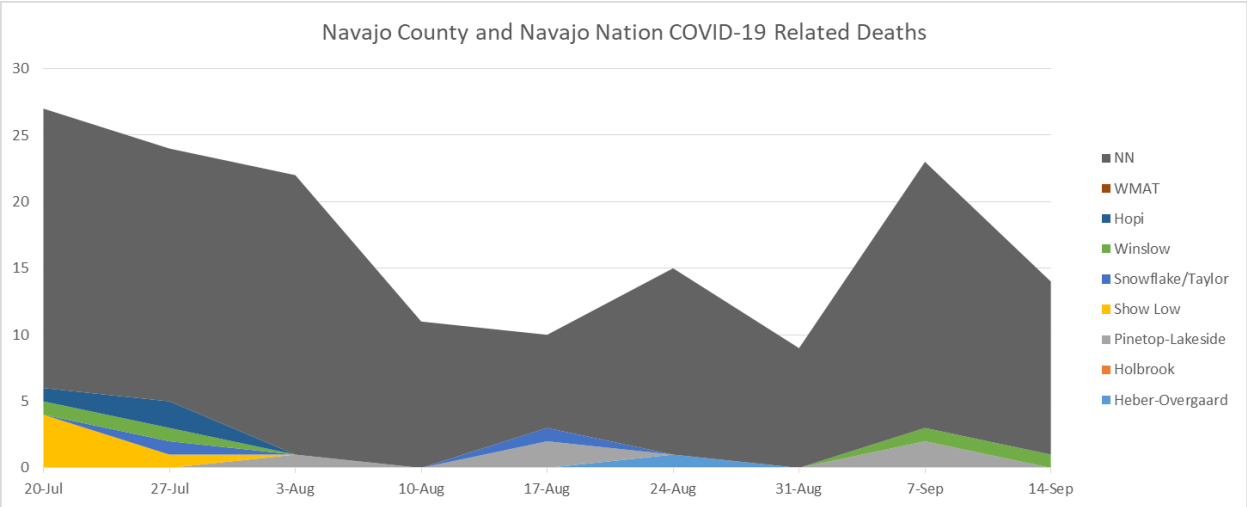

Navajo County Non-Tribal New Cases per Week
250
200
150
100
50
0
6/8/2020
6/15/2020
6/22/2020
6/29/2020
7/6/2020
7/13/2020
7/20/2020
7/27/2020
8/3/2020
8/10/2020
8/17/2020
8/24/2020
8/31/2020
9/7/2020
9/14/2020
Snowflake/Taylor
Show Low
Pinetop-Lakeside
Holbrook
Heber-Overgaard
Winslow

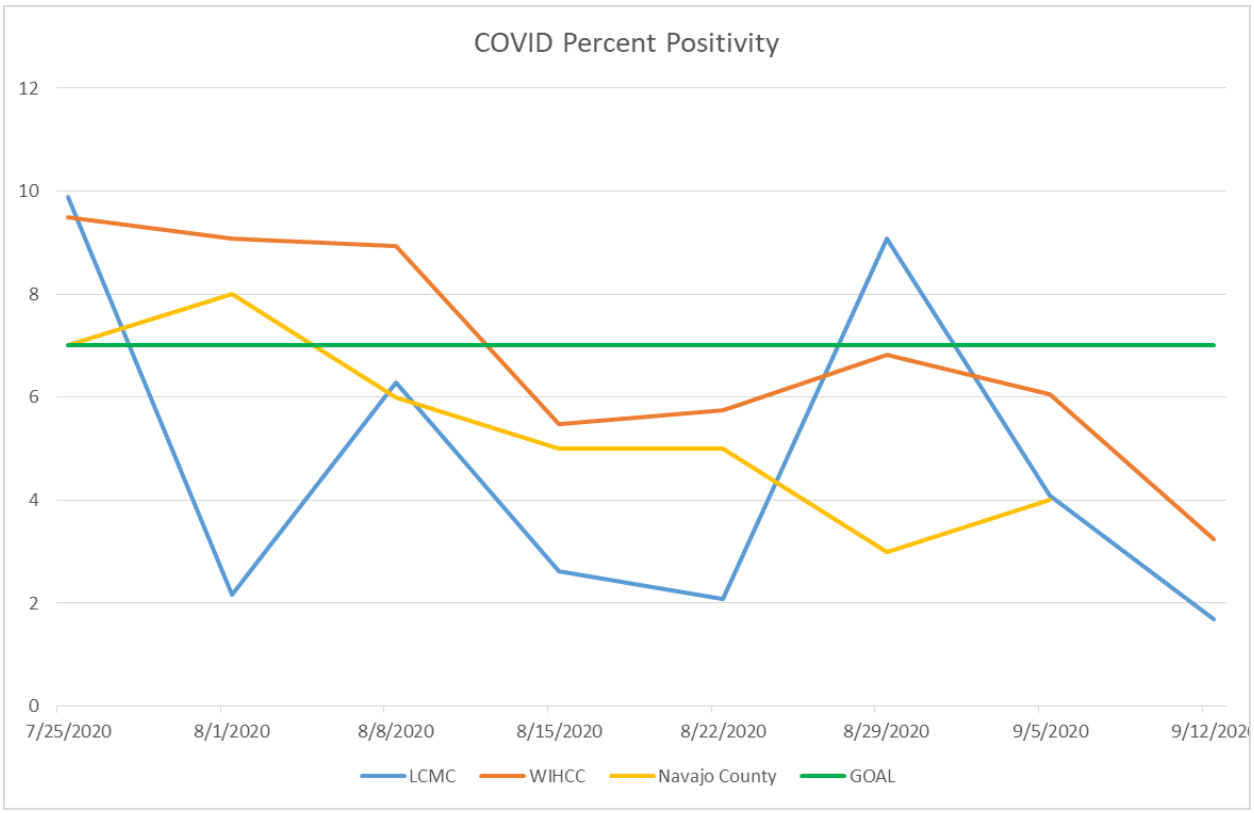

Tribal New Cases per Week
1600
1400
1200
1000
800
600
400
200
0
6/8/2020
6/15/2020
6/22/2020
6/29/2020
7/6/2020
7/13/2020
7/20/2020
7/27/2020
8/3/2020
8/10/2020
8/17/2020
8/24/2020
8/31/2020
9/7/2020
9/14/2020
WMAT
Hopi
NN Winslow service area
Navajo Nation


Winslow active cases
90
80
70
60
50
40
30
20
10
0
7/27/2020
8/3/2020
8/10/2020
8/17/2020
8/24/2020
8/31/2020
9/7/2020
9/14/202


LCMC COVID Volumes 7-Day Average
6.0
5.0
4.0
3.0
2.0
1.0
0.0
1-Jul
8-Jul
15-Jul
22-Jul
29-Jul
5-Aug
12-Aug
19-Aug
26-Aug
2-Sep
9-Sep
MS
ED


LCMC and WIHCC COVID Clinic Volumes
300
250
200
150
100
50
0
1-Jul
8-Jul
15-Jul
22-Jul
29-Jul
5-Aug
12-Aug
19-Aug
26-Aug
2-Sep
9-Sep
LCPO Resp. Clinic
LCPO Carside
WIHCC Resp Clinic
WIHCC Carside Clinic


Navajo County and Navajo Nation COVID-19 Related Deaths
30
25
20
15
10
5
0
20-Jul
27-Jul
3-Aug
10-Aug
17-Aug
24-Aug
31-Aug
7-Sep
14-Sep
NN
WMAT
Hopi
Winslow
Snowflake/Taylor
Show Low
Pinetop-Lakeside
Holbrook
Heber-Overgaard


COVID Percent Positivity
12
10
8
6
4
2
0
7/25/2020
8/1/2020
8/8/2020
8/15/2020
8/22/2020
8/29/2020
9/5/2020
LCMC
WIHCC
Navajo County
GOAL

Addressing Health Care Issues

LCMC has done a great deal to help address the health care issues discussed in this Assessment. Still, there are some additional points to be made on the topic of addressing community health issues.

A. Access to Care

LCMC continues to assist patients to enroll in Arizona's Health Care Cost Containment System (AHCCCS) and tries to connect them with resources when they are in the hospital. Patients also have access to financial counselors to help them enroll in AHCCCS.

Additionally, during the 2019 fiscal year, LCMC developed stronger ties and collaboration with local social service agencies to support those living in poverty. LCMC also works to hire locally and offers programs to support and train community members for careers as nurses.

B. Program Development

The Hospital also tries to hire locally and offers programs to support and train community members for careers as nurses. LCMC works closely with Northland Pioneer College as well as other educational institutions to provide a place for training as well as a future career.

LCMC now has Rural Health Clinic (RHC) status. LCMC is working to change its clinic from hospital based to an RHC to decrease costs to patients by eliminating facility fees.

C. Education

Education has been recognized as an important factor in reducing poverty, as well as providing a ladder out of poverty. LCMC maintains and continues to improve upon active engagement with the local high school and community college, including service on the Health Professions and Business Advisory Committees. It anticipates implementing a renewed Volunteer Program, which will include a specific focus to high school students to introduce them to health professionals.

D. Health Care Delivery

LCMC's Quality Department commenced a Community Collaboration Initiative. Several meetings have been held with social service and clinical organizations in the Winslow community, including: WIHCC; North Country and Community Bridges; local behavioral health agencies; and Adult Protective Services and Social Security. Those meetings have already contributed to more effective collaboration on patient care matters. LCMC continues to work with regional government and private agencies to develop a transportation model in support of vulnerable and poor members of the community.

The Hospital continues its work with the local prison and Department of Corrections staff regarding safe and effective care of inmates with behavioral health issues. The Hospital also participates in state and Health Choice Integrated Care and Planned Assistance Network of Arizona to improve the quality of behavioral health and integrated medical care.

Conclusion

Little Colorado Medical Center serves one of the poorest regions in the country. While the Hospital has done much to mitigate adverse health outcomes, many of the health trends in the region are structural in nature. One lone critical access hospital cannot reverse significant historical trends, trends that tend to adversely affect its predominantly American Indian population. These are complex and chronic socio-economic problems, which require a concerted effort on the part of the community and beyond. That said, LCMC has banded together with its community partners and become a stronger patient advocate for it. There is an inherent strength and resiliency in this community, which underpins LCMC's ongoing mission to serve it.

The forthcoming implementation strategy will try to improve upon LCMC's programmatic goals developed since the 2017 Assessment. Improving health while improving the community is still a primary goal of LCMC.

There is no shortage of work that needs to be done. Hopefully, the forged connections LCMC has made through these strange and adverse times will prove fruitful in future public health endeavors.

APPENDIX 1

Supplemental Community Observations

- Lack of medical providers
    - Recent doctor retirements have depleted the available providers and there is no one to replace them
    - Used to have specialists come into the community (e.g. Orthopedics and Cardiovascular)
    - Providers who grew up in the community tend to stay
        - Have a CNA fast-track program – but nothing planned with the middle school or high school to get people interested in medicine, or medical sciences
    - Need specialists:
        - Pediatrician, Ortho, Cardiovascular, Kidney
    - Hard to recruit people who can fulfill multiple roles
- Lack of Transportation
    - Because of the lack of local providers, people have to drive to Flagstaff, or further, to get needed medical attention
        - Lack of non-emergent/non-medical transport
            - That was improving before COVID-19 where there were some private transport that accepted insurance or direct payment. That has gone away
            - IHS always had transport
    - Lack of money also prevents people from travelling
    - Difficult to get transportation without insurance
- ER Patient Volumes have Increased
    - While there was a decrease during COVID-19, the volumes have increased to pre-COVID levels since the State reopened with the reintroduction of motor-vehicle accidents
        - Assaults and alcohol traumas remained relatively stable during COVID
        - People were holding off care during COVID. Seeing patients with chronic illnesses coming with acute care needs. They were not seeing any providers, were not adhering to medication regimens, stayed away from the ER even if they needed to come in
        - Seeing several critical patients in one shift
    - Trauma used to be >30 patient, then 30, now 40 to 60/mo.
        - Assaults because of domestic violence, alcohol and drug induced mania
        - MVAs because of I-40
        - Falls, especially head traumas from falls because of alcohol
- Substance Abuse
    - Meth has remained stable

        - Psych patients that come in with significant mania and hallucinations
    - Opioids have overtaken
        - Last 8 months issued Narcan to police department
        - Train locals with 2 minute video and pamphlets on how to administer Narcan after an overdose. People come into LCMC after completing the training to receive their Narcan
        - Had a shipment of what looked like OxyContin to the community but was actually Fentanyl – led to a series of overdoses
        - Had a reduction in overdoses during COVID
    - Interference with providing care
        - Family members will come in intoxicated
        - People will come into the facility looking for the detox center
- Behavioral Health
    - Increase in psych patients to the ER
        - Some drug or alcohol induced
    - Had a rash of suicides
        - Police changed policy to speak directly with patients with reported suicidal thoughts
    - ChangePoint can only transfer Title 36 patients who have AHCCCS insurance in the same county
        - For everyone else, the hospital has to find placement, which means transport
            - The hospital only has two ambulances. So a transport puts one ambulance out of commission for 8-9 hours depending on where the transport is going (e.g. as far as Tucson)
        - Hospital based transports means longer stays in the ER because LCMC has to find a bed for the psych patient
            - Longer stays in the hospital means more staff and staff time dedicated to a particularly difficult patient, which means less staff time for other patients in need of medical care
    - Transport of Psych patients is a daily issue now
- Education
    - Low education among population prevents them from understanding some of the information they receive from providers
    - Cultural issues to educating some American Indian persons who rely on traditional medicine
    - LCMC would benefit from a nutrition education program to address high rates of obesity, heart disease and diabetes
- Obesity, Diabetes and Heart Disease
    - Diet is a major factor
    - Difficult to adhere to a diet of fresh fruits and vegetables when there is no running water or refrigeration on Native land
- Care Delivery

    - Seamless transfer of care between LCMC and WIHCC
    - Difficult to coordinate and communicate care outside of the community when seeking advice or referrals
- Opiate Abuse
    - Moved away from an opiate prescription model and toward a model that does therapeutic care
- Senior Population
    - No running water or electricity on the Nation
    - Need physical therapy
    - Not seeking care because of COVID risks
- LCMC
    - Anything that is more than overnight for dialysis will be transported to another hospital
        - LCMC does not have dialysis
    - LCMC direct route for most patients
        - Have tried to reduce since COVID
    - COVID has helped build a bridge between the hospital and local providers
        - To mitigate the spread, educate the staff and prevent a wave that overwhelms the healthcare system
    - Shut down the physician's clinic during COVID

APPENDIX 2

Community Needs Survey

2020 COMMUNITY NEEDS SURVEY

INTRODUCTION

Hello, my name [NAME] and I am calling on behalf of the Little Colorado Medical Center. We are conducting a community-wide health survey and would like to take a moment of your time to ask you a few questions related to community health. Do you have about 5 to 10 minutes to spare for a brief survey? It will go a long way in helping our local hospital assess the health needs in our community.

Are you over the age of 18 and able to answer some questions?

DEMOGRAPHIC QUESTIONS

To start, I'm going to ask some details so we know who is being represented in our survey data. These are optional, but we do appreciate having the extra information. Also, I am not asking any identifying information. This survey will be kept anonymous.

1. What is your gender? Male or Female.

2. What is your age? What are the ages of those living in your household?
    a. 0-1
    b. 2-12
    c. 13-17
    d. 18-24
    e. 25-34
    f. 35-44
    g. 45-54
    h. 55-64
    i. 65-74
    j. 75 or older

3. What is your current relationship status?
    a. Married
    b. Living with a significant other
    c. Single
        i. Divorced
        ii. Separated
        iii. Significant other, but living apart
        iv. No current relationship

4. What is your race/ethnicity?

a. American Indian or Alaska Native
b. Hispanic American
c. White/Caucasian
d. Black or African American
e. Asian/Pacific Islander
f. Multiple Ethnicity

5. Do you speak a language other than English at home?
    a. Navajo
    b. Hopi
    c. Spanish
    d. Other

6. What is your highest level of education?
    a. Less than high school
    b. High school
    c. Some college
    d. Associate Degree
    e. Bachelor Degree
    f. Graduate Degree

7. Are you currently employed?
    a. Full-time
    b. Part-time
    c. Not employed
    d. Retired
    e. Not able to work

HEALTH SURVEY

1. Do you have a personal medical provider?

2. Do you have health insurance?
    a. Private
    b. Medicare
    c. AHCCCS
    d. VA
    e. IHS
    f. No insurance

3. How far do you travel for medical care?
    a. Less than 5 miles
    b. 6-20 miles
    c. 21-50 miles
    d. Over 50 miles

4. In the past year, have you delayed or avoided seeking medical care?
    a. Pandemic
    b. Unable to afford
    c. Service was not available in the area
    d. Other

5. How often do you exercise in a week?
    a. Never
    b. Once a week
    c. 2 to 4 times a week
    d. 5 to 7 times a week

6. How would you rate your overall diet?
    a. Excellent
    b. Very Good
    c. Good
    d. Fair
    e. Poor

7. What are the most important community health issues to you?
    a. Access to a medical provider
    b. Affordable health care
    c. Obesity
    d. Heart disease
    e. Drug and Alcohol use
    f. Domestic Violence
    g. Diabetes

8. What is a major need in the community
    a. Transportation service to medical providers
    b. Counseling and mental health services
    c. Employment
    d. Access to healthy food
    e. More affordable housing

CONCLUSION

All of us at Little Colorado Medical Center appreciate your assisting us with our Community Health Needs Assessment. This information will go a long way in helping us identify community needs and addressing them.

While I still have you here, is there anyone else in the household that would be willing to take the survey? Would you mind asking them?

Community Advisory Board Questionnaire

Community Advisory Board Questionnaire

I. Poverty/Education
   a. How does income level affect community health?
   b. Is there a housing crisis in Winslow and the surrounding communities?
      i. Any programs to increase the availability of housing? How do people access these programs?
   c. What programs or community improvement projects are available that are aimed towards attracting and retaining residents?

II. Behavioral Health/Substance Abuse
   a. Is substance abuse (i.e. alcoholism and drug abuse) an issue? What drives substance abuse? What are the tertiary outcomes of substance abuse (e.g. domestic violence, chronic or acute diseases)
      i. How would you assess the access to mental health services?

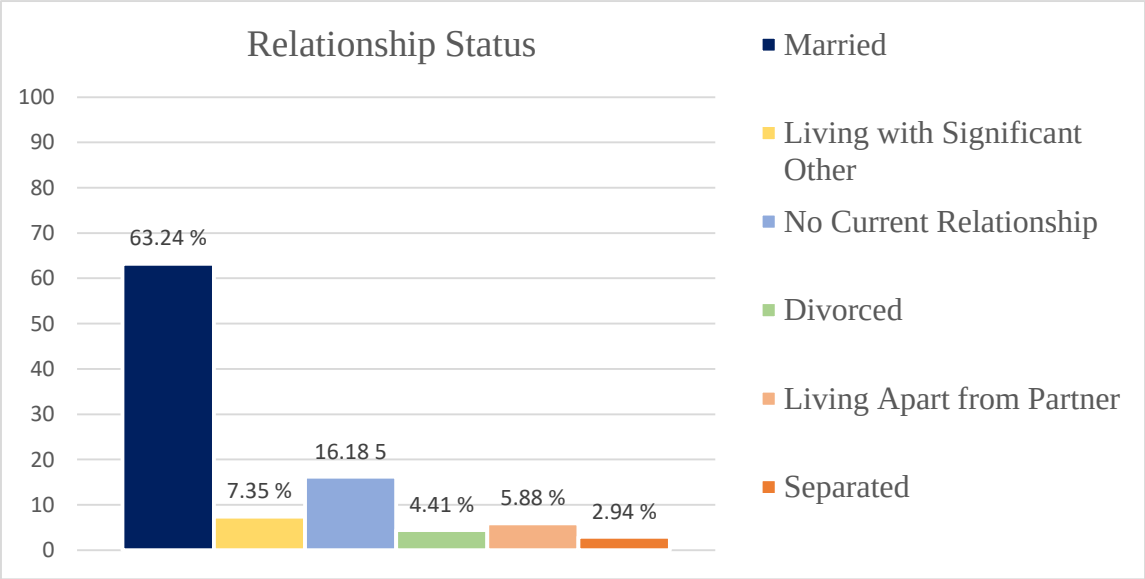
III. Access to Care: Seniors; Native American Communities; Chronic/Acute Health care Needs
   a. What chronic diseases are most effecting the community?
   b. What health issues are unique or prominent among various age groups? **Newborns; Adolescents; Teenagers; Young Adults; Middle Aged Persons; Elderly**
      i. What programs are available to seniors? How do you help make seniors aware of these programs and get connected with these programs?
      ii. How has the COVID-19 crisis affected your pushing services to seniors?
   c. Do you think there is a lack of **health insurance** among members of the community?
      i. What is the driving factor for access, or lack thereof, to insurance? What can be done to improve access to insurance? What is currently being done to improve access to insurance?
   d. What chronic health issues are prominent in the **American Indian population**?
      i. What social or cultural issues affect the delivery of care to the American Indian population?
      ii. What programs are available to increase the availability of access to health care services to American Indians?
      iii. How are programs increasing the availability of fresh fruits and vegetables on the Nation and Reservation? Also, access to running water?
      iv. How are we improving communication to residents of the Nation and Reservation about the services they receive and the health care services available to them?
   e. What is being done to **improve the quality of care**?

i. What is being done to decrease the response time to deliver quality care?

IV. Health Care Delivery and Assets
   a. How can we offset some of the reliance people have on using emergency medical services? Is there a non-emergent setting that is available to people? Would greater access to non-emergent care resolve the issue in the first place?
   b. Is there an issue with people delaying their care?
   c. Because of the utilization rates of certain health care services is there a burnout among providers of those services?
      i. What can be done to curb burnout among providers?
   d. What are the current methods employed to deliver and communicate care to:
      i. Adolescents
      ii. Teenagers
      iii. Young Adults
      iv. Adults
      v. Seniors
      vi. Prisoners
   e. What are community assets improving access to nutrition and clean water? To exercise? Transportation?
   f. What future programs are being proposed or worked out to improve:
      i. Access to health care
      ii. Physical and mental fitness
      iii. Nutrition
      iv. Curb chronic disease or manage existing chronic disease
      v. Push services out into the community

APPENDIX 3

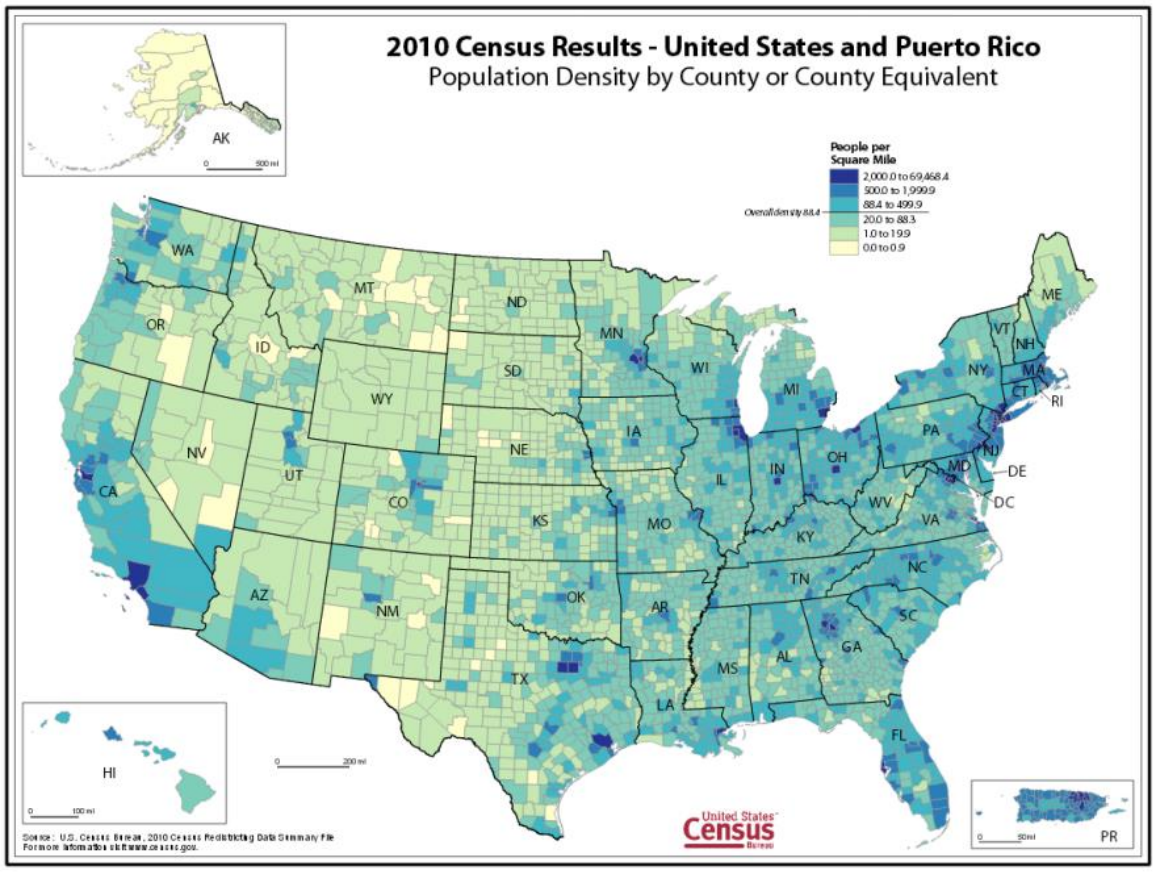
Miscellaneous Data



N 68
Source: Community Needs Survey

Sources

[i] U.S. Census Bureau and The University of Arizona County Maps on Population Density.



[ii] U.S. Census Bureau, Community Survey
[iii] U.S. Census Bureau, Community Survey
[iv] Arizona Department of Health Services, *https://pub.azdhs.gov/health-stats/hip/index.php?pg=mental*.
[v] Arizona Department of Health Services, *https://pub.azdhs.gov/health-stats/hip/index.php?pg=drugs*.
[vi] Arizona Department of Health Services, *https://pub.azdhs.gov/health-stats/hip/index.php?pg=alcohol*
[vii] Arizona Department of Health Services, *https://pub.azdhs.gov/health-stats/hip/index.php?pg=falls*
[viii] University of Arizona Center for Rural Health