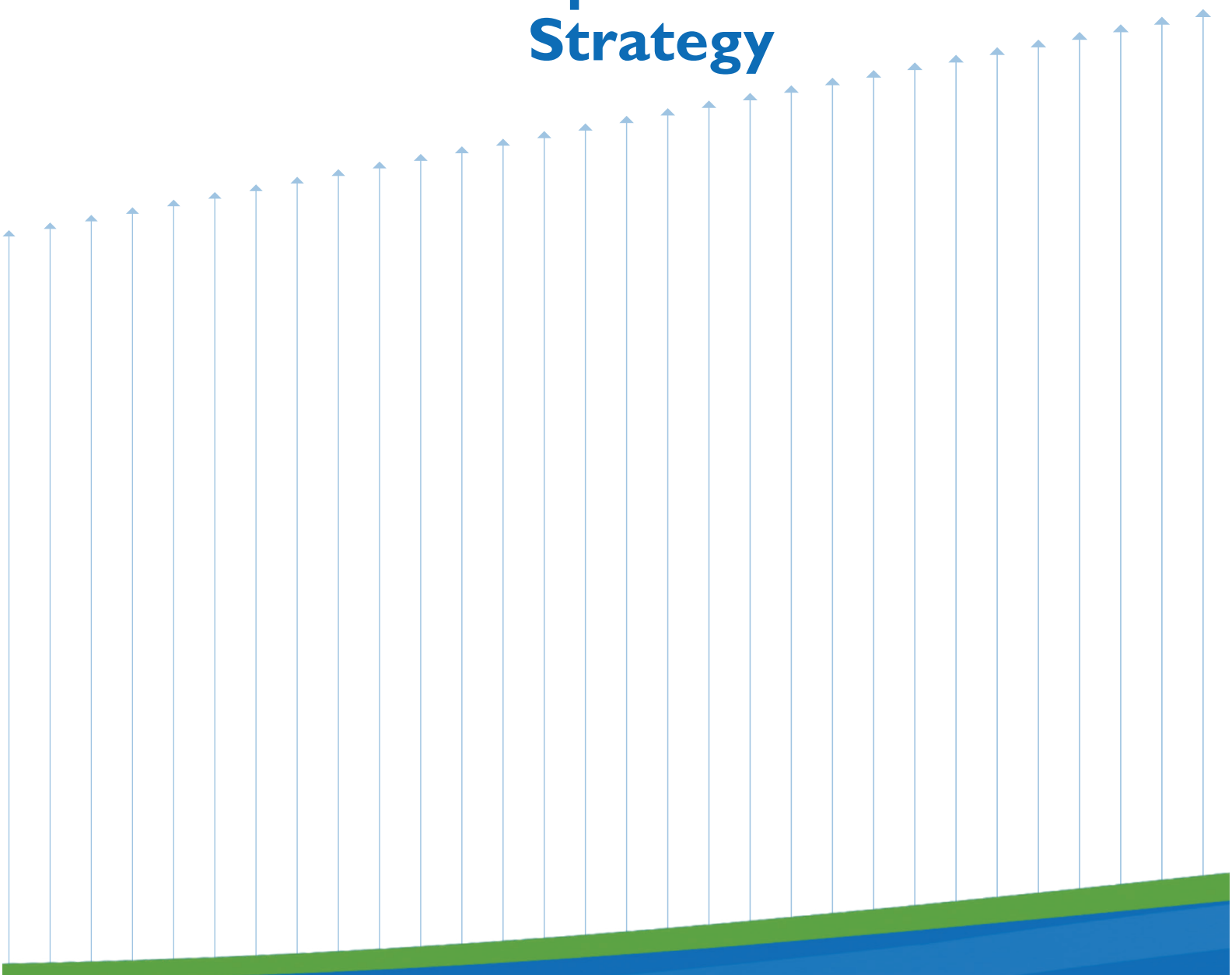
2013 Lake Region Healthcare Community Health Needs Assessment Implementation Strategy



Lake Region HEALTHCARE

Vision. Integrity. Award winning care.

IMPLEMENTATION STRATEGY

Lake Region Healthcare (LRH) has a long history of meeting the health needs of Otter Tail County. LRH's vision is to be 'Minnesota's preeminent regional healthcare partner.' LRH's aim is: 'Helping people in our region improve their health.' Collaboration with many local agencies will be the key to effectively understanding and meeting the health care needs of the people in our community. We are committed to working together to make a positive difference. Improving the health of people who live, work and vacation in this beautiful lakes area is our aim and our privilege.

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 Elbow Lake.

LRH is living our mission through the work and care that we deliver. This past year we received a HealthStrong Hospital Award and an 'A' in the Leapfrog safety rating. HealthStrong Hospital recipients are recognized for exceptional performance for factors such as outstanding quality and safety programs, loyal and satisfied patients, and efficient and appropriately priced service. We also continue to actively participate in the Minnesota Hospital Association's Patient Safety Initiatives. These awards and initiatives are a reflection of the dedication of our passionate staff. Our commitment to continuously improve our services for patients, and our community alike, brings us closer to our goals and vision. We continue to add medical staff and invest in cutting edge technology to meet our community's health care needs right here, close to home.

This implementation strategy summarizes the plans for LRH to sustain and develop new community wellness programs that will benefit our community by 1) addressing prioritized needs from the 2012-2013 Community Health Needs Assessment (CHNA) conducted by LRH in conjunction with Otter Tail Public Health and 2) responds to other identified community health needs identified by secondary data sources. LRH has chosen to utilize the term 'community wellness' as it promotes an active and proactive approach to meeting the health needs of the community.

TARGET AREA AND POPULATIONS

The core of our patients live in Otter Tail County. The total population of Otter Tail County is 57, 288, where the median age is 46.3 and 25% of residents are 62 or older. Males and females are evenly split and race is 96% white, 2.9% Hispanic or Latino, 1.0% African American, 0.6% American Indian, 0.5% Asian, and 0.1% Native Hawaiian or Pacific Islander. Median household income is $45,500, as compared to the statewide median income of $58,476. 10% of households are single parent householders and 9% of families in Otter Tail County have income below the poverty level. Of that 9%, over half of them are female householders with no husband present and with children under 5 years old. (U.S. Census).

Otter Tail County is also one of the few rural counties projected to see growth in population over the next 30 years. According to the state demographer's office, the number of households in Otter Tail County is projected to grow by nearly 15% from 2010 to 2040.

According to the U.S. Department of Health and Human Services, there are six medically underserved communities in Otter Tail County. These include: Battle Lake, Henning, New York Mills, Parkers Prairie, Perham and Pelican Rapids. These areas all fall within our primary and secondary service areas. These cities, along with Fergus Falls will be the main focus of our community wellness initiatives.

HOW THE IMPLEMENTATION STRATEGY WAS DEVELOPED

LRH's implementation strategy was developed based on the findings and priorities established by the collaborative CHNA that was conducted with Otter Tail Public Health, and a review of the hospital's existing community wellness activities.

LRH collaborated with Otter Tail Public Health to conduct a CHNA in 2012-2013. Focus groups were held to engage community members to identify community health needs. Finally, local, state and national data was analyzed to identify health needs of the service area. This information was presented to a collaborative community health team that is led by LRH. LRH developed detailed plans to address these community health needs. This plan will be monitored and evaluated on an ongoing basis by this collaborative team. A community wellness team was developed to establish goals and action plans related to identified community health needs. In addition, existing committees, positions and resources will be summarized that are currently meeting community health needs of our service area.

HOW PRIORITIES WERE ESTABLISHED

LRH set out to review the needs of our residents by reviewing both primary and secondary data of our target population. We partnered with our local Public Health department and Perham Health in conducting a Community Health Needs Assessment (CHNA), conducted waiting room surveys, and performed focused interviews with different populations around the county. Populations that are at risk and disparate were included in these interviews including low income, single parent, minority populations and other at risk populations. This data was termed primary data. Secondary data was obtained from local, state and national sources with more detail of this data described in the Community Health Needs Assessment.

LRH established a Community Health Needs Team (CHAT) to review the data from the CHNA, as well as primary data from local, state, and national sources as described in the CHNA. The members of the CHAT reviewed the data and prioritized identified needs. The needs were prioritized based on the seriousness of the issue, whether the health need particularly affected persons living in the poverty or reflected health disparities, whether the health needs align with Healthy People 2020 objectives, and availability of community resources to address the need. Each team member utilized these criteria to rank problems into a list of 10 priorities for the community. From this list of 10 priorities, the CHAT held further discussions to rank the needs into the top 5 health need priorities.

The data was compiled and brought forth to the CHAT team. This was a multidisciplinary team that was established to review the data and prioritize health needs. This team is comprised of hospital staff, hospital leadership, and community partners. Additional invitations are extended to other community partners and residents as needed to help the team identify barriers to access, identify effective solutions and provide resources to implement those solutions.

The CHAT identified the below list of community health problems from primary and secondary needs assessment data as priority items for the community:

1. Poor nutrition, lack of access to fresh fruit and vegetables
2. Obesity
3. Lack of specialized medicine (Cardiology)
4. Lack of community engagement and/or barriers to engaging the community
5. Substance abuse/Tobacco use
6. Decreased rates of well child and teen check ups
7. Increased rates of people with chronic health conditions
8. Increased rates of injury and fatalities related to misuse of alcohol and/or lack of seatbelts and helmets.
9. Lack of early identification of chronic health conditions
10. Increasing cancer rates
11. Difficulty navigating community services
12. Poverty/Socioeconomic disparities

MAJOR IDENTIFIED HEALTH NEEDS

From the list of identified health needs, the group prioritized the list of needs based on a voting method in which the needs were ranked from most important health need to less important health need. The group determined the priority of health needs by aligning needs with the mission, values and vision of LRH. The needs were assessed against current and future resources dedicated to these identified needs.

Of this list, LRH has prioritized health needs that we feel that we can address in the coming years these include:

1. Poor nutrition, lack of access to fresh fruit and vegetables.
2. Obesity
3. Increasing cancer rates
4. Increasing rates of people with chronic conditions
5. Increased rates of injury and fatality related to misuse of alcohol and lack of seat belt use.

DESCRIPTION OF WHAT LRH IS DOING AND WILL DO TO ADDRESS COMMUNITY NEEDS

LRH believes in being a good community partner by supporting various charitable causes throughout our service areas. We regard partnerships with nonprofit organizations as an important investment in the future of the communities we serve and the vitality of our organization.

LRH has a long history of being an active partner in supporting community needs. In 2012, we participated in and assisted with many community projects, festivals, educational programs, youth sports activities, local government, health programs and nonprofit organizations. Several thousand dollars were donated to local charitable causes and the hours contributed by LRH volunteers and representatives are virtually countless.

The following are a few of the causes supported in 2012 by LRH as a community-minded organization and by our employees through their "Together We Serve" committee efforts:

*Habitat for Humanity
*YMCA
*Local Sports Teams
*Local Sportmen's Clubs
*Local School Post Prom Events
*The Matthew House
*MS Walk
*MS Tram
*Local Park & Rec Services
*Local Education Foundation and Scholarship Programs
*Helmets for Kids
*Friends of Scouting
*Lakeland Hospice
*United Way of Otter Tail County
*A Center for the Arts
*Young Life
*Channel of Love Ministries
*The Salvation Army
*Toys for Tots
*Warm Coats for Warm Hearts

LRH has a history of providing leadership, financial support and volunteer support to meet the needs of our community members. A summary of Community Benefit Financials from numbers reported at cost from FY 2011 990 Schedule H:

Financial Assistance:	$1,438,622
Bad Debt Expense:	$1,207,806
Unreimbursed Medicare:	$7,500,000
Unreimbursed Medicaid:	$3,538,451

In additional to the CHAT, LRH has taken the lead in additional areas to promote community wellness and benefit. LRH has established and chairs a community wellness team to address identified community health needs related to obesity and lack of physical activity in the community. This committee is a multidisciplinary team that focuses on four main areas for our community: Physical Activity, Nutrition, Local Foods and worksite wellness.

LRH has an active role on the Forward Fergus Falls initiative looking to advance the community, health and safety of the residents of Fergus Falls. The goal of Forward Fergus Falls is to make Fergus Falls the 'healthiest city in Minnesota'.

In additional to community involvement and committees, LRH has hired and devoted resources for specific wellness activities and community benefit. LRH has a Wellness Coordinator that leads group fitness classes that are open to employees, as well as community members. LRH also has a Cancer Care and Research Center Wellness Coordinator dedicated to wellness services to enhance the treatment and recovery course for cancer patients, as well as chronic disease patients that utilize our services.

ACTION PLANS

An action plan was developed surrounding each identified health needs and other actions around community wellness activities. A description of methods to meet and/or sustain work already completed for each of the health needs is described below:

1. Establish Cost Center for Community Wellness Activities
    a. In fiscal year 2013 (starting October 1, 2012) – dedicated a cost center for community wellness activities.
    b. Budgeted operating and capital expenses for fiscal year 2014.

2. Include Community Wellness in Strategic and Operational Plans
    a. Board approved strategic initiative for 2013: Establish leadership role in area health business by implementing community health initiative. Implement at least three community wellness initiatives involving at least one other community partner implemented by December 31, 2013.
        i. This goal has been met through the Lake Region Takes Root project, Physical Activity education in local schools, Couch to 5K program and community nutrition programs.
    b. Established system's diagram detailing operational activities for LRH.
        i. Provide Wellness Services is a core conversion process of overall system's diagram of LRH.

3. Rising rates of obesity and declining physical activity
    a. LRH formed a community wellness committee to address community wellness needs. This committee meets 2-3 times per year as a large group. The committee has four sub-committees that focus on these key areas: physical activity, nutrition, local foods and worksite wellness. These committees meet ongoing throughout the year and report back to the large committee.
    b. LRH continues to lead several initiatives related to declining physical activity levels in the community these actions include:
        i. Plans to work with the city of Fergus Falls to install fitness routes on the campus of LRH as well as around a local walking path in Fergus Falls. This will include installing signs that instruct community members to engage in exercises along the walking routes. This provides community members a no cost option to exercise within Fergus Falls. There will be two routes located within Fergus Falls.
        ii. Currently partnering with Stratis Health on a Community Transformation Grant (CTG) related to identifying community resources related to exercise. This includes piloting identifying patients willing to meet with the wellness coordinator to determine activity goals.
        iii. Continue to offer classes to community members through Phatty Natties – a group exercise program supported by Lake Region Healthcare.
        iv. Expand group fitness classes to chronic disease groups and at-risk populations. Two athletic trainers will become certified in chronic disease groups in the fall of 2013 with plans to offer specific.
        v. Partner with Minnesota Community and Technical Collages in a Couch to 5K program.
        vi. Hold an annual 5K and Half Marathon race each year.
        vii. Planning to sponsor/lead a community challenge aimed at obesity and physical activity.

ACTION PLANS - CONTINUED

viii. Continued work aimed at worksite wellness.

ix. Developing a corporate wellness program to offer to area businesses lead by LRH athletic trainers.

x. LRH is applying to become a bicycle friendly business.

xi. Forward Fergus Falls has adopted these Healthy People 2020 goals for nutrition and weight status aimed at community wellness:

1. Increase the proportion of Americans who have access to a food retail outlet that sells a variety of foods that are encouraged by the Dietary Guidelines of Americans.
    a. Promote and create awareness of local and surrounding area Farmer's Markets.
2. Continue implementation and awareness of the Community Garden (Lake Region Takes Root).

xii. Forward Fergus Falls has adopted these Healthy People 2020 goals for physical activity aimed at community wellness:

1. Increase the proportion of trips made by walks
2. Increase the proportion of trips made by bicycling
3. Increase the number of people who regularly exercise
4. Poor nutrition, lack of access to fresh fruit and vegetables.
    a. Spring of 2013 planted a community garden with the motto of 'Lake Region Takes Root'. This is a community effort to combat rising obesity and lack of fresh fruits/vegetables in our community.
    b. The vision of the project: build a healthier population by engaging community partners to create a sustainable local food system that provides education for all ages and opportunities to increase access to fruit and vegetables.
    c. Lake Region provided land to establish the garden.
    d. The project will be a phased in approach with the focus of building the infrastructure over a 3 year period.
    e. Food will be donated to at-risk populations.
    f. In 2013:
        i. Prepared site – started soil amendments.
        ii. Installed water line and hydrants.
        iii. Erected storage shed for tools, supplies.
        iv. Planted orchard (fruit trees), erected fencing.
        v. Moved and constructed raised bed boxes. Planted raised beds with produce. Received donated beds from Fergus Falls Kennedy School.
        vi. Amassed a volunteer base and garden coordinator.
        vii. Constructed an educational pergola in the middle of the garden (donated and completed with assistance from Home Depot).
        viii. Working with local service groups on volunteers and money to sustain the project in conjunction with operating/capital money by LRH.
        ix. Weekly distribution of harvested produce to Women, Infant and Children recipients (WIC) coordinated in partnership with Otter Tail Public Health.
        x. Weekly distribution of harvested produce to local Food Shelf and other agencies as determined by amount of food produced.
    g. In 2014:
        i. Finish irrigation system.
        ii. Finish soil amendments.
        iii. Continued food production and distribution.
        iv. Continue recruitment of volunteers.
    h. In 2015:
        i. Establish a partnership with area schools and other facilities to promote educational offerings on gardening and food production/consumption.
        ii. Continued food production and distribution.
        iii. Expand reach to surrounding communities.

i. Reach of the project:
    i. WIC recipients are utilizing the garden an educational venue. These families come to the garden and learn how to garden, harvest and cook the produce. Produce is given to the families.
    ii. Produce is donated to local food shelf.
    iii. Produce is donated to other at risk populations – local group homes.

5. Increasing cancer rates.
    a. In 2010, opened a dedicated Cancer Care and Research Center (CCRC).
    b. Medical team dedicated to oncology and radiation oncology, which includes: 2 oncologists, 1 Radiation Oncologist and 1 Nurse Practitioner.
    c. Expanding outreach services to surrounding areas.
    d. Latest radiation therapy equipment. Until the CCRC was open, patients had to drive upwards of 60 miles to receive these treatments.
    e. Full infusion services administered by chemotherapy certified infusion nurses through the Oncology Nursing Society.
    f. Social services, patient navigator, and wellness coordinator dedicated to patient experiences during and after cancer care is received.
    g. Library of cancer resources for patients and their families.
    h. Positive Image Boutique with wigs, caps, shawls, pillows and other amenities made and donated by volunteers who have a gift for helping cancer patients.
    i. Expanding programs related to cancer prevention and general wellness.
    j. Redesigning and expansion of wellness programs offered to cancer and chronic disease patients. Programs to include:
        i. Yoga classes
        ii. Art Therapy
            1. Partner with local galleries and college to offer programs to patients.
        iii. Satellite Wellness programs to surrounding communities
        iv. Food for Your Health – series of educational offerings related to nutrition and cooking aimed chronic disease and cancer patients.
        v. I Can Cope courses.
        vi. General Cancer Support Groups.
        vii. Breast Cancer Support Groups.

6. Increasing rates of people with chronic conditions.
    a. LRH has instructors certified in courses related to Chronic Disease Self-Management courses.
    b. Offered three sessions in 2012 and two sessions in 2013 related to CDSM.
    c. Plans to continue offering CDSM courses in 2013 and 2014. Working with local healthcare providers to determine frequency and population.
    d. Right Side Up Falls Prevention Project. This is a program lead by Pharmacy that facilitates evaluation of medication and environmental factors and their potential impact on falling and safety in patient homes. Pharmacists go into the home of eligible community members and evaluate risk factors and recommend potential changes in environment and medication regimens.
    e. Golden Start Initiative. This initiative looks to coordinate increased rates of breast feeding in our community population. This is coordinated by a RN that promotes the importance of breast feeding. This program is coordinated with Otter Tail Public Health and PartnerSHIP 4 Health.
    f. Medication Management Therapy program. Eligible patients meet with clinical pharmacists to evaluate medication regimens. Education for patients on medications is provided.

ACTION PLANS - CONTINUED

g. Piloting programs related to obesity management and exercise. These programs are facilitated by athletic trainers who meet with patients and set goals related to activity. Medical providers determine willing participants at clinic visits and refer into the program.

h. Expand group fitness classes to chronic disease groups and at-risk populations. Two athletic trainers will become certified in chronic disease groups in the fall of 2013 with plans to offer specific courses aimed at populations that have chronic diseases and/or are at risk.

  i. Pilot program related to intensive obesity management in primary care clinics is being researched. This would be a multidisciplinary program that would include: a medical provider (managing medical treatment), dietician (coaching on nutrition elements), and a wellness coordinator (focusing on physical activity).

j. Pilot program in clinic services targeted at providing clinical information pulled from the electronic health record to providers that relates to MN Community Measures targeting Diabetes and Cardiovascular disease, as well as other chronic disease groups. This will allow providers to identify those patients that are not managed appropriately and format a treatment plan.

k. In Fall/Winter of 2013, starting planning process to obtain Health Care Home certification for clinic services to provide care coordination for patients with chronic health conditions.

7. Increased rates of injury and fatality related to misuse of alcohol and lack of seat belt use.

   a. Involved with the Otter Tail County Safe Community Coalition Advisory Board. LRH assists in promoting the prevention of drunk driving and increased seat belt usage which has been an identified concern in our community.

   b. LRH Emergency Department Director holds a seat on the Advisory Board which also has representatives from: Sheriff's department, local police department, Otter Tail County Public Health, County Attorney's office, Probation Court, MADD, other local healthcare agencies, EMS, and community members.

   c. Some examples of past and upcoming activities include:

      i. Drunk driving simulators at local high schools
      ii. Mock accidents
      iii. Community presentations on safety
      iv. Billboards related to misuse of alcohol and lack of seat belt use

NEXT STEPS FOR PRIORITIES

For each of the priority areas listed above, LRH will work with community wellness team and community partners to:

- Identify any related activities being conducted by others in the community that could be built upon.
- Develop measurable goals and objectives so that the effectiveness of their efforts can be measured.
- Build support for the initiatives within the community and among other health care providers.
- Develop detailed work plans.

PRIORITY NEEDS NOT BEING ADDRESSED AND THE REASONS

LRH has not chosen to directly include these needs in our implementation strategy. We see these needs as important and may continue to look at programs targeted at these needs.

1. Lack of specialized medicine (Cardiology).

   a. A more thorough assessment of ability to offer these services will be evaluated in the coming year(s).

2. Lack of community engagement and/or barriers to engaging the community.

   a. This is a larger issue that should be prioritized at the community level with all key stakeholders. LRH is willing to engage in discussions related to this topic.

3. Substance abuse/tobacco use.
   a. LRH will continue to work with community partners to do our part to help decrease rates of tobacco use and promote abstinence of illegal substances in the community.
   b. We will look to Public Health and PartnerSHIP 4 Health to take the lead in this work by identifying and educating the public on the importance of decreasing tobacco use and abstaining from illegal substances.
   c. LRH will internally educate patients and refer as appropriate as prior. All patients are screened for tobacco use at each clinic visit and hospital admission.
   d. LRH currently offers smoking cessation counseling. LRH is sending two employees to complete tobacco cessation specialist certification training in the fall of 2013 sponsored by PartnerSHIP 4 Health.

4. Decreased rates of well child and teen check-ups.
   a. LRH will continue to work with community partners to do our part in helping increase well child and teen check-ups.
   b. LRH currently offers well child and teen check-ups within clinic services.
   c. We will look to Otter Tail Social Services and Public Health to identify and educate the public on the importance of these check-ups.
   d. LRH will internally educate patients.

5. Lack of early identification of chronic health conditions.
   a. LRH will continue to encourage yearly exams for identification of chronic health conditions.
   b. Continue to work with Public Health for identifying and educating the public on chronic health conditions.
   c. Current marketing plan is aimed at encouraging patients to establish care with a primary care provider.
   d. Opened a Walk-In-Clinic in 2012 to provide extended hours and no-appointment access for patients.

6. Difficulty navigating community services.
   a. LRH will continue to work with community partners to do our part in helping our community understand services offered in the area.
   b. We will look to Otter Tail Social Services and Public Health to help coordinate and communicate additional community services.
   c. LRH will continue to provide assistance to help patients navigate internal services, as well as educate patients on community resources.

7. Poverty/Socioeconomic disparities.
   a. This is a larger issue that should be prioritized at the community level with all key stakeholders. LRH is willing to engage in discussions related to this topic.

APPROVAL

Each year at their September meeting, the LRH Board of Trustees, which includes representatives from the surrounding service area, will approve the Community Wellness Implementation Strategy for addressing priorities identified in the most recent Community Health Needs Assessment and other plans for community benefit. This report was prepared for the September, 2013 meeting of the Board of Trustees.

LRH Board of Trustees approval:

_____
By Name and Title

_____
Date

Lake Region
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