Banner Health 2022 CHNA

Banner Churchill Community Hospital

Making health care easier, so life can be better.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Community Health Needs Assessment Background

The Patient Protection and Affordable Care Act (PPACA) outlines requirements that nonprofit hospitals must satisfy to maintain their tax-exempt status under section 501(c)(3) of the Internal Revenue Code. One such requirement added by the ACA, Section 5019(r) of the Code, requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt implementation strategies to address the identified needs for the community at least once every three years. As part of the CHNA, each hospital is required to collect input from individuals in the community, including public health experts as well as residents, representatives, or leaders of low-income, minority, and medically underserved populations.

Summary of Prioritization Process

As part of the process for evaluating community need, a Banner Health formed a CHNA Steering Committee. This committee, which was commissioned to guide the CHNA process, was comprised of professionals from a variety of disciplines across the organization. This steering committee provided guidance in all aspects of the CHNA process, including development of the process, prioritization of the significant health needs identified and development of the implementation strategies, anticipated outcomes, and related measures. A list of the steering committee members can be found in Appendix B.

In the spirit of the organization's continued commitment to providing excellent patient care, Banner Health established systemwide guidelines for each of its acute care hospitals and three inpatient rehab facilities with the following goals at the heart of the endeavor:

- Effectively define the current community programs and services provided by the facility.
- Assess the total impact of existing programs and services on the community.
- Identify the current health needs of the surrounding population.
- Determine any health needs that are not being met by those programs and services, and/or ways to increase access to needed services.
- Provide a plan for future programs and services that will meet and/or continue to meet the community's needs.

Summary of Prioritized Needs

Banner Health has a strong history of dedication to its community and providing care to underserved populations. The CHNA process continues to help identify additional opportunities to better care for populations within the community who have special and/or unmet needs; this has only strengthened Banner's commitment to *"making health care easier, so life can be better"*. The following statements summarize each of the areas of priority for Banner Churchill Community Hospital and are based on data and information gathered through the CHNA.

1. **Access to Care**
    a. Approximately 10% of survey respondents identified Access to Care as a primary health concern (BH Western Division Community Survey, 2022).
    b. Survey responses identified affordability and availability as the most significant barriers in accessing healthcare in their communities (BH Western Division Community Survey, 2022).
2. **Chronic Disease Management**
    a. Overweight, obesity, diabetes, and heart disease are all top health issues seen in Western Division communities (BH Western Division Community Survey, 2022).
    b. COPD is a top 5 condition for Emergency Department patients in Western Division (McKesson, 2019-2022)
    c. The majority of Western Division counties have a higher rate of adult obesity compared to the National rate (County Health Rankings, 2022).
3. **Behavioral Health**
    a. Substance and alcohol abuse was the number one community concern (BH Western Division Community Survey, 2022).
    b. Survey respondents identified mental health services as being a primary community resource need (BH Western Division Community Survey, 2022).
    c. The majority of key informants identified the community need and ongoing concerns as being related to access to mental health resources in their communities (BH Western Division Key Informant Interviews, 2022).

The CHNA Report was adopted by the Banner Health Board of Directors on December 9th, 2022

INTRODUCTION

Purpose of the CHNA Report

The purpose of this CHNA is to identify and prioritize significant health needs of the community served by Banner Churchill Community Hospital (BCCH). The priorities identified in this report help to guide the hospital's ongoing community health improvement programs and community benefit activities. This CHNA report meets requirements of the ACA that nonprofit hospitals conduct a CHNA at least once every three years.

Banner Churchill Community Hospital is dedicated to enhancing the health of the communities it serves. The findings from this CHNA report serve as a foundation for understanding the health needs found in the community and will inform the implementation strategies selected. This report complies with federal tax requirements set forth in Internal Revenue Code Section 501(r) requiring hospital facilities owned and operated by an organization described in Internal Revenue Code Section 501(c)(3) to conduct a CHNA at least once every three years. Regarding the CHNA, the ACA specifically requires nonprofit hospitals to:

1. Collect and take into account input from public health experts, community leaders, and representatives of high need populations – this includes minority groups, low-income individuals, medically underserved populations, and those with chronic conditions;
2. Identify and prioritize community health needs;
3. Document a separate CHNA for each individual hospital; and,
4. Make the CHNA report widely available to the public. In addition, each nonprofit hospital must adopt an implementation strategy that describes how the hospital will address the identified significant community health needs.

This is the fourth cycle for Banner Health, with the third cycle completed in 2019. Feedback on the previous CHNA and Implementation Strategy will be addressed later in the report.

This CHNA report was adopted by the Banner Health's board on December 9th, 2022.

This report is widely available to the public on the hospital's website bannerhealth.com, and a paper copy is available for inspection upon request at CHNA.CommunityFeedback@bannerhealth.com

Written comments on this report can be submitted by email to:
CHNA.CommunityFeedback@bannerhealth.com

About Banner Health

Headquartered in Phoenix, Arizona, Banner Health is one of the nation's largest nonprofit health care systems and is guided by our nonprofit mission: "Making health care easier, so life can be better." This mission serves as the cornerstone of operations at our 30 acute care facilities located in small and large, rural and urban communities, spanning 6 western states. Collectively, these facilities serve an incredibly diverse patient population. In these communities, Banner Health provides more than $650M annually in charity care – treatment without expectation of being paid. As a nonprofit organization, Banner reinvests revenues to add new hospital beds, enhance patient care and support services, expand treatment technologies, and maintain equipment and facilities. Furthermore, Banner subsidizes medical education costs for hundreds of physicians in our residency training programs in Phoenix and Tucson, Arizona and Greeley, Colorado.

With organizational oversight from a 14-member board of directors and guidance from both clinical and non-clinical system and facility leaders, more than 52,000 employees work tirelessly to provide excellent care to patients in Banner Health acute care hospitals, rehabilitation hospitals, urgent cares, clinics, surgery centers, home care, hospice facilities, telehealth, and other care settings.

While Banner has the experience and expertise to provide primary care, hospital care, outpatient services, imaging services, rehabilitation services, long-term acute care, and home care to patients facing virtually any health conditions, an array of core services and specialized services are also provided. Some of the core services include: cancer care, emergency care, heart care, maternity services, neurosciences, orthopedics, pediatrics and surgical care. Specialized services include behavioral health, burn care, high-risk obstetrics, Level 1 Trauma care, organ and bone marrow transplantation and medical toxicology. We also participate in a multitude of local, national, and global research initiatives, including those spearheaded by researchers at our three Banner- University Medical Centers, Banner Alzheimer's Institute, and Banner Sun Health Research Institute.

Ultimately, Banner's unwavering commitment to the health and well-being of its communities has earned accolades from an array of industry organizations, Banner Health's Supply Chain was recognized as second in the nation in 2021, and one of the nation's Top 10 Integrated Health Systems according to SDI and Modern Healthcare Magazine. Banner Alzheimer's Institute has also garnered international recognition for its groundbreaking Alzheimer's Prevention Initiative, brain imaging research and patient care programs. Further, Banner Health, which is the second largest private employer in both Arizona and Northern Colorado, continues to be recognized as one of the "Best Places to Work" by Becker's Hospital Review.

Banner Health's COVID-19 Impact Statement

In December of 2019 SARS-CoV-2, also known as COVID-19, was discovered in Wuhan, China. The first case treated at a Banner facility was on March 7th, 2022. In March 2022, Banner implemented the following in response to the pandemic:

- Convened EOC Command Center to plan, monitor, and execute a response plan.
- Developed a digital dashboard to monitor all activity.
- Expanded Telemedicine services for Banner Urgent Care and all Banner Medical Groups.
- Leveraged Banner Innovation Group to address real time problems, defined by EOC, such as PPE supply.
- Banner paused elective surgeries, enacted a no visitor policy, and where possible, moved employees to work from home status.

Throughout the COVID-19 Pandemic, Banner was a leader in the communities they were located in, by treating patients with COVID-19 and providing consistent and ongoing communication to the public. Since March 2020, Banner has faced multiple COVID-19 surges, PPE shortages, staffing difficulty (involving shortages, staff safety, and employee health), however, Banner continues to be committed to *"Making health care easier, so life can be better."*

Banner Health leveraged technology to provide care and up to date information to community members throughout the pandemic. Through the BannerHealth.com website and Banner apps, Banner provided a trusted source of communication to our communities.

- Banner Website Page Views: From March 2020 to December 2022, there were over 8,310,000 total pageviews to COVID-related pages on Banner's website.
- Buoy App
    - Banner provided a symptom checking platform to its communities, patients went through a series of questions to determine if their symptoms were COVID influenced.
    - From March 2020 to December 2021, 138,659 patients were triaged through the symptom checker with COVID-19 results.
- Emails were used to both inform patients of COVID related information as well encourage the adoption of telehealth services
    - Over 6 million COVID related emails were opened
    - 340,000 telehealth related emails were opened by patients in the first year of the pandemic.

Within Banner Health acute care hospitals, Banner followed state and national guidelines to expand bed capacity, to serve both COVID and non-COVID patients in our facilities. In our Arizona facilities, we expanded bed capacity so that in total we had an over 50% increase of beds in preparation for the surge of COVID-19 patients, for our Western Region facilities we had a 28% increase in beds (bed increase includes ICU and Medical Surgical beds). Since the start of the pandemic, Banner has provided care to over 43,000 patients with COVID at Urgent Care facilities, more than 38,000 with COVID in our clinics, and

nearly 94,000 with COVID as patients in our hospitals. In all Banner has served 47% of all hospitalized COVID-19 patients in the state of Arizona throughout the pandemic.

From 2020 to 2022 Banner Health infused over 25,000 monoclonal antibody doses. While the acuity of patient who received a dose of monoclonal antibodies has varied throughout the COVID-19 pandemic, those with the highest acuity were triaged to receive priority scheduling in receiving a dose.

When vaccinations became available to the public, Banner Health partnered with county and state health agencies in administering vaccines. In Banner Health's larger markets, Maricopa and Pima County Arizona, Banner worked with county partners to set up vaccination pods, where Banner employees, county employees, and volunteers worked daily for over two months to provide initial and second dose vaccines to county residents. The two vaccine pods Banner supported in Maricopa County (Arizona Fairgrounds & Sun City) administered over 190,000 vaccines, including both initial and second dose. In Pima County, Banner also supported two vaccine pods, which administered over 160,00 initial and second vaccinations. In Banner Health's Western Division Market, a different approach was used, providing vaccinations on a smaller scale through hubs and clinic visits, with nearly 48,000 vaccinations, initial and second doses, administered. Hubs were set-up to provide efficient and physically distant vaccinations in the community on a smaller scale than the Arizona locations. Internally, Banner Health mandated employees were vaccinated for COVID-19 to protect our patients and staff.

As COVID-19 moves into the *Control Phase*, Banner Health continues to provide COVID-19 focused care in our communities. Banner maintains consistent communication with county and state partners, monitoring COVID-19 in the communities. A long COVID treatment plan was developed, to provide ongoing care to COVID-19 survivors suffering from long COVID symptoms. Physicians and providers from specialties ranging from pulmonology, neurology, sleep medicine, behavioral health, and more have partnered to provide the highest quality patient care and experience to support those with long COVID symptoms.

About Banner Churchill Community Hospital

Banner Churchill Community Hospital is a 25-bed critical access hospital located within western Nevada, in Fallon, the county seat of Churchill County. The hospital opened in 1996 to serve the community and has never strayed from the community focus, constantly striving to live the Banner Health mission of making health care easier, so life can be better.

Banner Churchill Community Hospital (BCCH) is committed to providing a wide range of quality care, based on the needs of the community, including the following services:

- Acute Care
- Ambulance Services
- Care Coordination
- Cardiac Pulmonary Rehabilitation Program
- Emergency Care/ Trauma Services
- Infusion Services
- Lab Services
- Maternity Services
- Women's Health
- Medical Imaging
- Occupational Health
- Orthopedic Services
- Outpatient Services
- Physician Clinics (with locations in Fallon and Fernley)
- Rehabilitation
- Surgical Care
- Sleep Studies

As noted above, Banner Churchill Community Hospital also operates several physician clinics across Fallon and Fernley and owns and operates an ambulance service or emergency medical service (EMS), which covers more than 5,900 square miles.

The staff of 11 active physicians, alongside 300 employees, and 65 volunteers, provides personalized care complemented by leading technology from Banner Health resources directed at preventing, diagnosing, and treating illnesses. On an annual basis, Banner Churchill Community Hospital health care professionals render care to about – 57,470 outpatients, over 1,400 inpatients, and nearly 17,700 patients in the Emergency Department (ED). The staff also welcomes an average of 268 newborns into the world each year.

BCCH serves the cities of Fallon and Fernley as well as Churchill County leveraging the latest medical technologies to ensure safer, better care for patients. Physicians and clinical personnel document patient data in an electronic medical record rated at the highest level of implementation and adaptation by HIMSS

Analytics, a wholly-owned nonprofit subsidiary of the Healthcare Information and Management Systems Society.

This facility also offers Banner TeleHealth. This advanced technology enhances the care and safety of critically ill patients by teaming our on-site medical staff with patients' care from a remote monitoring center 24 hours a day, seven days a week

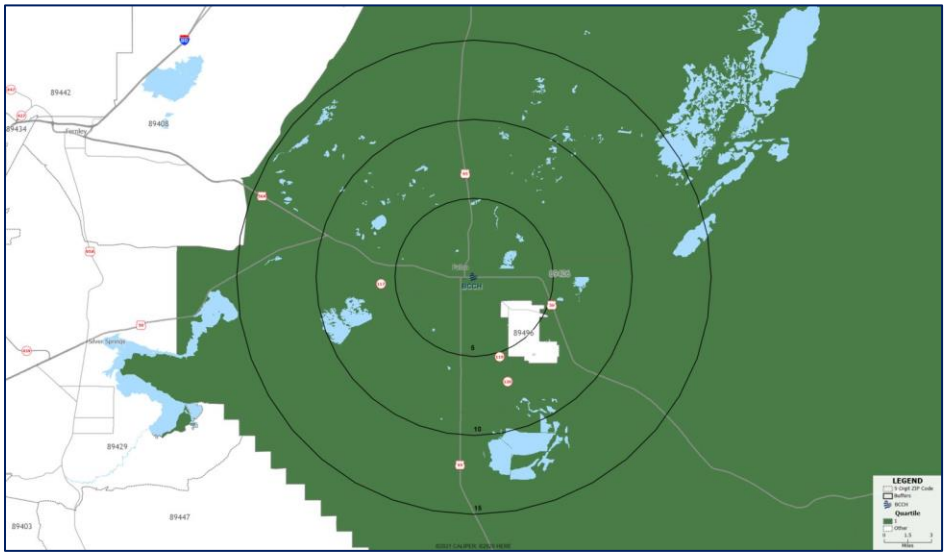
Banner Churchill Community Hospital is focused on meeting the needs across the community for clinical excellence and quality outcomes. To help meet the needs of uninsured and underinsured community members, Banner Fort Collins follows the Banner Health process for financial assistance, including financial assistance and payment arrangements. A strong relationship with the community is a very important consideration for Banner Health Giving back to the people we serve through financial assistance is just one example of our commitment. In 2021, Banner Churchill Community Hospital reported $3,967,000 in Charity Care, while it wrote off an additional $2,490,000 in Bad Debt, on uncontrollable money owed to the facility.

Description of Community and Morgan County

Banner Churchill is located within Churchill County in Fallon, Nevada. Fallon is a remote city located about 60 miles east of Reno. It is surrounded by farms and ranches, and the Lahontan valley Wetlands. The county is comprised largely of agricultural areas, the principal crop is alfalfa, grown for livestock feed. Churchill County is also the center of honey production for Nevada. The largest single employer is the Naval Air Station Fallon, a training airfield that has been the home of the U.S. Navy's so-called "Top Gun" air-to-air combat training since 1996.

Facility Inpatient Origin by Zip Code Map

January 1, 2020 through December 31, 2020 (Top 3 contiguous quartiles = 75% of total discharges)



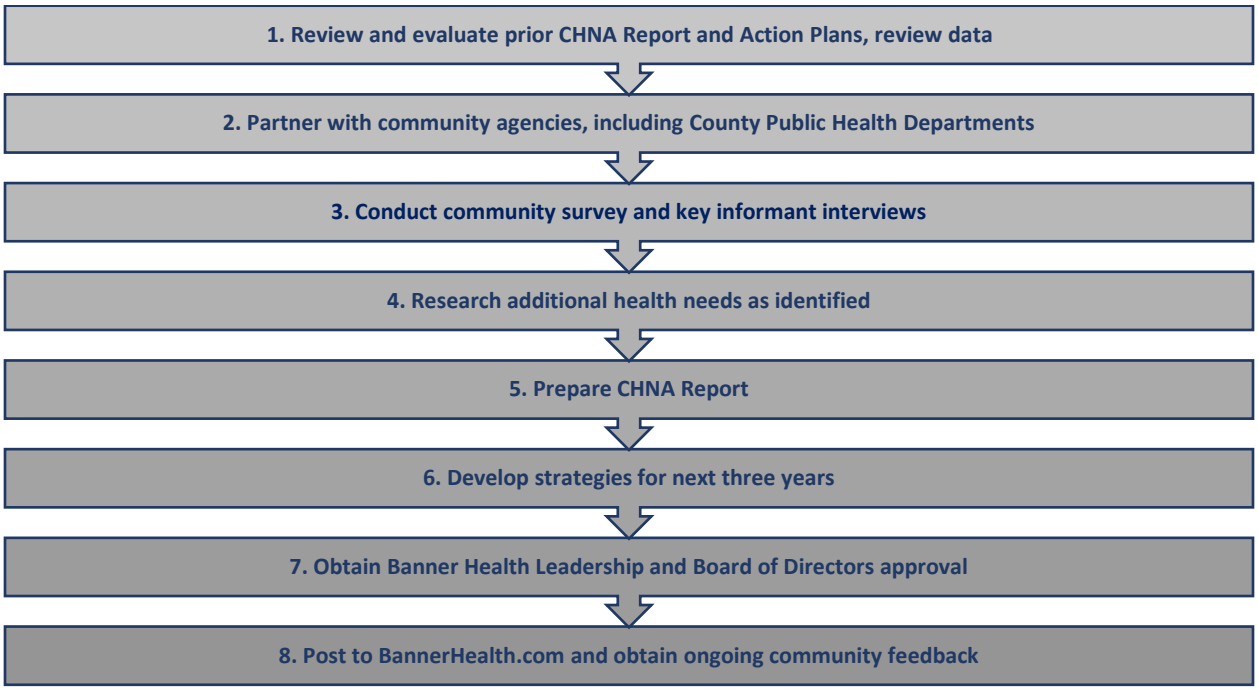
Community Demographics

	BCCH PSA	Churchill County	NV
Population (2021)	25,774	25,901	3,160,524
Male	12,949	13,015	1,587,962
Female	12,825	12,886	1,572,562
Age			
Median Age	40	41	38
0 to 17 years	5,705	5,729	709,253
18 to 34 years	5,488	5,504	736,264
35 to 64 years	9,523	9,578	1,198,727
65 years and over	5,058	5,090	516,280
Race			
White	20,112	20,222	1,894,760
Black	645	646	318,914
American Indian	1,319	1,323	38,323
Asian/Pacific Islander			
Other Race	1,561	1,565	432,701
Ethnicity			
Hispanic	3,930	3,947	947,203
Social & Economic Factors			
Median Household Income	54,456	54,533	62,819
No HS Diploma	1,478	1,489	283,738

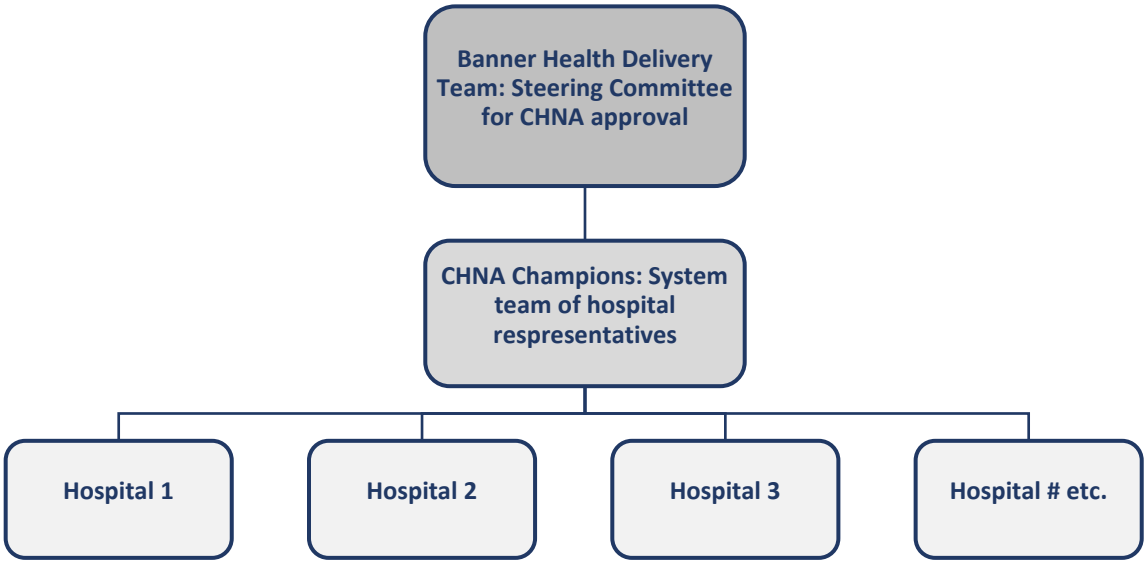
PROCESS AND METHODS USED TO CONDUCT THE CHNA

Banner Churchill Community Hospital process for conducting Community Health Needs Assessments (CHNAs) leverages a multi-phased approach to understanding gaps in services provided to its community, as well as existing community resources. In addition, a focused approach to understanding unmet needs, especially for those within underserved, uninsured, and minority populations included in a detailed data analysis of national, state, and local data sources is conducted, including obtaining input from leaders within the community.

Banner Churchill Community Hospital eight-step process is based on Banner Health's experience from previous CHNA cycles, outlined below. The process involves continuous review and evaluation or CHNAs from previous cycles, through both the action plans and reports developed on a three-year cycle. Through each cycle Banner Health and Banner Churchill Community Hospital has been able to provide consistent data to monitor population trends.



Banner Health CHNA Organizational Structure



Primary Data

Primary data, consists of new data that is obtained via direct means. For Banner health, primary data is created by rendering healthcare services to patients; the data includes inpatient or outpatient counts, visits, payer, etc. For the CHNA report, primary data was also collected directly from the community through surveys, focus groups, and key informant interviews.

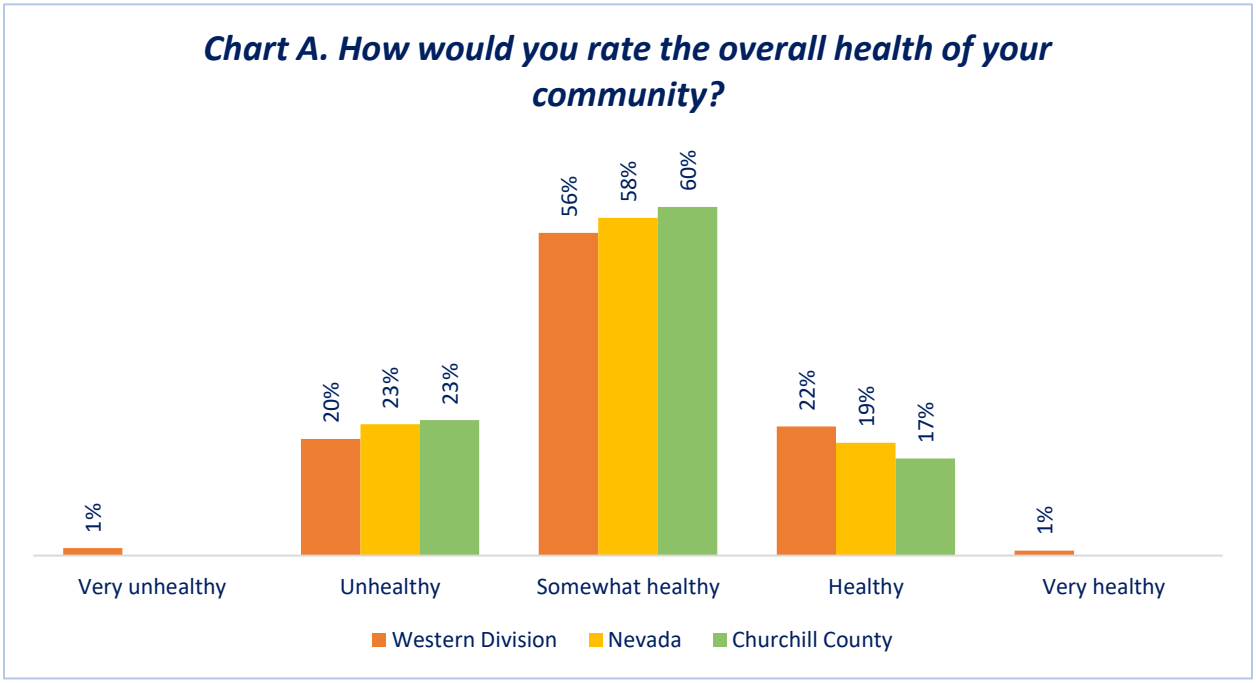
The primary data for the Community Health Needs Assessment originated from Cerner (Banner's Electronic Medical Record) and McKesson (Banner's Cost Accounting / Decision Support Tool). These data sources were used to identify the health services currently being accessed by the community at Banner locations and provides indicators for diagnosis-based health needs of the community. This data was also used to identify the primary service areas (PSA = 75%), inform the Steering Committee Appendix B, and facility champions on what the next steps of research and focus group facilitation needed to entail.

Community Survey

To understand community health needs, a community health assessment survey was administered to community members in Banner's Western Division markets. Community health assessment surveys were administered between May-July 2022. Surveys were intended to provide information about prominent health problems facing the community. The survey had a total of 15 questions to identify factors which contributed to overall quality of life, more important health issues and behaviors, rating scales, and impact COVID-19 had in their life and in the community. A total of 234 surveys were collected from our Western Division community partners, 31 from our Nevada partners, and 30 from Churchill County.

Demographic detail of participants can be found under Appendix A.

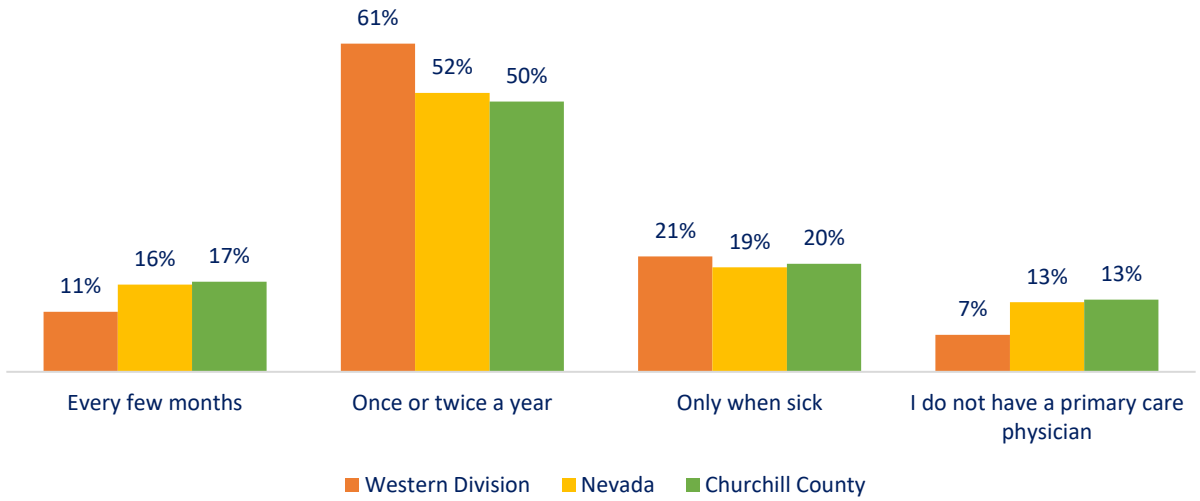
The majority of respondents rated the community as being somewhat healthy, with Nevada respondents leaning on the unhealthy compared to the overall Western Division, refer to chart below. Of those Nevada respondents who noted that their community was unhealthy, 85% of them identified as being healthy or somewhat healthy. The majority of Churchill County respondents rated their personal health as healthy (53.3%) and their mental health as healthy (43.3%).



Source: Banner Health Western Division CHNA Survey, 2022

When it came health behaviors of visiting their primary care physician the majority of all respondents, identified as going one to two times a year. However, in Goshen County 20% only went when sick and an additional 13% does not even have a primary care provider. In a recent study, regarding correlation to Primary Care Providers and patient health, results concluded that "patients who had a primary care physician … had a high mental health component score, and low physical health component score" (Yokokawa, Ohira, Ikegami, et al., 2021). This shows a correlation between routine visits with your Primary Care Physician (PCP) and a person's healthy – based on the results of the study those who visit a PCP when sick or do not have one, are at a higher risk for poorer health.

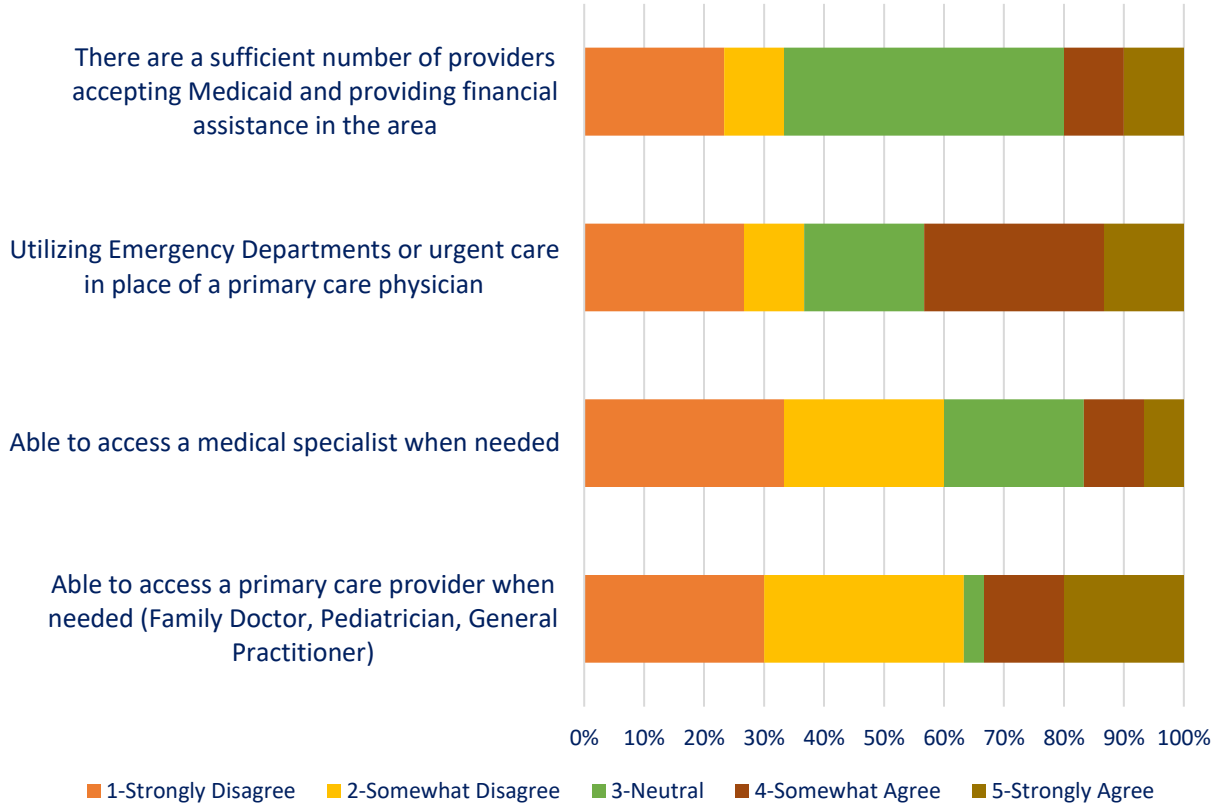
Chart B. How often do you visit your primary care physician?



Source: Banner Health Western Division CHNA Survey, 2022

In Churchill County, respondents were asked to rate their experience in accessing healthcare. The majority of agreed that that it was difficult to access a medical specialist and primary care provider when needed. When it came to determining if there are financial access concerns or if Medicaid patients had difficulty in finding a provider, the majority of responses were neutral.

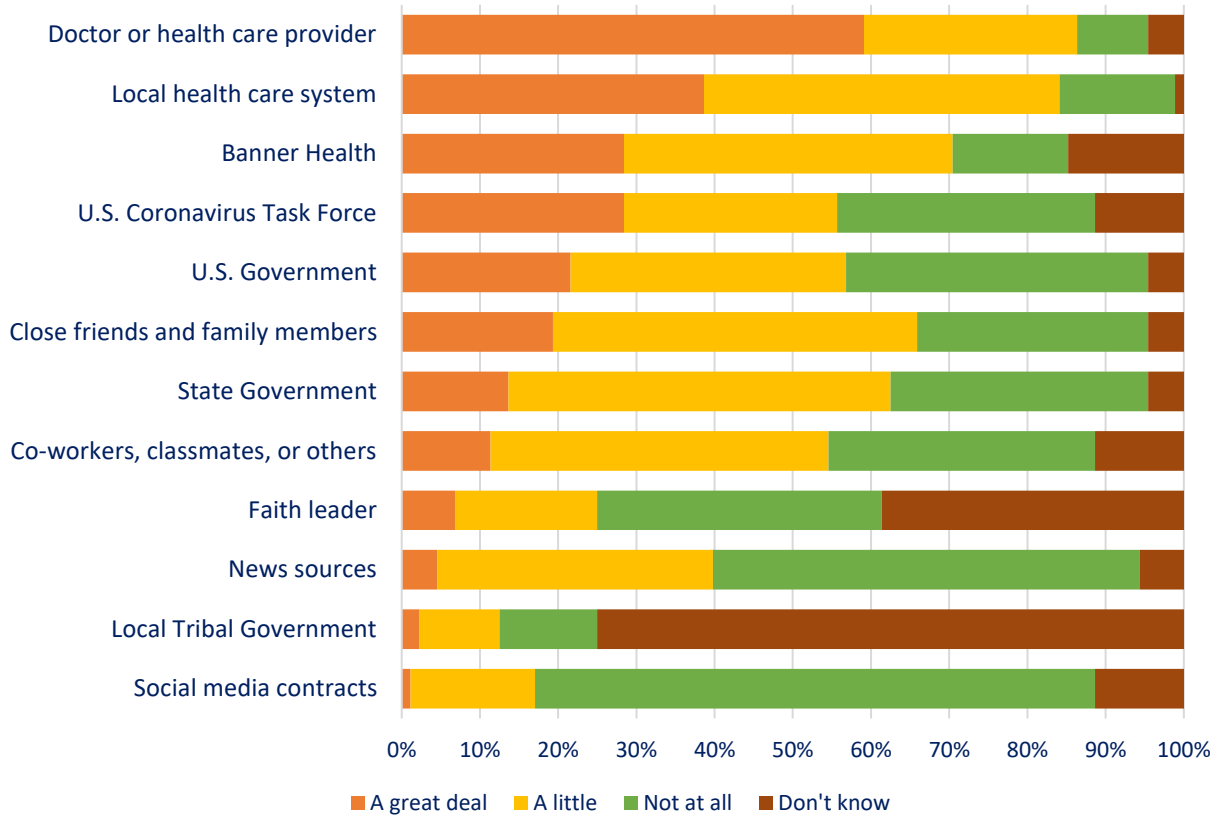
Chart C. On a scale of 1 through 5, please rate each of the following statements about your experience in accessing health care services.



Source: Banner Health Western Division CHNA Survey, 2022

Survey participants were also asked two COVID related questions, the first related to their experience during COVID, the later their trust in COVID-19 related health communication. Overall, the majority of respondents identified increased stress or anxiety as a problem themselves or someone in their household is having as a result of COVID-19. In Wyoming, survey respondents noted that their greatest source of trust was in their Doctor/Health care provider, the local health care system, and Banner Health.

Chart D. Level of trust in COVID-19 information services:



Source: Banner Health Western Division CHNA Survey, 2022

Key Informant Interviews

Banner Health conducted a series of Key Informant Interviews with community members identified by Facility Champions. Key informants represented local health departments, fire departments, behavioral health centers, local community colleges, and social service departments. Through a series of eight questions, key informants defined their opinion of health and what quality of life meant, they identified top community needs, and discussed the impact COVID-19 continues to have in their community.

While the definition of health varied person by person, the primary theme was the ability to live a safe and productive life. Listed below are a few of the quotes on what respective key informants identified as being healthy:

- *"Having the ability to access preventative care and treatment as needed so that you can live a safe and productive life."*
- *"Having the necessary tools and information to make the best health decisions for self and families to thrive."*
- *"State of good physical, mental, and spiritual wellbeing."*

Themes of important issues that affect the health of people in their community involved the following:

- Access to providers confidently and timely
- Access to resources like childcare, housing, and healthcare
- Literacy in health education, and
- Mental health support

When it came to services that the needed in the communities, key informants identified two primary populations needing extra support – the elderly and youth. Both populations were recognized as needing additional mental and behavioral health support. Transportation was recognized as a foundational barrier in accessing health services. The primary health theme that came up was access to care that was both affordable and available during the weekend – examples of walk-in clinics open during the weekend, and urgent care were provided. Overall, key informants discussed the concerns of access to care that takes place in rural communities.

Secondary Data

Banner Churchill Community Hospital's process for conducting their Community Health Needs Assessment CHNA) leveraged a multi-phased approach to understanding gaps in services provided to the community, as well as existing community resources. The CHNA utilized a mixed-methods approach that included the collection of secondary or quantitative data with review and input from key informants, and meetings with internal leadership. The advantage of using this approach is that it validates data by cross verifying from a multitude of sources.

Secondary data includes publicly available health statistics and demographic data. With input from stakeholders, champions, and the steering committee, additional health indicators of special interest were investigated. Comparisons of data sources were made to the county, state, and PSA if possible.

Data analytics were employed to identify demographics, socioeconomic factors, and health trends in the PSA, county, and state. Data reviewed included information around demographics, population growth, health insurance coverage, hospital services utilization, primary and chronic health concerns, risk factors, and existing community resources. Several services of data were consulted to present the most comprehensive picture of Banner Churchill Community Hospital's PSA's health status and outcomes.

Appendix A has data sources listed.

Top Leading Causes of Death

Banner Churchill Community Hospital considered the top five leading causes of death for Churchill County and Nevada (Table 1) in the secondary data review.

Table 1. Top 5 Leading Causes of Death

	Churchill County	**Nevada**
1	Diseases of the heart	Diseases of the heart
2	Malignant neoplasms	Malignant neoplasms
3	COVID-19	COVID-19
4	Accidents (unintentional injuries)	Accidents (unintentional injuries)
5	Chronic lower respiratory diseases	Chronic lower respiratory diseases

Source: CDC, 2020; Note: Suppressed data indicates not enough volume to be confident in rankings

County Health Rankings

Banner Health leveraged County Health Rankings as a guiding light in understanding how counties Banner facilities were located in did compared to other counties. County Health Rankings are, "based on a model of community health that emphasizes the many factors that influence how long and how well we live" (County Health Rankings, 2022). The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors)." Additionally, data is provided that indicates Areas of Strength, where the county has health data that is stronger when compared to the state data, and Areas to Explore, where the county has health data that is not meeting state level of health – this is an area where counties can focus to improve the Health Outcome rankings.

Table 2. Churchill County Areas of Strength and Areas to Explore

Areas of Strength	Areas to Explore
Health Behaviors: • Physical inactivity	**Health Behaviors:** • Adult smoking • Adult obesity
Social & Economic Factors: • High school completion • Unemployment • Social associations	**Clinical Care:** • Mammography screening • Flu vaccinations

Source: County Health Rankings, 2022

Health Outcomes Ranking and Map

2022 Nevada County Health Outcomes Rankings: Churchill County ranked 13 out of 16 participating counties, an increase from the 2019 health outcomes (7 of 16).

Health outcomes determine how healthy a county is by measuring how people feel while they are alive and how long they live. Health outcomes are influenced by health factors, which are thus influenced by programs and policies in place at the local, state, and federal levels. Health outcomes indicate whether health improvement plans are working. Listed below are the two areas that the study looked at when determining health outcomes:

- Length of Life: measuring premature death and life expectancy.
- Quality of Life: measures of low birthweight and those who rated their physical and mental health as poor. (County Health Rankings, 2022)

Health Factors Ranking and Map

2022 Nevada County Health Factors Rankings: Churchill County ranked 8 out of 16 of the participating counties, a decrease from the 2019 health outcomes (10 of 16).

Health factors represent things that can be modified to improve the length and quality of life and are predictors for how healthy communities can be in the future. While there are many factors, from education to the environment in which a person lives, this study focused on the following four factors:

- Health Behaviors: rates of alcohol and drug abuse, diet and exercise, sexual activity, and tobacco use.
- Clinical Care: showing the details of access to quality of health care.
- Social and Economic Factors: rating education, employment, income, family and social support, and community safety.
- Physical Environment: measuring air and water quality, as well as housing and transit. (County Health Rankings, 2022)

Data Limitations and Information Gaps

Although the data sources provide an abundance of information and insight, data gaps still exist, including determining the most appropriate depth and breadth of analyses to apply. Additional gaps include:

Table 6. Data Limitations and Information Gaps

Data Type	Data Limitations and Data Gaps
Primary Data	• Data collection hit a barrier, due to COVI-19, data was forced to be collected in a virtual format via online surveys or virtual focus groups. • Survey respondents were under included in a few demographic areas – age of those 12-24, Hispanic ethnicity, and men.
Secondary Data	• Due to COVID-19 the national and state reporting cycle on public health data is behind, while normally this data has been published with a 1–2-year age, some data posted, like that of cancer incidence, was posted 5+ years ago at this time. • 2020 Census data was expected to be utilized at this time, however due to COVID and data issues from its collection process, much of the data has yet to be released. • Behavioral Risk Factor Surveillance system (BRFSS) and American Community Surveys (ACS), both yearly national surveys were conducted in both 2019 and 2020, due to COVID-19 there were delays in data collection and reporting out.

Prioritization of Community Health Needs

Building on Banner Health's past three CHNA reports, the steering committee and facility champions worked with Banner Health corporate planners to prioritize health needs for Cycle 4 of the CHNA. Facility stakeholders, community members, and public health professionals were among major external entities involved in identifying health needs, which were then brought to the steering committee. Both Banner Health internal members, and external entities were strategically selected for their respective understanding of community perspectives, community-based health engagement, and health care expertise. To be considered a health need the following criteria was taken into consideration:

- The PSA had a health outcome or factor rate worse than the average county / state rate
- The PSA demonstrated a worsening trend when compared to county / state data in recent years
- The PSA indicated an apparent health disparity
- The health outcome or factor was mentioned in the focus group
- The health need aligned with Banner Health's mission and strategic priorities

Using the previous CHNAs as a tool, the steering committee reviewed and compared the health needs identified in 2022 to the previous health needs. The group narrowed the community health needs to three. It was determined that Banner Health, as a health system would continue to address the same health needs from Cycle 3, the 2019 CHNA, due to the continued impact these health needs have on the overall health of the community. These needs and the strategies to address the needs align with the short- and long-term goals the health system has, specific strategies can be tailored to the regions Banner Health serves, and the health needs can address many health areas within each of them. The graphic below lists the three health needs, and the areas addressed by the strategies and tactics.

Improving the health of the communities we serve	Chronic Disease Management	Behavioral Health
•Access to and navigating healthcare services •Access to supportive care after hospital discharge •Access to care post-COVID •Employee wellness •Integrating Social Determinants of Health with Banner	•Health Literacy •Health Management •Diabetes and heart disease management •Diagnosing and managing dementia •Ongoing care for those with long-COVID •Preventative cancer education •Cancer screenings	•Access to mental health resources •Mental health care for those affected by COVID related experiences •Substance and alcohol abuse and misuse prevention

COVID-19 in the Prioritization Process

While prioritizing needs, COVID-19 was a consistent theme that arose in all forms of primary data collection. COVID-19 has had an impact on the measurement of health needs, socioeconomic factors, facility volumes, and health behaviors to name a few. Banner Steering Committee and facility leadership determined that for Banner Health's CHNA process, rather than adding a fourth community health need, Banner would incorporate COVID-19 into each of the three community health needs. Banner Health will continue to provide ongoing care for those affected physically and mentally by COVID-19 throughout Cycle 4 of the CHNA process.

DESCRIPTION OF PRIORITZED COMMUNITY HEALTH NEEDS

Banner Health has a strong history of dedication to its community and of providing care to the underserved populations. The CHNA continues to help identify additional opportunities to better care for populations within the community who have special and / or unmet needs, this has only strengthened our commitment to improving the health of the communities we serve. The following statements summarize each of the areas of health needs for Banner Churchill Community Hospital and are based on data and information gathered through the CHNA process.

Community Health Need #1: *Improving the health of the communities we serve*

To "*Improve the health of the communities we serve",* it is essential to understand the factors that affect our communities in improving their health. These factors range from insurance status, Social Determinants of Health (SDoH), utilization of hospitals and emergency departments, and access to providers, to name a few. Based on the areas of focus for this health priority SDoH, poverty level, insurance status, and access to primary care providers are covered.

Social determinants of health are the conditions in the environment where people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People2030 via HHS, 2022). Health People 2030 a national 10-year plan identifies public health priorities to improve the health and well-being across the United States, their key focus is SDoH. These SDoH have a foundational role in our lives, such as safe housing, racism, violence, access to nutritious foods, job opportunities, polluted air, and literacy skills. To further understand these determinants of health, they have been grouped into five key areas:

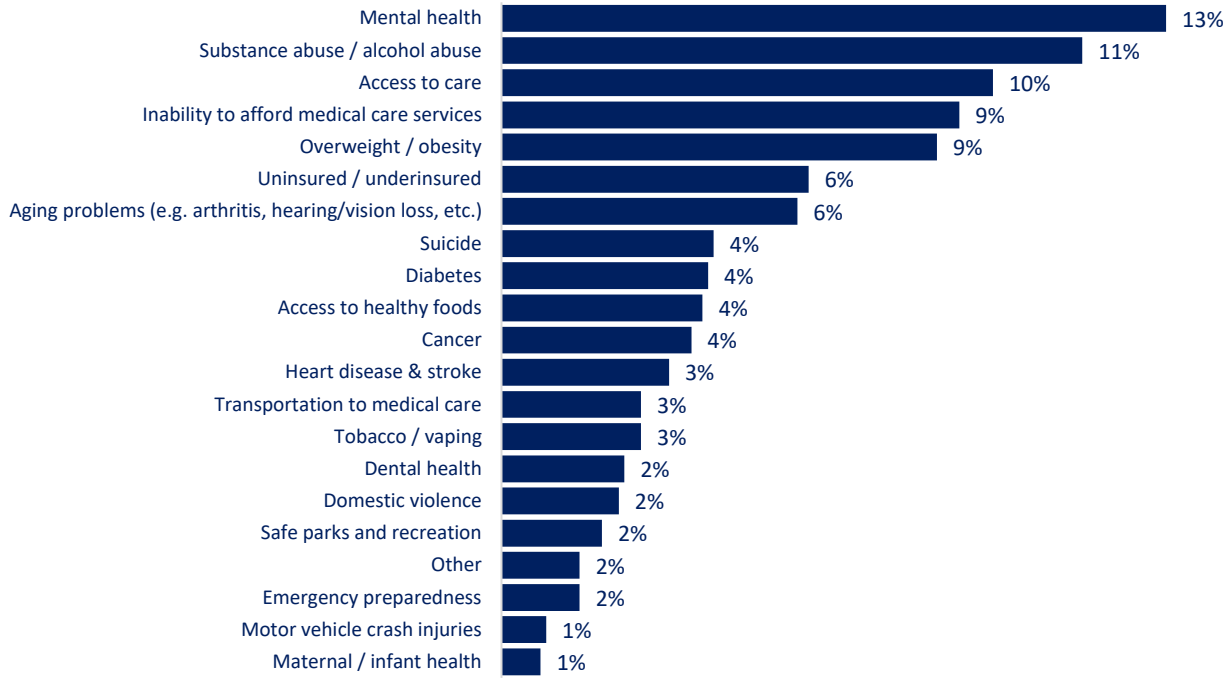
- Economic stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

In the context of health care access and quality, Healthy People 2030 has identified a series of areas to focus on to address SDoH. These areas all reflect the foundational problem of people in the United States not getting the health care services they need. Areas of focus include: uninsured populations, PCP access, navigating health care, and preventative health (Healthy People2030 via HHS, 2022). For Healthy People 2030, the two primary objectives to address health care access and quality are listed below:

- Reduce the proportion of emergency department visits with a longer wait time than recommended
- Increase the proportion of adults who get recommended evidence-based preventative health care

Via the community survey conducted with all of our Western Division facilities, this includes our hospitals in California, Nevada, Nebraska, Colorado, Wyoming, and Norther Arizona, themes that reflect access to care were prevalent as top community health issues. This includes access to care (10%), Inability to afford medical care services (9%), uninsured/underinsured (6%), and transportation to medical care (3%).

Chart E. What are the top health issues you see in your community?



Source: Banner Health Western Division Community Survey, 2019-2020

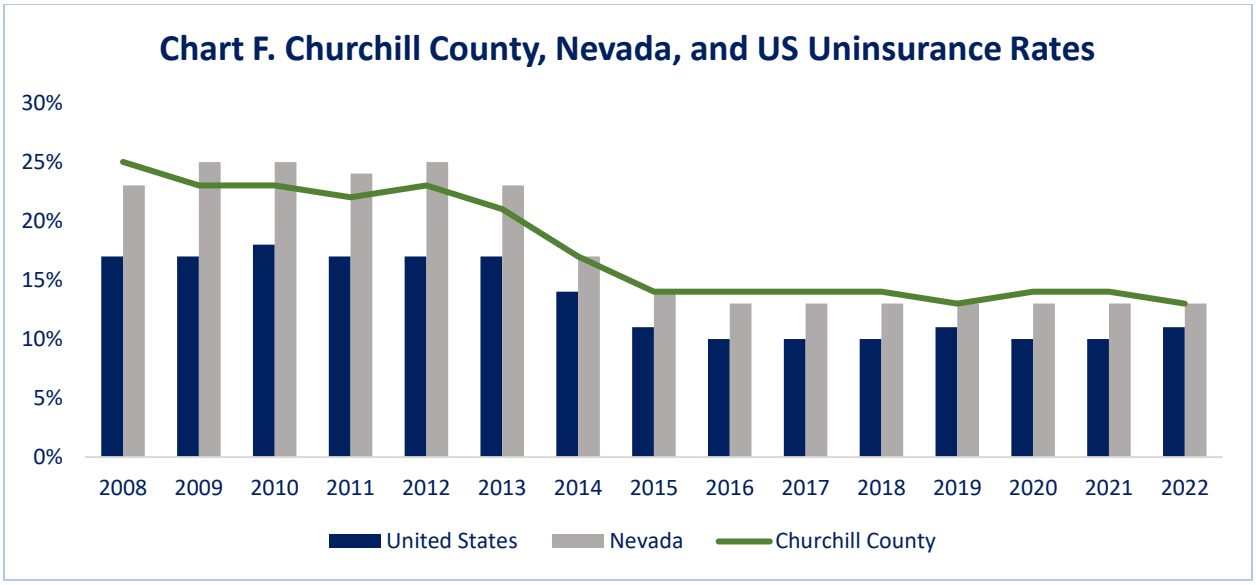
When it comes to the populations in Churchill County living under the poverty level, Churchill County has a slightly higher poverty level than that of Nevada and the United States. Nevada has a higher rate of those eighteen and under living under the poverty level when compared to the United States and Churchill County. Females consistently have a higher rate of living below the poverty level than that of males.

Table 4. Populations living below the poverty level

	United States	Nevada	Churchill County
Population	12.8%	13.10%	13.20%
Under 18	17.5%	18.20%	14.90%
Male	11.6%	12.10%	12.40%
Female	14.0%	14.10%	13.90%
White	10.6%	11.00%	10.60%
Black/African American	22.1%	23.00%	43.50%
American Indian/Alaskan Native	24.1%	23.60%	21.10%
Asian	10.6%	9.00%	6.60%
Native Hawaiian/Pacific Islander	16.8%	16.60%	66.67%
Other	10.3%	18.80%	48.98%
Hispanic	18.3%	18.68%	49.14%

Source: American Community Survey, 2019-2020

Over a 14 year span you can see the decrease in uninsurance rates, most notably the drop from 2013 to 2015 as the Affordable Care Act went into place. Data indicates Churchill County and Nevada have a greater uninsurance rate than that of the United States. Health insurance is recognized as a contributing factor to health outcomes, contributing to the affordability of health services and the utilization of primary care/preventative health care services (KFF, 2013).



Source: County Health Rankings, 2008-2022

A contributing factor to health access and a social determinant of health is access to a primary care provider (PCP). A PCP makes it possible for a person to get preventative health services as well as provides tools to better maintain a healthy lifestyle. In Nevada and Churchill County, the rate of the population per primary care provider (PCP) is higher than the national rate, this means for Churchill County and Nevada residents; it is harder for people to find and access a PCP than in other parts of the country.

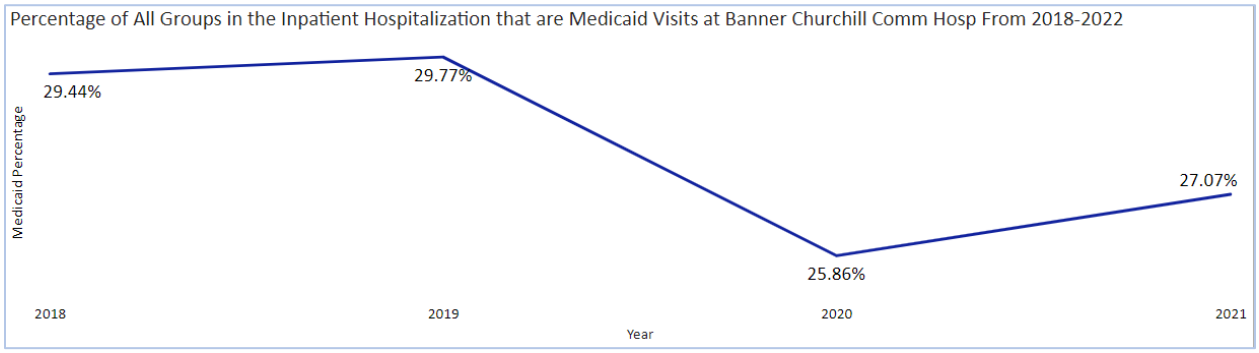
Table 5. Ratio of Population to Primary Care Physicians

	2019	2020	2021	2022
United States	1,050:1	1,030:1	1,030:1	1,010:1
Nevada	1,760:1	1,770:1	1,710:1	1,710:1
Churchill County	1,730:1	1,680:1	1,880:1	2,260:1

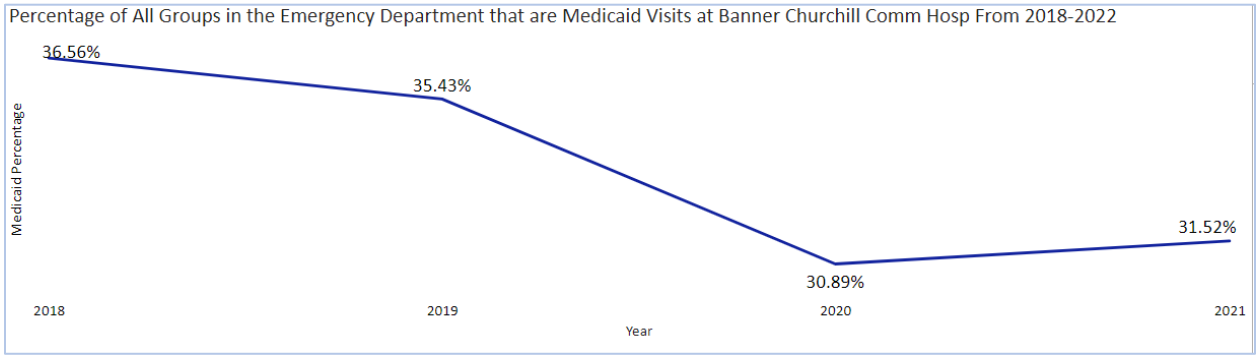
Source: County Health Rankings, 2019-2022

Understanding the rate of Emergency Department visits and admits into a hospital for those insured via Medicaid can be used to provide context on the health behaviors and health trends of poorer populations. Medicaid was designed to provide health coverage for low-income children and families who lack access to private health insurance – the two qualifying factors include: income and health status (KFF, 2013). Health status refers to physical, mental, and intellectual abilities. Nationally, the financial qualification for Medicaid is based on federal poverty level, for children and adults it is at least 133%, however states have the option to raise that level to expand coverage (Medicaid, 2022).

When we look at Medicaid utilization of health services it is a way to see the trends of the effect of the economy, health related policies, and overall health behaviors on those lower income populations. When comparing Medicaid utilization trends from our primary service to the county or state, it provides an opportunity to understand if our hospitals are providing care at a higher average to Medicaid patients – and determine health strategies to provide quality care to an already at-risk population.

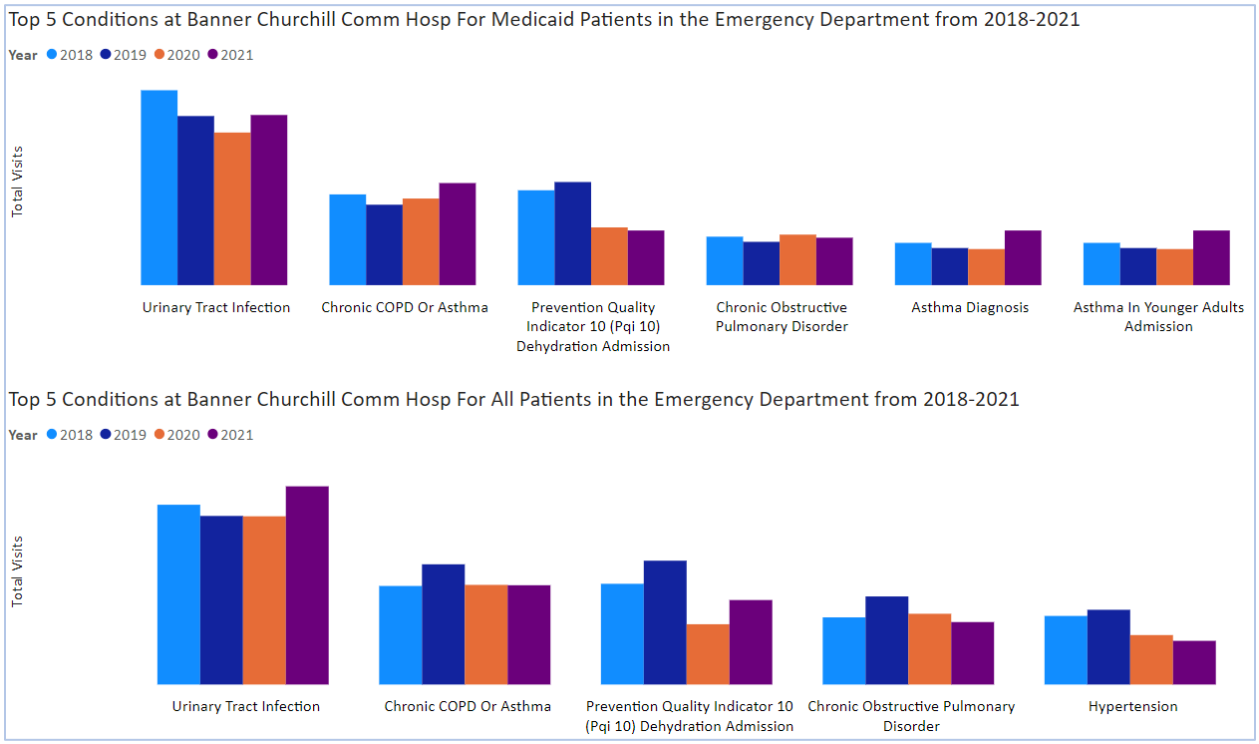


Source: McKesson via Banner Health, 2018-2022



Source: McKesson via Banner Health, 2018-2022

A comparison of top health conditions in the Emergency Department based on payor type – Medicaid and All Payors, is another way to view access to primary care and health education of the patient. Utilization of the ED can be broken out into two groups – emergent issues and health issues that can be addressed at a primary care location or urgent care location. Health conditions that could be treated at a primary care location or urgent care location are indicative of healthcare management and access to primary care, such as UTIs and Asthma.



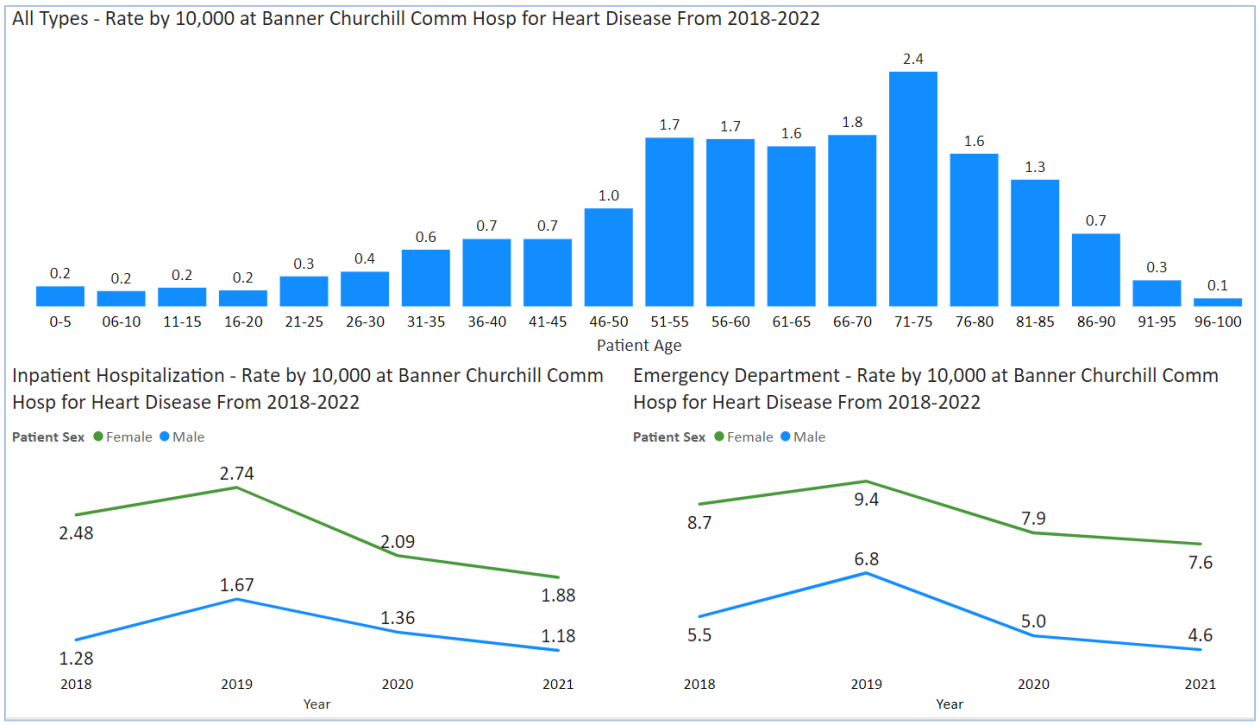
Source: McKesson via Banner Health, 2018-2022

Community Health Need #2: *Chronic Disease Management*

Chronic Disease was identified as another Health Priority; Banner Health decided to focus on how to support the management of chronic diseases. When looking at state, county, and hospital data the prevalence of chronic diseases was present as a top ten condition for Emergency Department visits, Inpatient admits, and incidence of death. When indicating community health concerns, many respondents identified obesity and lack of physical activity – these are both themes that are known to be correlated to chronic diseases. Access to safe places to recreate, access to affordable and healthy foods, and the financial freedom to focus on physical health are all factors that are correlated to SDoH as well as chronic disease management.

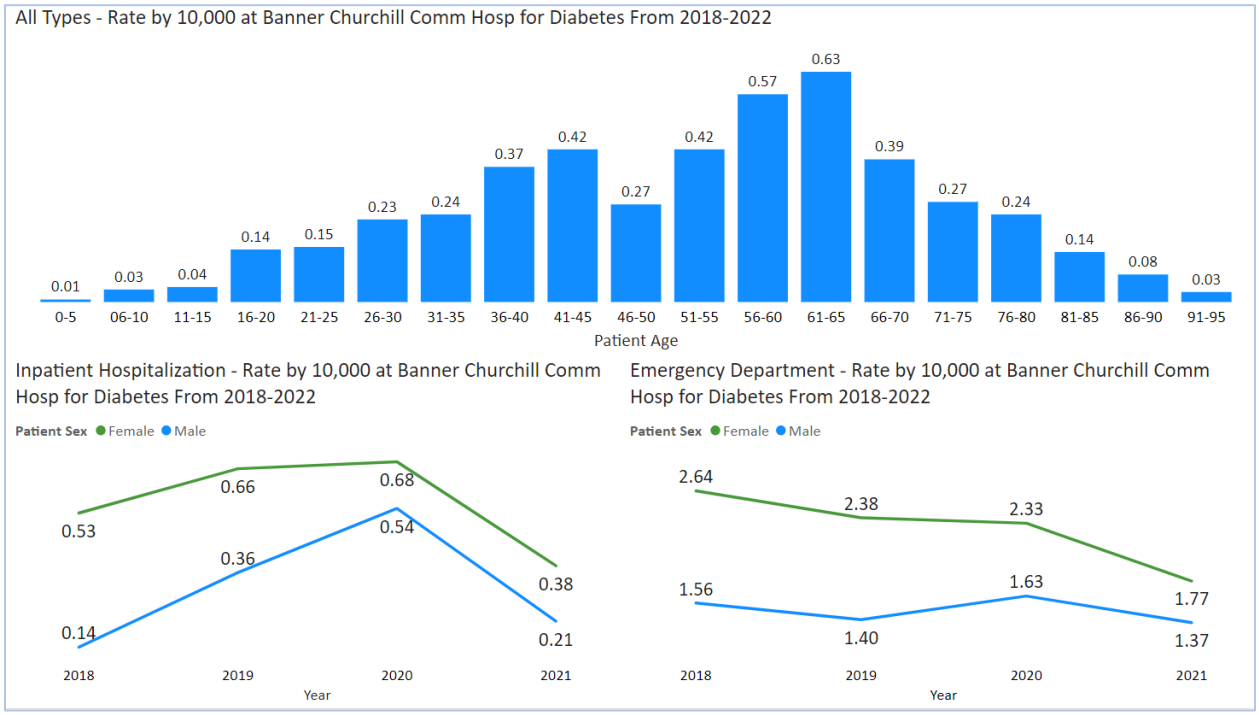
This report focuses on the utilization of the ED visits and IP admits for those with a primary diagnosis of *heart disease* or *diabetes*. These rates indicate management of disease or lack of management – leading to ED visits and IP admits. Looking at these utilization rates helps identify trends in occurrence of these chronic diseases as well as utilization of care. Overall data indicates a drop in visits for both chronic disease states in 2020 – this can be attributed to COVID-19 and the change in behaviors in accessing healthcare throughout the pandemic. For those with diabetes and chronic disease, COVID-19 put them at higher risk of a severe disease course.

Data indicates, from five-year trends, that ED visits and IP admits for heart disease are most common for those 51 to 80, with the highest occurrence of visits and admits at Banner Churchill Community Hospital being those who are 71 to 75. Females consistently have a higher rate of IP admits and ED visits over a four-year period. From 2019 to 2021 there was a decline for both IP admits and ED visits at Banner Churchill Community Hospital.



Source: McKesson via Banner Health, 2018-2022

Data indicates, from five-year trends, that ED visits and IP admits for diabetes are most common for those 36 to 77, with two peaks of a higher rate of occurrence at 41-45 and 61-65 at Banner Churchill Community Hospital. Females consistently have a higher rate of IP admits and ED visits over a four-year period. In 2020 there was an increase for both males and females IP hospitalizations, both genders saw a decline in 2021 at Banner Churchill Community Hospital. Over a four-year period, females have had a declining rate of ED visits at Banner Churchill, with males having an increase from 2019 to 2020.



Source: McKesson via Banner Health, 2018-2022

Cancer incidence rates, age adjusted and based on a five-year average indicates a few things – a higher prevalence in Churchill County, and Nevada having a lower rate than both the county and national rates. However, females have a higher incidence rate of cancer in Churchill County than that of the state and national rates. While breast cancer rates are highest on a national level compared to the state and county, cervical cancer rates are highest for Nevada, with suppressed rates for Churchill County.

Table 6. Churchill County Age Adjusted Cancer Incidence Rate

	United States	Nevada	Churchill County
All Cancer Sites	448.6	398.8	423.2
Females	422.7	390.5	441.5
Males	487.4	412.4	408.2
Breast (Females)	126.8	115	121.4
Cervical (Females)	7.7	9.1	0
Colon & Rectal	38.0	35.6	34.8
Females	33.4	30.9	38.7
Males	43.5	40.8	31.4
Lung & Bronchus	57.3	51.9	68.7
Females	50.8	51.8	66.6
Males	65.7	52.2	70.9
Prostate (Males)	106.2	85.9	79.8

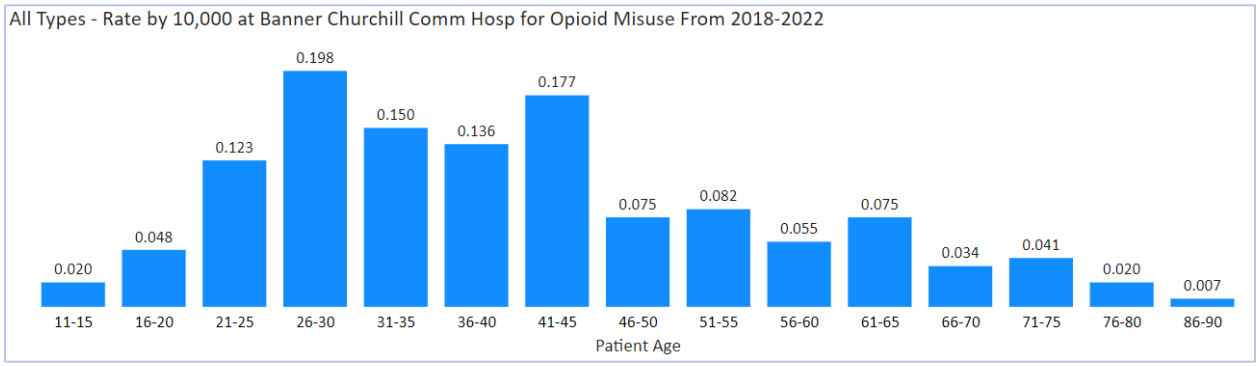
Source: National Institute of Health: National Cancer Institute, State Cancer Profiles, 5-Year Average

Community Health Need #3: *Behavioral Health*

Community feedback gathered through surveys and focus groups indicated a rise in Behavioral Health as a primary concern. Specific behavioral health concerns that were highlighted by participants include mental health issues and alcohol/substance abuse. An outcome of the COVID-19 Pandemic has been a rise in the focus of health care provider mental health – a result of the emotional and psychological trauma of providing care to patients with COVID-19. The occurrence of burnout for physicians and nurses, manifesting through anxiety, depression, and stress has been attributed to COVID-19 and the pressures put on them to treat patients battling COVID-19 (Sung, Chen, Fan, et al. 2021). Measures to understand the prevalence of behavioral health concerns include *Mental and Behavioral Health Disorders* and *Opioid Drug Use.*

Mental health disorders are prevalent throughout the world, one in eight people in the world live with a mental disorder, anxiety and depressive disorders being the most common (Institute of Health Metrics and Evaluation, 2022). "A mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior." (WHO, 2022) It is estimated that there was an over 25% increase in anxiety and depressive disorder in 2020 because of the COVID-19 pandemic (WHO – Mental Health and COVID-19,2022).

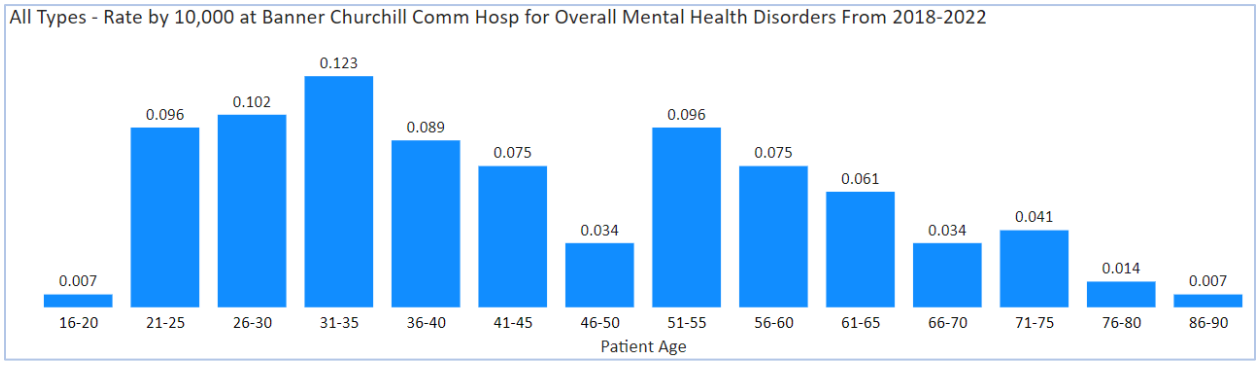
Occurrence for Mental Health, from five-year trends in the Emergency Department, is greatest for those 26 to 30 and 41 to 45.



Source: McKesson via Banner Health, 2018-2022

Opioid use disorder and addiction continues to be at epidemic levels in the United States and world. In the United States, three million people suffer from opioid use disorder, with more than 500,000 people dependent on heroin alone (Azadfard, Hecker, Leaming, 2022). Nationally, the response ranges state to state and county to county – with communities enacting prescription drug monitoring programs and communities providing naloxone access for overdoses. Additionally, states have begun to tackle the financial impact of opioid use disorder through legal action against pharmaceutical companies – applying the financial wins to addressing the opioid use problems in their communities. Measuring opioid misuse in our hospitals and communities is a way in which we can understand the rate of prevalence of opioid abuse that leads to hospital visits and admits.

At Banner Churchill Community Hospital Emergency Department visits and Inpatient admits for opioid misuse are most prevalent for those aged 31-35, with a high range of occurrence from ages 21-55.



Source: McKesson via Banner Health, 2018-2022

Overall CDC data indicates that drug overdose rates increased from 2019 to 2020.

Table 7. Drug Overdose Rates per 100,000

	2019 Age-Adjusted	2020 Age-Adjusted
United States	21.6	28.3
Nevada	20.1	26

Source: CDC, Drug Overdose, 2019-2020

Needs Identified but Not Prioritized

Additional needs identified through data collection and community input were age related health concerns, aging problems, cancer, and access to healthy foods. In many of Banner's facilities a high percentage of the aged population is served, as a result tactics have been developed that acknowledge and address concerns of the aged populations. It was determined to group cancer into Chronic Disease Management as opposed to having it stand along Significant Health Need, as a result a specific strategy has been developed to educate and create access to cancer screenings.

COVID-19 remains an ongoing health concern in many communities. While Banner Health decided to not develop a Significant Health Need that is specific to COVID-19, health priorities have been developed that are related to the effects of COVID-19 and have developed tactics to address these health priorities.

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2019 CHNA FOLLOW-UP AND REVIEW

The link to the 2019 report and implementation strategies was posted on the Bannerhealth.com website and made widely available to the public. Over the past three years, Banner Health has monitored its Community Feedback email account and responded to emails in a timely manner. Comments can be sent to CHNA.CommunityFeedback@bannerhealth.com.

Table 8 has a summary of topics of emails received since 2019, all emails were responded to in a timely manner with answers or directions on where to receive an answer.

Table 8. Community Feedback Summary

Submission Year	Message Topics
2019	*Topics covered getting access to communication regarding community wellness events, community outreach and assistance programs, senior center programs and food delivery programs, as well as guidance on smoking cessation, and how to become a volunteer at a Banner Health facility.*
2020	*Topics covered guidance on scheduling an appointment, support in identifying substance abuse treatment centers, schools reaching out to support hospitals during the pandemic, guidance on COVID protocol once diagnosed, community event participation, direction on how to be a volunteer at Banner Health, smoking cessation, and communication on health mobile events.*
2021	*Topics covered information on how to get a mentally unstable person the health support they need, how to navigate COVID hospital and clinic protocols, where to donate blood, navigation of insurance, and how to schedule a COVID-19 vaccine appointment.*
2022	*Topics covered smoking cessation, scheduling a doctors appointment, what hospital protocol was pertaining to partners being with the mother during delivery, as well as a positive review on the quality of food during recovery.*

Table 9 indicates what actions have been taken by Banner Churchill Community Hospital since the cycle 3 CHNA Implementation Strategies were approved by the Banner Board December 2019. COVID-19 has had an ongoing impact on the Banner Churchill Community Hospital's Strategies and Tactics due to the impact it had on overall system health priorities and focus. Data collection and monitoring had gaps in the data collected for certain tactics, and in some cases, data was no longer collected or focused on.

Table 9. Western Division Implementation Strategies Outcomes

Strategies	Outcomes
Significant Health Need: Access to Care	
Strategy #1: Increase access points for primary care services	• Employed additional Primary Care Providers and Advanced Practice Providers to increase access to care.
Strategy #2: Increase access to ambulatory care settings.	• Grew access to ambulatory services for our community through Urgent Care, Ambulatory Surgical Centers, and Physical Therapy.
Strategy #3: Deploy care models and tools that improve affordability of care for Banner Health Network members.	• Promoted access to Banner Medical Group, to reduce utilization of the Emergency Room • Identified 22 core measures for annual wellness visits to set quality measures – including chronic disease management, cancer screenings, and immunizations.
Significant Health Need: Chronic Disease Management (Diabetes/Heart Disease/Cancer)	
Strategy #1: Continue to improve the coordination of care for patients with chronic disease diagnosis	• Utilized pharmacists to assist in chronic disease management via telephone consultations. • Offer cancer screenings through clinics. • Provided education and assistance with medication adherence, including cost of medication.
Strategy #2: Growth of preventative care and wellness programs in the communities we serve.	• Provided Medicare Advantage Wellness visits through deploying MDs, NPs, and PAs. • Offered same day mammography access in ambulatory settings (health centers and Imaging locations).
Strategy #3: Continued enhancement of measurement /oversight of clinical quality measures for chronic disease patients.	• Decreased hypertension through an increase in clinical measures for BP control. • Decreased HbA1cs through an increase in clinical measures for diabetic patients. • Monthly clinical performance meetings focusing on diabetes and hypertension for Quality Improvement.
Significant Health Need: Behavioral Health	
Strategy #1: Provide services to increase awareness and access to address general psychiatric health needs.	• Continue to partner with community outpatient behavioral health providers to provide coordinated care. • Encouraged patients to get initial behavioral screenings in the Emergency Department.
Strategy #2: Utilize internal and external resources to address opioid addiction in Banner Health communities.	• Implemented a system wide primary care strategy to identify opioid use disorder.
Strategy #3: Utilize internal and external resources to improve clinical quality for suicide, depression patients in Banner Health communities.	• Working to be a "Zero Suicide" health system, where all non-clinical hospital employees are trained to Question, Persuade, and Respond when interacting with a person having a suicidal crisis. • Provided depression screenings during Clinic Appointments.

APPENDIX A. LIST OF DATA SOURCES

Primary and Secondary Data Sources

- Stratasan via ESRI Demographic
- Stratasan via ESRI Insurance Estimates
- County Health Rankings
- McKesson

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Survey Flyer

Survey

1. **Zip code where you live: _____**

2. **Sex:**
   a. Male
   b. Female
   c. Non-binary or non-identifying
   d. Other: _____

3. **Age**
   a. 0-17
   b. 18-25
   c. 26-39
   d. 40-54
   e. 55-64
   f. 65+

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1. **How would you rate the overall health of your community?**
   a. Very unhealthy
   b. Unhealthy
   c. Somewhat healthy
   d. Healthy
   e. Very healthy

2. **What makes a community healthy? _____**

3. **What are the top health issues you see in your community? (Choose 3)**
   - Access to care
   - Access to healthy foods
   - Aging problems (e.g. arthritis, hearing/vision loss, etc.)
   - Cancer
   - Dental health
   - Diabetes
   - Domestic violence
   - Emergency preparedness
   - Firearm related injuries
   - Heart disease & stroke
   - Homicide
   - Inability to afford medical care services
   - Mental health
   - Maternal / infant health
   - Motor vehicle crash injuries
   - Overweight / obesity
   - Safe parks and recreation
   - Sexually transmitted infections
   - Substance abuse / alcohol abuse
   - Suicide
   - Teenage pregnancy
   - Tobacco / vaping
   - Transportation to medical care
   - Uninsured / underinsured
   - Other _____

4. **What are the most important factors that will improve the quality of life in your community? (Choose 3)**

- Low crime / safe neighborhoods
- Low level of child abuse
- Safe parks and recreation
- High performing schools
- Access to health care (e.g., family doctor)
- Clean environment
- Affordable housing
- Arts and cultural events
- Access to healthy foods
- Positive race / ethnic relations
- Good jobs and healthy economy
- Healthy behaviors and lifestyles
- Low adult death and disease rates
- Low infant deaths
- Emergency preparedness
- Access to public transportation

5. Other _____

6. **What health and quality of life resources or services do you think are missing in your community? (Choose 3)**
    - Affordable housing
    - Free / low-cost medical care
    - Free / low-cost dental care
    - Primary care providers
    - Medical or surgical specialists
    - Mental health services
    - Substance abuse services
    - Bilingual services
    - Transportation
    - Prescription assistance
    - Health education / information / outreach
    - Health screenings
    - None
    - Other _____

7. **What the most significant barriers that keep people in the community from accessing health care when they need it? (Choose 3)**
    - Availability of providers / appointments
    - Difficulty to navigate health care system
    - Difficulty to pay out-of-pocket expenses (co-pays, prescriptions, etc.)
    - Lack of childcare
    - Lack of health insurance coverage
    - Lack of transportation
    - Lack of trust
    - Language / cultural barriers
    - Time limitations (e.g. long wait times, time off work, etc.)

8. **How would you rate your physical health?**
    a. Very unhealthy
    b. Unhealthy
    c. Somewhat healthy
    d. Healthy
    e. Very healthy

9. **How would you rate your mental health?**
    a. Very unhealthy
    b. Unhealthy
    c. Somewhat healthy
    d. Healthy
    e. Very healthy

10. **How often do you visit your primary care physician?**
    a. Every few months
    b. Once or twice a year
    c. Only when sick
    d. I do not have a primary care physician

11. **On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about your experience in accessing health care services (1 – Strong Disagree; 2 – Somewhat Disagree; 3 – Neutral; 4 – Somewhat Agree; 5 – Strongly Agree)**
    a. Able to access a primary care provider when needed (Family Doctor, Pediatrician, General Practitioner)
    b. Able to access a medical specialist when needed (cardiologist, Dermatologist, Neurologist, etc.)
    c. Utilizing Emergency Departments or urgent care in place of a primary care physician
    d. There are a sufficient number of providers accepting Medicaid and providing financial assistance in the area

12. **As a result of COVID-19, are you or people in your household currently having any of the problems listed below? (Select all that apply)**
    - Job loss or working fewer hours
    - Trouble paying your bills
    - Loss or change in your housing
    - Not having enough food
    - Increased medical needs
    - Problems accessing health care services
    - Increased family caregiving demands
    - Loss of connection to faith or social groups
    - Increased stress or anxiety
    - Increased loneliness
    - None of the above
    - Other_____

13. **Level of trust in COVID-19 information sources (A great deal, a little, not at all, don't know)**
    a. Doctor or health care provider
    b. U.S. Coronavirus Task Force
    c. Close friends and family members
    d. U.S. Government
    e. State Government
    f. Local health care system
    g. Faith leader
    h. News sources
    i. Co-workers, classmates, or others
    j. Local Tribal Government
    k. Social media contracts
    l. Other

Key Informant Interview Questions

1. Can you give us a brief description of your specialized knowledge, expertise, and representative role?
    a. What populations/communities do you serve?
2. How do you define health?
    a. What do you think is necessary to live a healthy life?
3. What does quality of life mean to you?
4. What are the most important issues that affect the health of people in your community?
    a. Who is most affected by those?
5. How has the recent COVID-19 pandemic affected the health of the people you work with in your community?
    a. What new or unexpected health issues arose throughout the pandemic?
    b. How has your organization responded to communities in need during the pandemic?
    c. In what ways have you seen community resilience throughout the current pandemic? Can you provide any specific examples?
6. This question is being used to understand community assets and strengths of the communities/populations you work with. Part of the CHNA will list existing community resources and programs.
    a. What are some of the programs that exist in your community to promote:
        i. Physical health or exercise?
        ii. Mental health or psychosocial wellbeing?
        iii. Health for specific populations (infants, youth, seniors, minorities, LGBTQ+, etc.)?
        iv. Resilience in vulnerable communities?
7. What services are needed in the community? Who most needs them?
8. Is there anything else you would like us to know?

Western Division Community Survey Demographics

Table 10. Western Division Community Survey Demographics

	#	%
Total Responses	234	
Gender		
Male	50	21.4%
Female	181	77.4%
Non-binary or non-identifying	2	0.9%
Other	1	0.4%
Age		
0-17	1	0.4%
18-25	3	1.3%
26-39	53	22.6%
40-54	85	36.3%
55-64	48	20.5%
65+	44	18.8%

APPENDIX B. STEERING COMMITTEE AND COMMUNITY ADVISORY COUNCIL MEMBERS

Banner Health's CHNA Steering Committee is comprised of leaders from throughout Banner Health's system. These leaders represent our Arizona Community Delivery, Wester Division and Rural Facilities, as well as our Academic Medical Centers. In collaboration with Washakie Medical Center's leadership team and Banner Health's Strategy Planning department, the Steering Committee is instrumental in both the development of the CHNA process and the continuation of Banner Health's commitment to providing services that meet community health needs.

Table 11. Banner Health Steering Committee

Steering Committee Member	Title
Todd Werner	Senior Vice President, Acute Care Delivery
Sarah Frost	CEO, Banner University Medical Center – Tucson & South
Margo Karsten	Division President, Western Division
Daniel Post	CEO, Banner University Medical Center – Phoenix
Lamont Yoder	Division President, Arizona Community Delivery

CHNA Facility Based Champions

A working team of CHNA Champions from each of Banner Health's hospitals meets on a monthly basis to review the ongoing process of community stakeholder meetings, report creation, and action plan implementation. This group consists of membership made up of CEOs, CNOs, COOs, facility directors, quality management personnel, volunteer services leaders, and other clinical stakeholders.