2016-2018

Lake Region Healthcare

Community Health Needs Assessment Implementation Strategy

Lake Region HEALTHCARE

Vision. Integrity. Award winning care.

IMPLEMENTATION PLAN

BACKGROUND & PROCESSES

Lake Region Healthcare (LRH) in collaboration with Otter Tail Public Health Department and Minnesota Department of Health conducted a community health needs assessment (CHNA). The results of the CHNA along with numerous Community Conversations, focus groups, key informant interviews, and stakeholder meetings resulted in identifying the common issues within our service area. These common issues or themes were aligned to the Healthy People 2020 which has four overarching goals:

1. Attain high-quality, longer lives free of preventable disease, disability, injury and premature death;
2. Achieve health equity, eliminate disparities, and improve the health of all groups;
3. Create social and physical environments that promote good health for all;
4. Promote quality of life, health development, and healthy behaviors across all life stages

In addition to the primary data results, secondary data was reviewed to identify potential health care needs. Secondary data included: Minnesota State, County and Community Health Board Vital Statistics Trend report.

SUMMARY OF PRIORITIZED NEEDS

1. Reduce substance use (Opioid Epidemic)
2. Reduce obesity
3. Address mental health issues
4. Prevent adverse childhood events
5. Focus on chronic disease management (with an emphasis on hypertension and diseases associated with high cholesterol such as coronary heart Disease, stroke, peripheral vascular disease and diabetes)

"A healthy community is one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential. Healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn, and play within their borders—where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options."

The US Department of Health and Human Services

IMPLEMENTATION STRATEGY

Responding to the health needs of our communities, especially to the most vulnerable among us, is central to the mission of Lake Region Healthcare Corporation and our community partners such as Otter Tail Public Health. In order to address the priority needs, LRH will engage key community partners in implementing evidence-based strategies across the service area. These strategies include modifying policies and practices, providing support, enhancing access, changing consequences and incentives, providing information and enhancing skills.

The final approved version of the 2016 CHNA and Implementation Strategy are available to the public on the LRH website.

ABOUT LAKE REGION HEALTHCARE

Lake Region Healthcare Corporation (LRH) is a not-for-profit healthcare system with a 108-bed hospital, multi-specialty clinic, cancer center, assisted living community, and group fitness facility on our main campus in Fergus Falls. Expanded clinic hours are offered at our west-side Walk-In Clinic and outreach clinic services are provided in Ashby, Battle Lake and Barnesville.

LRH is the largest employer in Otter Tail County. With over 80 Medical Staff and over 900 employees, our team is dedicated to serving our patients and community with integrity, teamwork, compassion and excellence. LRH is governed by a 15-member Board of Trustees. These trustees are dedicated community members who care deeply about the health care services and people served at Lake Region Healthcare. LRH works closely with other resources in our community such as Otter Tail County Social Services and Public Health, senior centers and Skilled Nursing Facilities, Mental Health providers, State agencies, group homes, assisted living facilities, and other community resources.

ABOUT LAKE REGION'S COMMITMENT TO COMMUNITY BENEFIT

For more than 100 years, LRH has been dedicated to providing high-quality, affordable health care services and to improving the health of the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We believe strongly in solid community partnerships that have taken years to develop and grow. We have worked for many years side-by-side with our partner organizations to address serious public health issues such as obesity, access to care, and end of life decisions. These partnerships, combined with the knowledge we gather through the Community Health Needs Assessments allows us to develop strategies aimed at making long-term, sustainable change – and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

Our Vision

To be Minnesota's preeminent regional healthcare partner.

Our Values

Integrity: We communicate honestly, behave ethically and act responsibly as individuals and as an organization. We do the right thing even when no one is watching.

Teamwork: We contribute our individual best efforts to work as a group toward a common vision. We collaborate to provide superior care to our patients and partner to improve the health of our community.

Compassion: We provide care with kindness and consideration of each person's emotional, spiritual and physical needs. We create an environment conducive to healing, growth and well-being for all, including those with whom we work.

Excellence: We seek to be the best at everything we do.

Lake Region HEALTHCARE
Vision. Integrity. Award winning care.

HEALTH NEEDS OF THE COMMUNITY

The 2016 CHNA identified numerous health needs within LRH's service area:

- Nutrition, Physical Activity and Obesity
- Mental Health
- Access to Health Services
- Tobacco
- Maternal, Infant, and Child Health
- Substance Abuse
- Social Determinants of Health
- Clinical Preventive Services
- Environment Quality
- Injury and Violence
- Oral Health
- Reproductive and Sexual Health

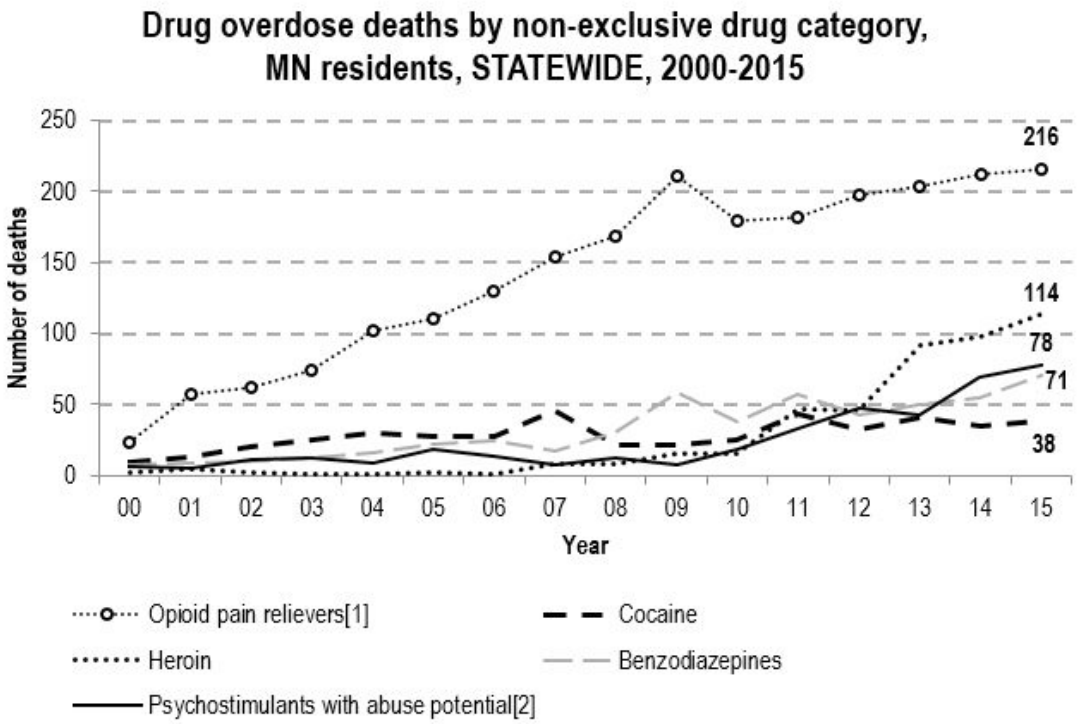
These needs were then prioritized based on the prevalence, severity, available data, and the ability of the healthcare system to impact the problem. This resulted in the following prioritized health needs:

1. Reduce substance use (Opioid Epidemic)
2. Reduce obesity
3. Address mental health issues
4. Prevent adverse childhood events
5. Focus on chronic disease management (with an emphasis on hypertension and diseases associated with high cholesterol such as coronary heart Disease, stroke, peripheral vascular Disease and diabetes)

LRH's resources, mission, goals and strategic priorities were taken into consideration in developing the implementation strategy. LRH will continue its historical practice of engaging our community partners in implementing evidenced-based strategies across the service area. Acknowledging the many organizations and resources that will be needed to accomplish the implementation strategy, we have strategically reviewed both internal and external resources and are positive about moving the implementation strategy forward.

SUBSTANCE USE

Recently, the Centers for Disease Control and Prevention declared the United States is experiencing an opioid overdose epidemic (CDC, 2016). In 2014, 28,000 people in the United States died of drug overdose, the highest number ever recorded, with more than half of these deaths related to prescription opioids or heroin (CDC, 2016). Since 1999, overdose deaths related to opioids and heroin have quadrupled throughout the nation (CDC, 2016). Minnesota has seen similar trends as a state. From 2014 to 2015, the state recorded an 11% increase in drug overdose deaths, both unintentional and suicide (MDH, 2016). With overdose rates four times as high in 2015 than in 2000 and more than half of these being related to prescription medications (See Figure 1.1 below) (MDH, 2016).



NOTE: Drug categories are not exclusive.

SOURCE: Minnesota death certificates, Injury and Violence Prevention Unit, Minnesota Department of Health (MDH), 2000-2015

1 Opioid pain relievers: Includes methadone
2 Psychostimulants with abuse potential: Include methamphetamine

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SUBSTANCE USE STRATEGY

1. **Establish a community coalition to access, plan, and develop strategies to address the opioid epidemic.**

2. **Host one or more community forums to raise awareness of the opioid epidemic.**

3. **Explore current best practices for health care provider prescribing practices for opioids.**

4. **Collaborate with public health to implement new legislation related to prescribing naloxone by the Community Health Board's Medical Consultant.**

5. **Collaborate with area pharmacies in an attempt to implement new legislation related to pharmacy take back of medications to remove unused medications from homes.**

6. **Promote the "Take It To The Box" option at local law enforcement agencies to collect unused medications in order to eliminate it from the supply stream and protect the environment from disposal of medications.**

7. **Ask Medical Staff to adopt the Chronic Pain Management "Best Practices Consensus Policy" that defines a patient's assessment for chronic pain, reassessment, chronic pain management agreement between provider and patient, patient's risk assessment, access to the Minnesota prescription drug monitoring program and exit strategy.**

8. **Continue the Community Paramedic program which includes home visits, health assessments and screenings. Community paramedics are able to collect and destroy old/discontinued medications including narcotics/ opioids through the sheriff's department. During the visit, they provide education about the uses of each medication as prescribed by their primary care provider. Working directly within the patient's home they are able to be the eyes and ears within the community in regards to actual medication compliance/abuse.**

OBESITY

Through the survey, we learned that approximately 28% of the population is considered overweight or obese as calculated using the Body Mass Index (BMI) chart. Rates in Clay County were lower, around 25%, but higher in Otter Tail and Wilkin Counties at around 30% and 40%, respectively (see Figure 2.1). According to the County Health Rankings, the state of Minnesota is experiencing an obesity rate of 26%. Therefore, rates within the service area and specified counties are considerably higher than the state average.

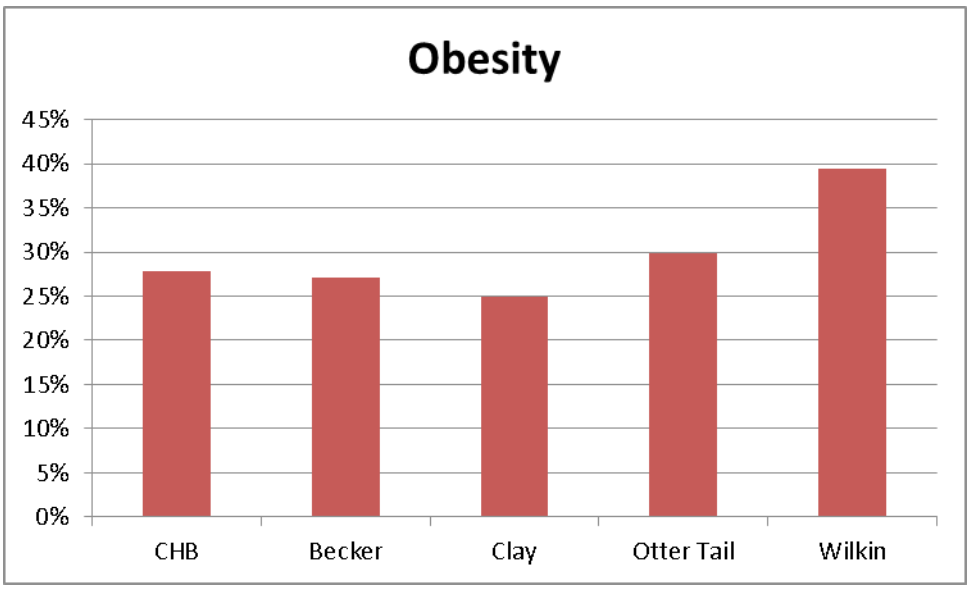


Figure 2.1

Even though obesity rates are considerably higher, the survey identified only 20% of the population within the service area is "very concerned" about obesity. These rates of concern also decreased within counties where obesity is more widespread (see Figure 2.1).

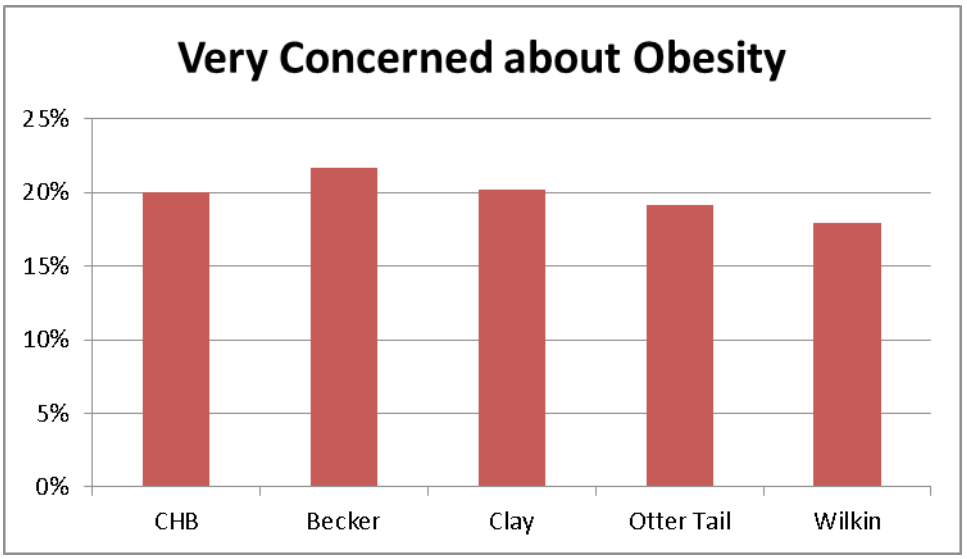


Figure 2.2

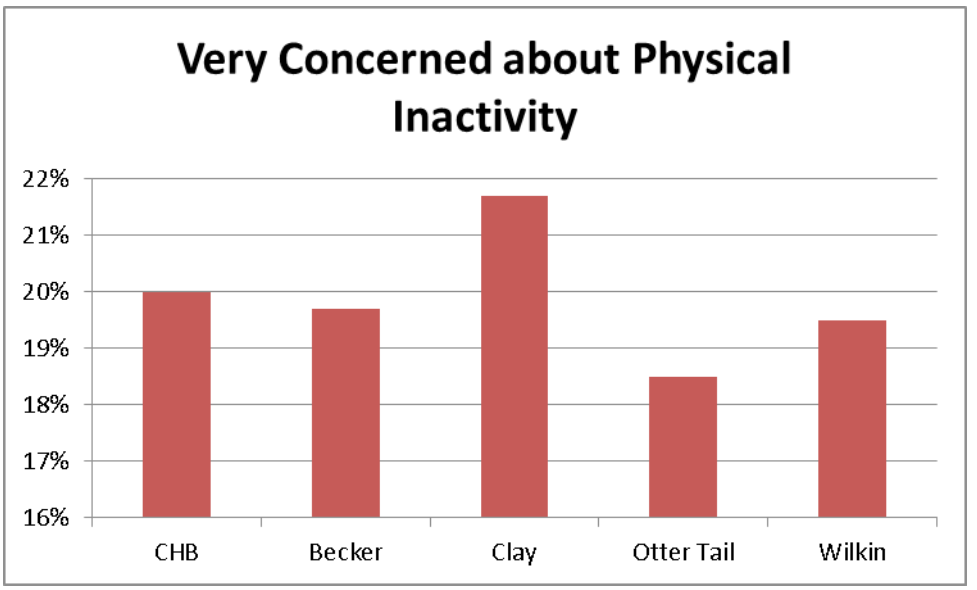


Figure 2.3

Though there was little concern of physical inactivity identified by the survey (see Figure 2.3), the County Health Rankings identified that approximately 20% of Minnesotans over age 20 reported no leisure time physical activity. Unfortunately, these rates were even higher among the CHB, ranging from 22 to 26% and concern was lowest among counties with the highest rates of physical inactivity. Like schools, worksites offer an ideal place to create a culture of wellness, due to the amount of time that adults spend at their place of employment. These changes not only benefit the health of the employee, but also the employer through decreased absenteeism and increased productivity.

Community Health Needs Assessment survey findings revealed the following self-reported healthy behaviors:

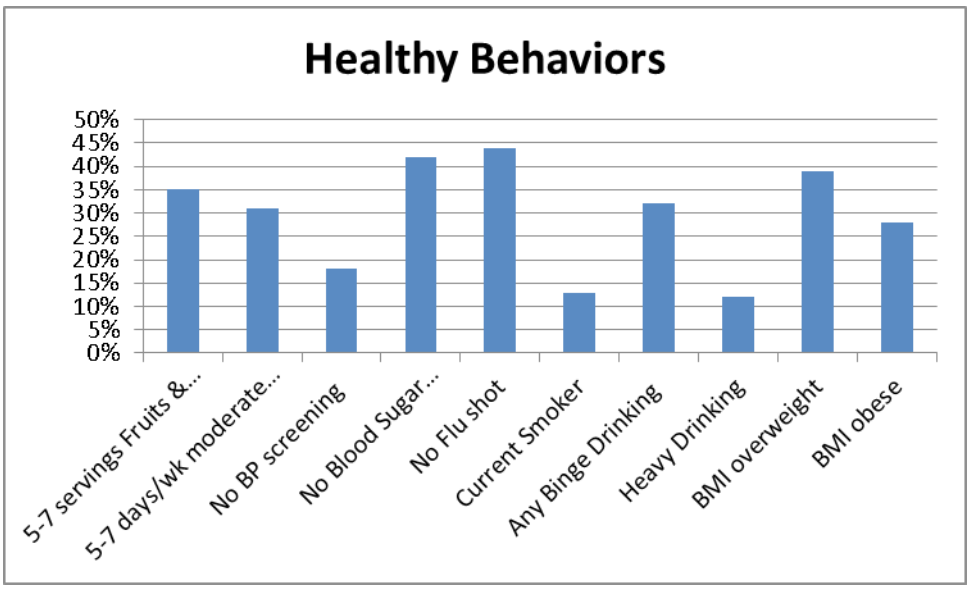


Figure 2.4

OBESITY STRATEGY

1. Include Community Wellness in strategic and operational plans.
2. Continue Wellness Committee work and sub-committee work.
3. Continue to offer classes to community members through Phatty Natty's, a group exercise program supported by LRH.
4. Increase CrossFit group class participation.
5. Develop a sustainability plan for the Lifestyle Medicine Program.
    a. Include concrete pre/post assessment.
    b. Increase physician involvement – currently 21 physicians involved.
    c. Obtain EIM (exercise in medicine) certification which will enable wellness services to be reimbursable and enhance sustainability of the wellness effort.
6. Increase youth participation in the Pebble Lake Youth Triathlon.
7. Develop process for scheduling annual diabetic check-ups.
8. Increase the number of healthful menu items in the cafeteria by implementing the action plan for "Putting Health on the Menu".
9. Use Child Nutrition Program standards to identify and begin offering more low/no –sugar drink options in vending.
10. Continue to evaluate our menus and services and implement a Healthy Food Initiative at LRH.
11. Provide group education at Cardiac Rehab once per month.
12. Evaluate the need for increased dietitian hours for Lifestyle Medicine and Cancer Center outpatient nutrition counseling.
13. Implement a healthy catering policy.
14. Support employee weight management goals and reduce risk of development of Type II Diabetes.
    a. Offer Diabetes Prevention Program to employees and spouses.
    b. Offer on-site Wellness Workshops.
15. Continue community garden, "Lake Region Takes Root" campaign (8000 lbs of food was produced the 2015 growing season which serviced 3500 people).
    a. Recruit a minimum of 20 volunteer groups during the 2016 and 2017 growing season.
    b. Develop a system for growing and distributing cut flowers from the garden to LRH patients and departments.
    c. Continue to provide produce to food shelves, WIC program, Salvation Army & A Place to Belong.

OBESITY STRATEGY - CONTINUED

16. Continue participation in community wide Healthy Restaurants initiative through the county and expand participation.
17. Continue the Streets Alive initiative.
18. Expand the number of bike friendly businesses.
19. Complete the Fergus Falls loop of North Country Trail.
20. Increase the number of teams participating in the Corporate Cup.
21. Continue Living Well Education Series for community.
22. Continue the Community Paramedic program which includes home visits, health assessments and screenings. As part of their routine screenings the Community Paramedics provide one on one education with the patient directly within their home about weight management, including techniques such as diet adjustment (including health food choices) exercise programs and resources within the community.
23. Expand PAD program that includes a walking program, a referral to lifestyle medicine program and strength training.
24. Develop a nutrition counseling program that offers counseling packages, similar to the personal training packages so that the general public is able to purchase and engage in these sessions as needed. Currently, nutrition counseling is only provided if referred by a physician.
25. Continue partnering with the PartnerSHIP 4 Health projects to "make the healthy choice the easy Choice" by working with worksites, healthcare, schools and communities to implement policies, systems and environmental changes.
26. Continue participation in the Live Well Fergus Falls Committee within the Forward Fergus Falls Initiative.
27. Continue numerous community active events; Lake Region run, Pebble Lake Youth Triathlon, Corporate Cup, Fergus Falls Race Series, etc.
28. Expand and grow the "I Can Prevent Diabetes Program" (ICPD) which focuses on the prevention of diabetes and the importance of diagnosing pre-diabetes. This is a 24 session lifestyle program that spans over one year period.
    a. Obtain CDC accreditation of the ICPD program

MENTAL HEALTH

The survey showed that 21% of the service area is affected by depression, with rates ranging from 17 to 25% within specific counties (See Figure 3.1). These statistics are a bit alarming, when considering that the National Health and Nutrition Examination Survey found that between 2009 and 2012, approximately 7.6% of Americans over age 12 had depression (CDC, 2015). These rates are more similar to those of Minnesota in 2011, when over 8% of Minnesotans experienced significant depressive systems (MDH, 2012). With these rates so significantly different, more specific data may be collected to determine similarities of question bases used to obtain these results. However, the number of poor mental health days reported, in the last 30 days and collected by the County Health Rankings, for Minnesota was 2.9 and the group of four counties ranged from 2.7 to 2.9 (2016).

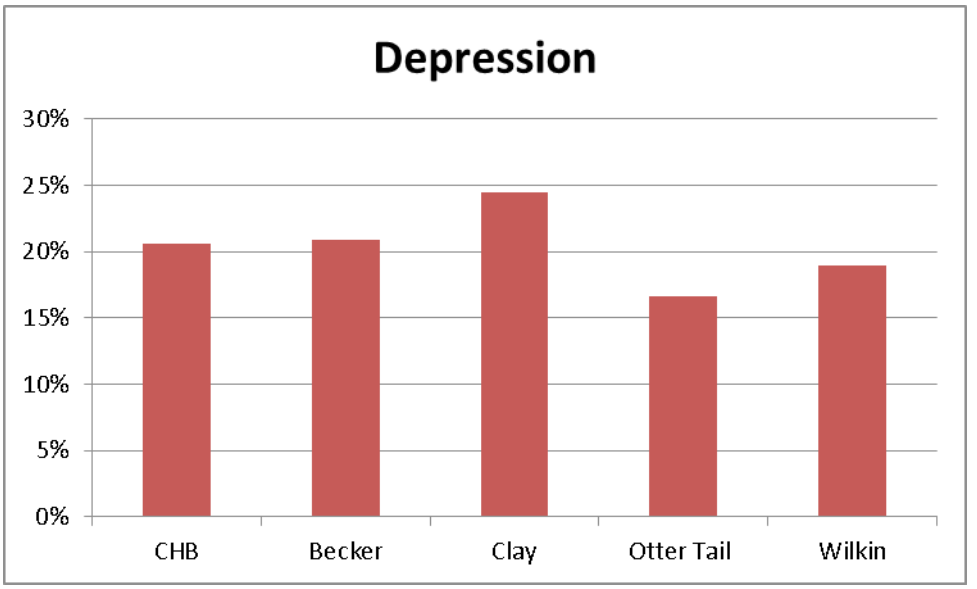


Figure 3.1

With rates seemingly high compared to state and national rates, there didn't seem to be significant concern of depression and consequent suicide (See Figure 3.2 and 3.3). Overall, throughout the service area, only 17% of the population was 'very concerned' about depression while 15% were 'very concerned' about suicide rates.

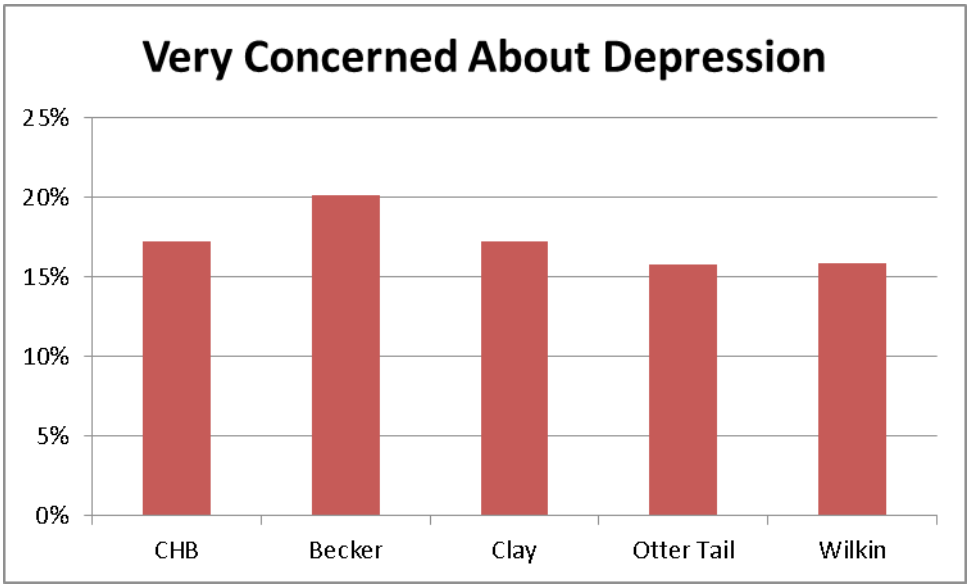


Figure 3.2

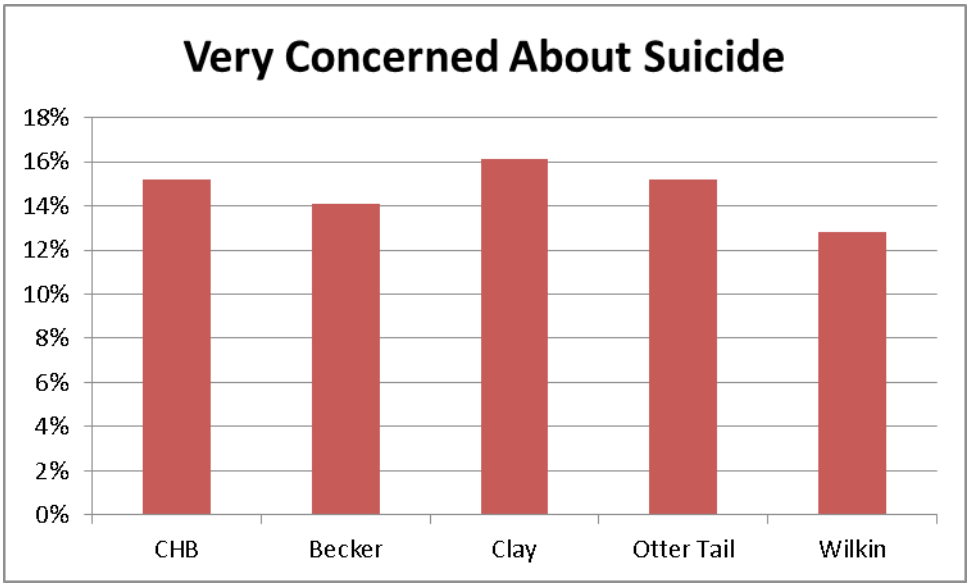


Figure 3.3

In 2014, suicide was the 8th leading cause of death within Minnesota, claiming 683 lives (MDH, 2014). Causes of death ranking ahead of suicide included cancer, heart disease, stroke and other chronic illnesses (MDH, 2014).

Another statistic to consider is the number of mental health providers within the specific counties. Throughout the state, there is an overall ratio of population to provider of 490:1 (County Health Rankings, 2016). This rate is similar to that of Clay County (450:1) and Wilkin County (590:1), however Becker County and Otter Tail County are experiencing a different disparity with rates at 760:1 and 990:1, respectively (County Health Rankings, 2016). As depicted from the survey that was conducted, this was of little concern of the residents within the service area (See Figure 3.4).

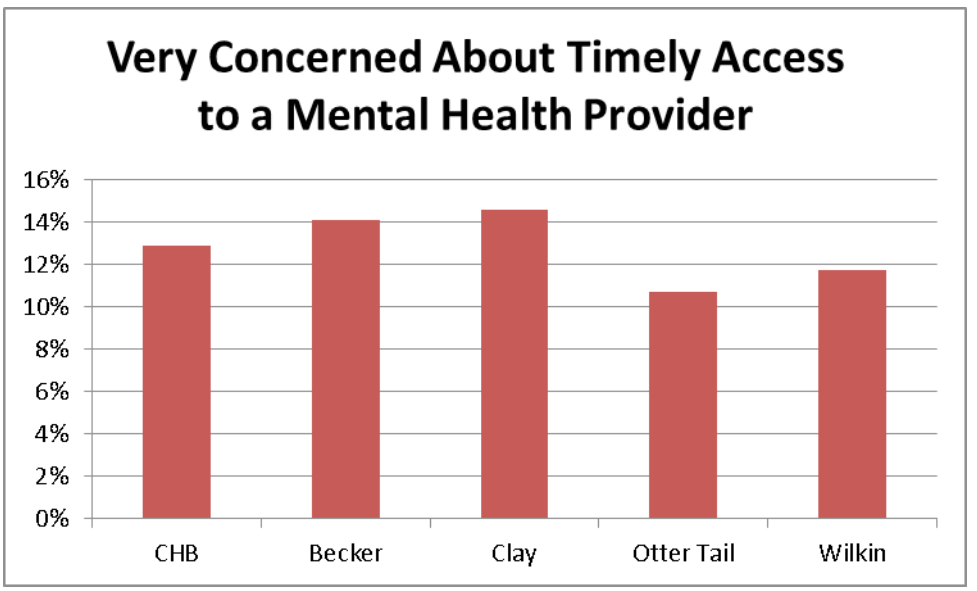
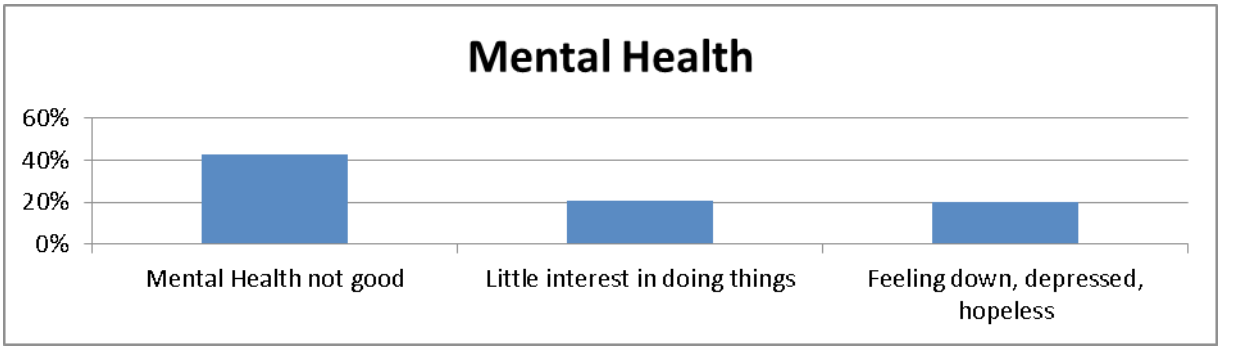


Figure 3.4

Community Health Needs Assessment survey findings revealed the following self-reported mental health findings:



MENTAL HEALTH STRATEGY

1. Continue the Community Paramedic program which includes home visits, health assessments and screenings. As part of their routine screenings the Community Paramedics perform mental status checks and home and safety checks and if concerns are noted communications is made with the primary care provider or the care coordinator.
2. Continue partnering with Lakeland Mental Health Center, Behavioral Health Care Home and Otter Tail Public Health to improve care coordination for persons with co-morbidities of chronic health conditions and behavioral health conditions. This is done through a Community Care Coordination Model that is in the early stages of being implemented. In the past, patients may have received care coordination for their chronic health conditions with exception to their behavioral health issues. Care Coordination for both health aspects can now be coordinated. (See Appendix A for Community Care Coordination Model)
3. Improve access to services for persons in need of detoxification services.

ADVERSE CHILDHOOD EVENTS

The last priority identified by Partnership4Health Community Health Board was Adverse Childhood Events. As defined by the Minnesota Department of Health, "an adverse childhood experience (ACE) describes a traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult (2013)." Different types of ACES include physical, sexual, or emotional abuse, mental illness of a household member, alcoholism of a household member, drug use by a household member, divorce or separation of a parent, domestic violence towards a parent, and incarceration of a household member (MDH, 2013). Over half (55%) of Minnesotans responding to a survey conducted by the Minnesota Department of Health, experienced at least on ACE in their childhood (MDH, 2013).

Through the survey that was conducted throughout the service area, it was identified that nearly 25% of the CHB as a whole is very concerned about child abuse and neglect, with rates lower in Otter Tail County, slightly higher in Clay and Wilkin Counties, and higher yet within Becker County (See Figure 4.1).

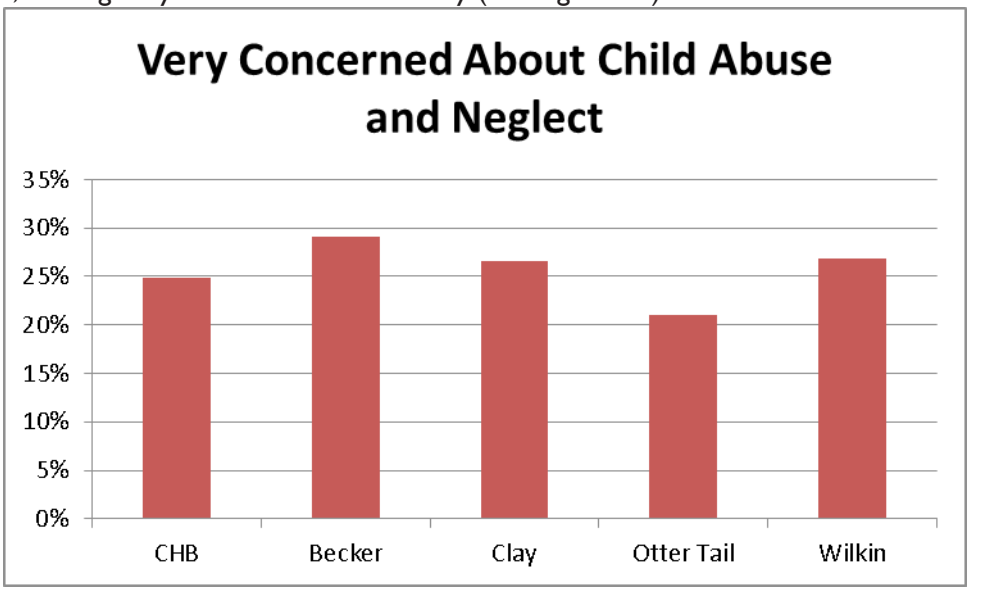


Figure 4.1

Those experiencing one ACE are more likely to experience others, and as the number of ACES increases, so does the risk for subsequent health problems as an adult (MDH, 2013). Figure 4.2 below, created by the Minnesota Department of Health shows the linkage between the number of ACES and subsequent chronic illness as an adult.

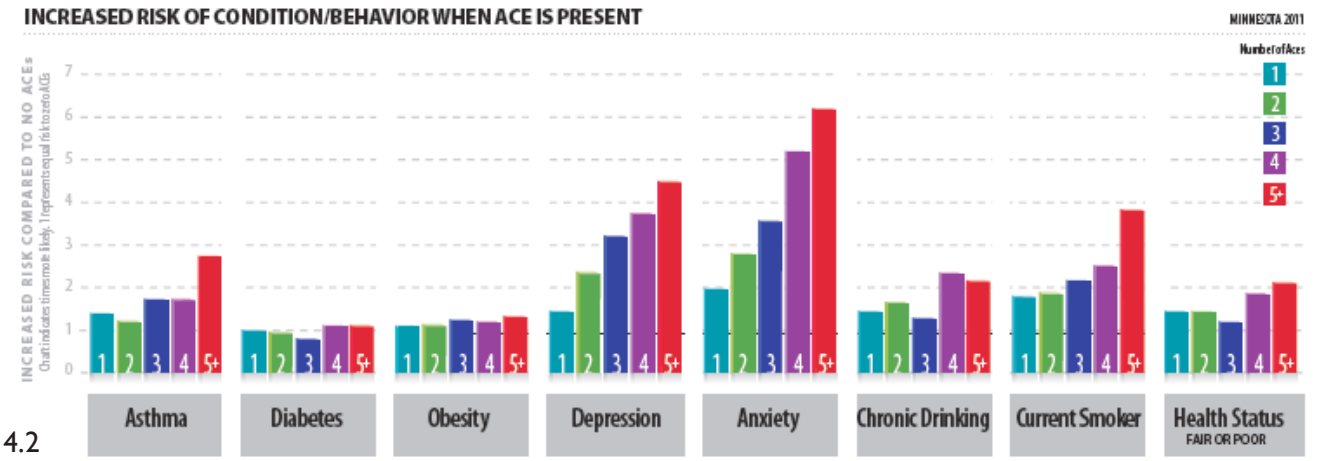


Figure 4.2

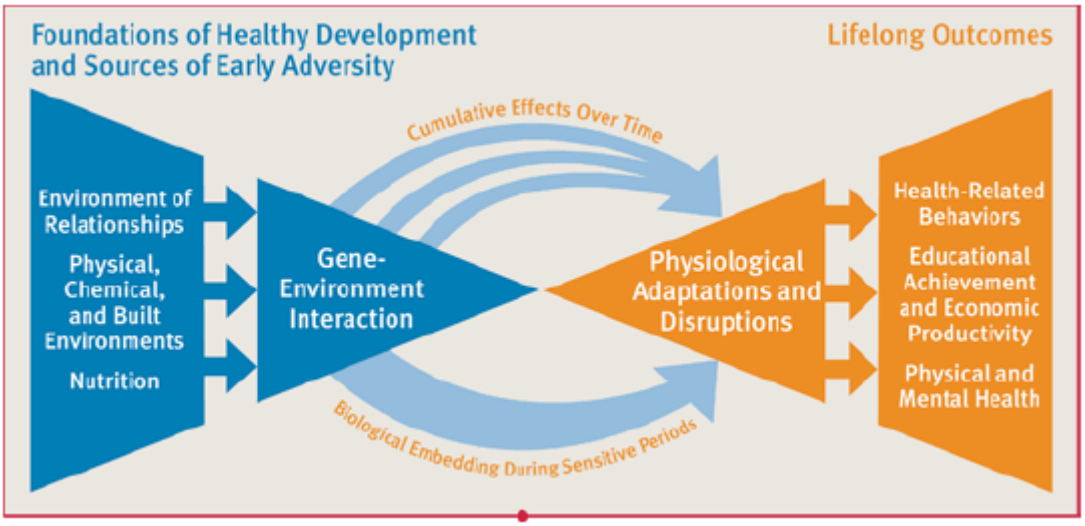


Figure 4.3

ADVERSE CHILDHOOD EVENTS STRATEGY

1. Through the Minnesota ACE Study a few strategies to reduce and build resiliency to ACES have been identified. These include:
    a. Increasing awareness of ACES and their impact on health through developing a language and working with education, welfare, healthcare, and other public systems.
    b. Help communities develop ways to prevent and respond to ACES.
    c. Continue to collect data on ACES and health outcomes by designating funds for research.

    Counties within the service area are working with these strategies by striving to become accredited sites of Healthy Families America, which is an evidence based home visiting model. Becker County has had their site visit for accreditation while the Clay, Otter Tail, and Wilkin Counties site visit is scheduled for July 2017. Goals of Healthy Families America include reducing child maltreatment, improving parent-child interactions and children's social-emotional well-being, and promoting children's school readiness (DHHS, 2013). Weekly home visits begin prenatally or within the first three months of the child's life and continue until they are 5 years old (DHHS, 2013). Activities and information offered during the visits are tailored to fit the specific needs of parents and children (DHSS, 2013).

2. Lake Region Healthcare women's health services will collaborate with the county programs to provide referrals to the Nurse Family Partnership and Health Families America.

3. Lake Region Healthcare pediatric services and the county programs will collaborate with the school system to make referrals to the Help Me Grow Program for children to access early childhood family education.

CHRONIC DISEASE MANAGEMENT *(with an emphasis on hypertension and diseases associated with high cholesterol such as coronary heart disease, stroke, peripheral vascular disease and diabetes)*

Chronic diseases and chronic conditions are those which persist over a long period of time, from months to years. These diseases are among the leading causes of death and years of potential life lost in Minnesota and also contribute significantly to long-term disability and poor quality of life. Examples of common chronic disease and conditions include: Alzheimer's disease, arthritis, obesity, asthma, chronic obstructive pulmonary disease, heart disease and stroke, diabetes, mental illnesses, and cancer.

Community Health Needs Assessment survey findings revealed the following self-reported chronic health conditions:

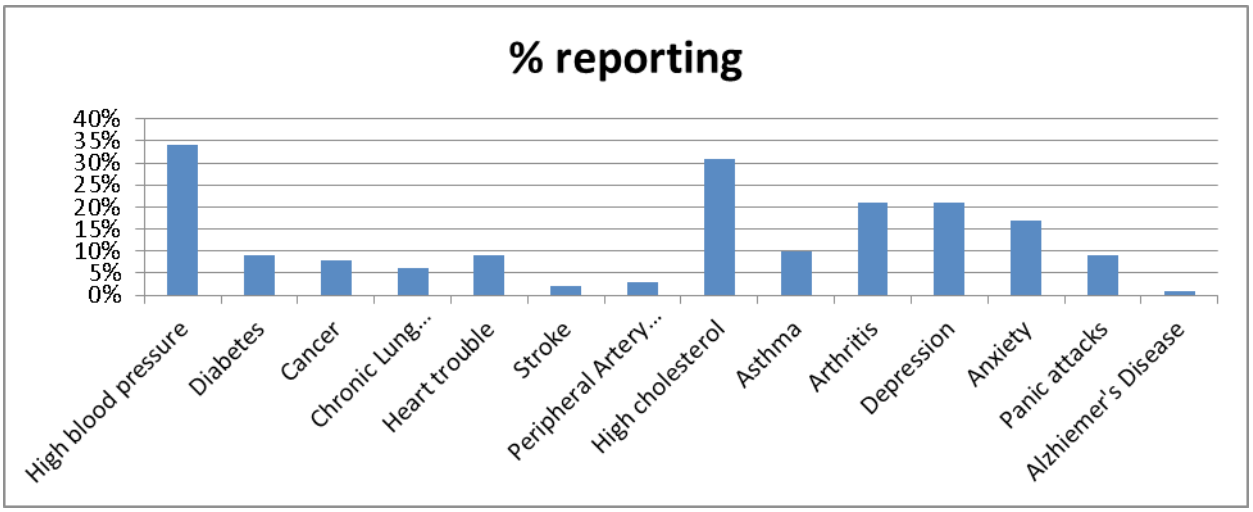


Figure 5.1

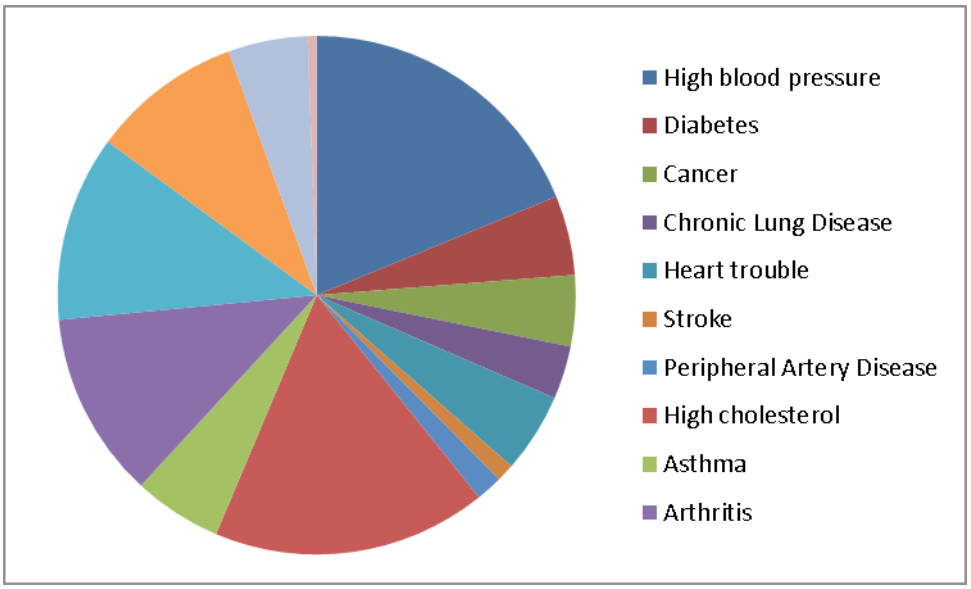


Figure 5.2

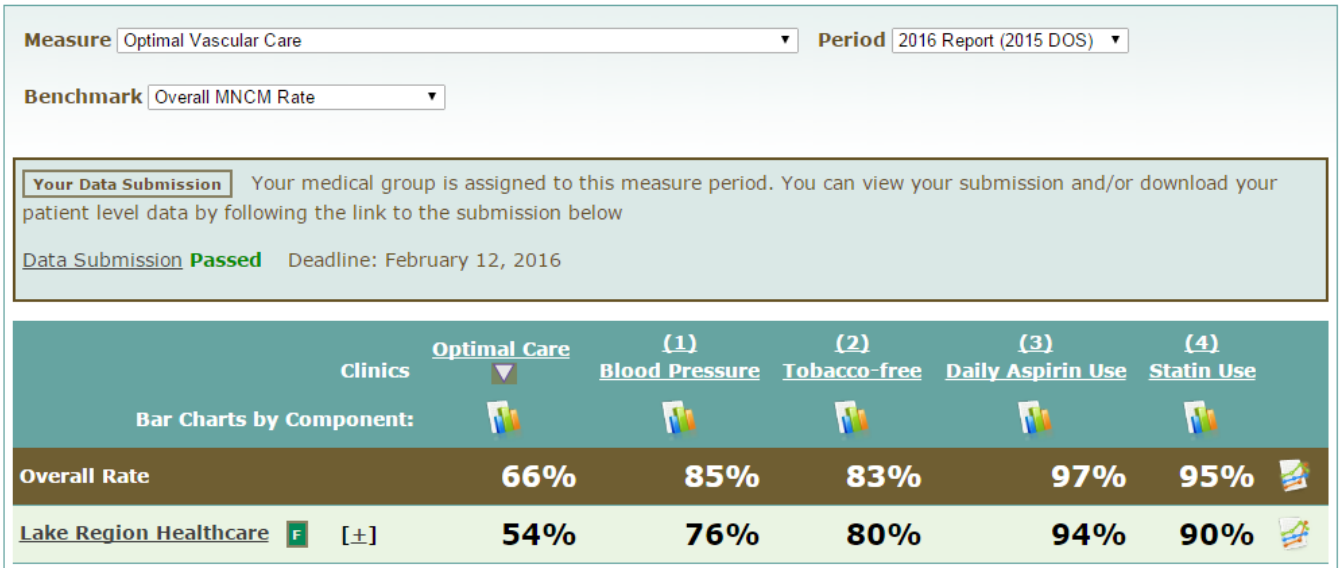


Figure 5.3

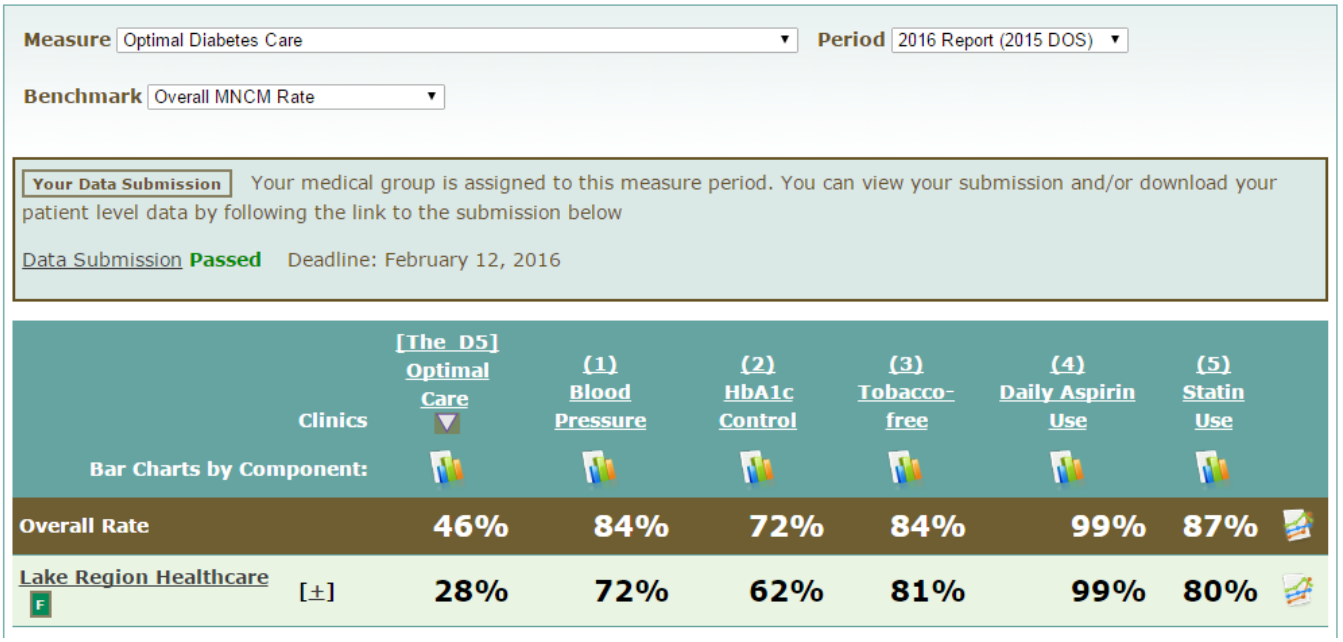


Figure 5.4

CHRONIC DISEASE MANAGEMENT STRATEGY

1. Promote the Community Paramedic program. Licensed by the State of Minnesota as CMPAs, these are experienced personnel with at least 5 years' experience as paramedics. MPAs have completed a specialized training course and completed 195 clinical hours in chronic disease management, psychiatry and healthcare access coordination techniques to develop a care plans for each individual patient. There is an emphasis on patients with cardiovascular and diabetic conditions.

2. Continue our efforts to improve our performance with the Minnesota Community Measures.

3. Continue the Medical Home Care Coordination program. The medical home care coordination program is certified through the State of Minnesota; this registered nurse run program focuses on the needs of the patient. The Medical Home acts a team member within the patients care team; the Care Coordinator supports quality patient and family-centered care principles. The Care Coordinator acts to support both the patients/family and the healthcare team through performing a variety of high level functions. The Medical Home is required to re-certify every 3 years through the State of Minnesota. During this process the program is evaluated for areas of both strengths and weakness, including areas and recommendations for improvement. Patient care audits are performed and evaluated as well. The Care Coordinator is required to participate in annual training at the Health Care Homes and State Innovation Model Learning Days Conference.

Services Provided:

a. Coordinates care efforts for a safe, effective, efficient and patient centered transition along the health continuum.
b. Provides pro-active disease management- including referrals to appropriate resources both internally and externally within the community.
c. Promotes and encourages patient/ family- centered care.
d. Develops (with patient/family assistance) jointly determined health care goals/ priorities with the creation of an individualized care plan.
e. Serves as an educator to the patient and their family.
f. Assists with arranging follow up appointments with their primary care providers as well as specialty care providers.
g. Attends appointments per patient request, to act as a neutral party and second set of ears. Also act as a patient advocate to ensure all of patient's concerns are addressed.

Priority Being Met:

Opioid Epidemic- Care Coordination also performs medication and medical condition review. During each of the patient's appointments with their providers, patients are provided with a list of current documented medications and asked to review and notify of any changes. Patients are notified by Care Coordination of the availability to destroy old medications they are no longer taking or that are expired, thus decreasing the availability of medications from the community.

Obesity (health lifestyle behaviors)- Care Coordination coordinates with dietary educators within Lake Region as well as the Community Paramedic in assisting patients with education about making healthy lifestyle food choices. Care Coordination is able to attend appointments with patients visiting with the educators and provides further support between appointment with patients by developing patient specific goals and care plans to assist them.

Mental Health- Numerous patients within the Care Coordination program have mental health diagnoses. Coordinating with the providers within the behavioral health unit at LRH, Care Coordination can act as the central door within the clinic providing easier access to the patient's mental health providers. The patients care coordinator is able to speak directly with the patient's mental health providers and update them on any changes or issues their patients may be having. Care Coordination once again is able to attend mental health appointments at patients request and help ensure

that patient is following the plan of care as constructed by the patient and their provider.

Chronic Health Conditions (specifically high blood pressure, high cholesterol) - With Care Coordination the focus is on chronic health conditions. Care Coordination is able to provide education on chronic disease diagnosis, treatment options, typical disease progression and future planning for ongoing care. The Coordination Program is also able to perform medication reconciliations and education on why medications are needed and refer patients to the medication therapy management program within our pharmacy department. Another service to assist patients with chronic diseases is decreasing unnecessary testing and care through timing the scheduling of all recommended preventative care services. Patients also have access to their health care team 24 hours a day, 7 days a week.

Program Goal:
The goal of Lake Region's Medical Home Care Coordination Program is to ensure the best care for our patients through the following strategies; education, medication reconciliation, decreasing unnecessary testing, improved communication, increased access, and creation of a comprehensive care plan. Working together with our patients we are able to improve their health and satisfaction and decrease cost.

4. Evaluate discharge planning activities and make adjustments to align with the required IMPACT Act requirements. These requirements include:
   - Beginning discharge planning at the time of admission
   - Discharge planning is a joint effort between the patient/patient rep, physician/provider & interdisciplinary team
   - Evaluation of readmission risk potential
   - Individualized discharge instructions
   - Care plan development with goal development and achievement
   - Working with community partners for transition of care coordination
   - Care Coordination and Community Paramedic referral for patients deemed as high risk for readmission
   - Proactive planning for post discharge needs
   - Utilization of Advanced Care Planning and Palliative Care

5. Continue and expand The Advance Care Planning/Healthy Conversations process. This process supports people with chronic health conditions by discussing what their preferred medical choices would be, in the event they were in a situation where they could not speak for themselves. This involves a thoughtful process where the patient chooses one or more health care agents who would know of the patient's wishes through dialogue, and by having a written document on a legal Health Care Directive form. These forms are also scanned into each patient's medical chart. At this time, Lake Region and its service area has at least 37 Advance Care Planning facilitators, who were trained using the Honoring Choices MN model. Several events and presentations have been taking place in Fergus Falls and the surrounding area to promote awareness/education about advance care planning.

   The impact and benefits of advance care planning conversations and completed Health Care Directives include more informed patient decisions that are supported/better understood by loved ones, fewer hospital re-admissions, less ICU days, and earlier selection of hospice care. Recently, nurses who meet with patients for their initial Medicare visits at both Lake Region and Prairie Ridge clinics became certified advance care planning facilitators. Efforts have also been made to bridge the gap between long term care facilities and the hospital so that completed health care directives and/or POLST forms (Provider's Orders for Life Sustaining Treatment) are readily available in records both at the long term care facilities and at Lake Region Healthcare.

6. Continue the expansion of Medicare Wellness Visits. This program is designed to detect illness and focus on disease prevention. It is offered to patients who have enrolled in Medicare Part B. It is a 30-60 minute one-on-one visit with a skilled wellness nurse to develop a personal prevention plan for the patient. Services provided include Height, weight and BMI calculation; blood pressure, pulse O2 stats exam; review of medical family and social history; detection of any cogitative impairment; vision and hearing screen; establishment of a list of current providers involved in patient's care; review of functional ability and level of safety; health education and preventive counseling; advanced care planning and a written screening schedule for the next 5-10 years.

7. Expand and grow the "I Can Prevent Diabetes Program (ICPD) which focuses on the prevention of diabetes and the importance of diagnosing pre-diabetes. This is a 24 session lifestyle program that spans over a one year period.
   a. Obtain CDC accreditation of the ICPD program.

8. Continue partnering with Otter Tail Public Health and other community stakeholders to implement the following programs:
   - Integrated Health Partnership for persons enrolled in Medical Assistance.
   - Minnesota Rural ACO for persons enrolled in Medicare.
   - Accountable Communities for Health to improve community care coordination; implement population health programming to promote preventive health care and person centered engagement to promote self-management of chronic conditions.

   LRHC is participating in value-based care initiatives for its Medicare and Medical Assistance patients through the Minnesota Rural Accountable Care Organization (ACO) and the Minnesota Integrated Health Partnerships (IHP) demonstration. In these value-based models, providers and hospitals are paid based on quality rather than the quantity of care they give patients, a departure from the traditional fee-for-service approach. Benefits of this approach include the delivery of a more efficient, comprehensive and cost effective care.

   Lake Region's efforts around these programs are focused around prevention and chronic disease management through the promotion of Annual Wellness Visits (AVWs), a Medicare program designed to detect illness and promote disease prevention, and increased referral into care coordination. Recently, a Wellness Nurse was hired to increase capacity and improve patients' access to AWVs. We also continue to analyze claims data for our Medicare and Medical Assistance population in combination with our Electronic Health Record data in order to identify high risk patients, such as those who are at risk of developing chronic conditions or abusing opioids, who may benefit from targeted interventions.

   Through its participation in these alternative payment and healthcare delivery models, Lake Region Healthcare aims to deliver higher quality and lower cost health care, and thus impact the four identified priority areas.

9. Expand and grow the Community Care Coordination model. As a certified healthcare home, Lake Region Healthcare plays a central role in this initiative. The Community Care Team (CCT) is a multidisciplinary care team that works collaboratively to provide medical and non-medical support, resources and education for individuals with chronic illnesses or those who need acute or post-acute care in their homes. The Fergus Falls CCT includes community paramedics and partners from mental health, long-term care, social services Public Health, Human Services and transportation. The team works collaboratively and collectively to provide patients the appropriate care they need, when they need it, which not only improves their health, but also helps avoid unnecessary hospitalizations (see Appendix A of the CHNA for the Community Care Coordination Model)

CONCLUSION

As a leading regional health care system, Lake Region Healthcare Corporation is committed to improving the health of the people and communities we serve. The process of conducting a Community Health Needs Assessment and developing implementation strategies has helped us to better understand the health care needs of our communities and the significant role we play in addressing those needs. In addition, this process has fostered more collaboration among the many community organizations that share our goal of improving the health of people in our region.

This implementation Strategy is a road map that will likely be revised and enhanced as we continue to address the pressing health issues facing our community.

We recognize that these issues are complex, inter-related and influenced by multiple factors. As a result, our strategies and activities address partnerships with key community collaborators. These long-term health issues will require sustained, coordinated approaches to achieve lasting improvement in the health of our community

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