CarrisHealth

2018 - 2019

Community Health Needs Assessment

Assessment Summary

Carris Health

Carris Health was created in January 2018 as a partnership between Willmar's Rice Memorial Hospital, ACMC Health and St. Cloud-based CentraCare Health. In January 2019, Redwood Area Hospital in Redwood Falls, Minn. and Family Practice Medical Center in Willmar, Minn. joined Carris Health. Carris Health is committed to strengthening health care in West Central and Southwest Minnesota by partnering with organizations that share the same passion for rural health care.

Carris Health serves people throughout West Central and Southwest Minnesota and is part of CentraCare Health, one of Minnesota's largest health systems and is a wholly owned subsidiary of CentraCare Health.

As a leading integrated health care provider in the region, Carris Health offers a full spectrum of inpatient and outpatient services in addition to long-term care services.

Birth Suites	Respiratory Therapy	Surgical Services
Dialysis	Rice Care Center & Therapy Suites	Willmar Diabetes Center
Emergency Services	Rice Home Medical	Willmar Regional Cancer Center
Imaging	Rice Hospice	Willmar Sleep Center
Laboratory	Rice Institute for Counseling and Mental Health	Willmar Surgery Center
Pediatrics	Rice Regional Dental Clinic	Wound + Ostomy + Continence
		Rice Rehabilitation Center

In addition to its full-spectrum inpatient and outpatient care, Carris Health strives to improve community health by implementing a diverse range of community benefit programs. Carris Health continues to evaluate and expand upon its role in promoting community health. Guiding this effort is the conviction that in order to advance the common good, special attention should be given to individuals who live at the margins of society – the poor and disadvantaged – and are more likely to encounter barriers to good health and wellness. This directive informs the organization's community benefit programs and the health needs assessment.

Project Overview

The Community Health Needs Assessment is a systematic, data driven approach to determining the health status, behaviors and needs of residents in the Carris Health Service Area. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness. Aligned with Carris Health's mission and fiscal strategy, the CHNA guides the organization to focus on community benefit activities that will support the needs of the most vulnerable and underserved populations

A Community Health Needs Assessment provides information so that communities and health systems may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. The CHNA provides a mechanism that allows stakeholders to understand not only current community resource gaps but also current disease etiology in addition to identifying and addressing broader determinants of health that are influencing outcomes of the population.

Affordable Care Act Mandate

Carris Health's Community Health Need Assessment and Action Plan, 2018-2019 was completed pursuant to the March 2010 mandate established by the Patient Protection and Affordable Care Act (PPACA). In order to qualify for status as nonprofit, tax-exempt hospitals under Internal Revenue Code section 501(r), Carris Health must "conduct a community health needs assessment (CHNA) and adopt [an] implementation strategy at least once every three years. (These CHNA requirements are effective for tax years beginning after March 23, 2012)."1 Compliance with this new regulation is reported to the Internal Revenue Service, which has issued guidelines on how assessments are to be documented.

In fiscal year 2018-2019, Carris Health completed a community health needs assessment which revealed six community health issues and proposed a comprehensive strategy to address each one of the six issues. Carris Health will reevaluate the community health needs in fiscal year 2022-2023 and adopt an action plan that will similarly promote community health in the subsequent three-year cycle. Above all, the assessment process has opened doors for greater collaboration among community partners by strengthening relationships and promoting a more efficient use of resources in monitoring and improving community health.

The CHNA Process

Conducting a health needs assessment is a multifaceted process that requires ample preparation, effective use of resources, sound methodology, and collaboration on behalf of all stakeholders. With that in mind, the assessment process was organized into five main phases, which were further broken down into a series of interconnected components:

- Formation of System-Wide Working Group and Definition of Service Areas
- Data Collection and Analysis (April-June 2018)
- Initial Prioritization (July-August 2018)
- Evaluation and Assessment of Community Members (September-October 2018)
- Final Prioritization (November-December 2018)

Although the process moved in this chronological order, the complexity of the assessment process necessitated a fluid movement between each phase. Indeed, key to a thorough and comprehensive assessment is the ability to examine and reexamine each component of the process in light of what is learned in later phases of assessment.

Carris Health's Systemic Approach

Carris Health takes pride in its level of involvement in the community and its receptiveness to the community's health care needs. Therefore, system administration considered it both reasonable and appropriate that staff and leaders within Carris Health be charged with the task of conducting the assessment, rather than contract with a third party removed from the community itself. An internal team called the CHNA Working Group was assembled, comprised of individuals with diverse knowledge and expertise in health care delivery, administration, planning and development, marketing, community and government relations, among other departments (see Figure 1). This group, which consists of individuals from across the Carris Health system, is indicative of the collaborative nature of the CHNA process and a testament, more generally, of the mutual support throughout the system. Additionally, hospital board members and executives were engaged in the assessment process at an early stage.

In the initial stages of data analysis and prioritization, all working group members were presented with data broken down by county in order to indicate most clearly those issues that were prevalent throughout the Carris Health service area and those issues unique to each Carris location. Furthermore, each member of the working group participated in the prioritization process so that the final set of community health needs might accurately reflect genuine issues that are prevalent within the broader Carris Health service area. An implementation strategy, specific to the needs of the corresponding service area was developed in response to the findings of the collaborative assessment process.

Figure 1. Community Health Needs Assessment Working Group, 2018-2019

Name	Title	Affiliation
Ann Stehn	Kandiyohi Public Health Director	Kandiyohi Public Health
Teri Beyer	Chief Quality Officer	Carris Health
David Borgert	Executive Director, Government & Community Relations	CentraCare Health
Caryn McGeary	Director, Population Health & Clinical Services	Carris Health
Jessica Vagle	Director, Adult Health Care/Care Management	Carris Health
Kelly Tauber	Director, Population Health & Virtual Health	Carris Health
Chery Johnson	Supervisor, Public Health	Kandiyohi Public Health
Denise Kragenbring	Supervisor, Public Health	Kandiyohi Public Health
Kristin Anderson	Kandiyohi SHIP Coordinator	Kandiyohi Public Health
Stacey Zondervan	Family Practice	Carris Health
Lynn Stier	Director, Performance Improvement Acute Care	Carris Health
Jennie Lippert	Kandiyohi Public Health Director	Kandiyohi Public Health
Santo Cruz	Executive Director, Government & Community Relations	CentraCare Health

Carris Health Service Area

CentraCare Health provides comprehensive, high quality care to people throughout Central Minnesota. Our network is comprised of:

- 25-bed critical access hospital (Redwood, Minn)
- 100-bed, Level 3 Trauma hospital (Willmar, Minn)
- 5 primary care clinics (New London, Litchfield, Redwood Falls, Willmar)
- 2 multi-specialty clinics (Willmar)
- 55-bed skilled nursing facility
- 23-unit short stay rehabilitation care facility

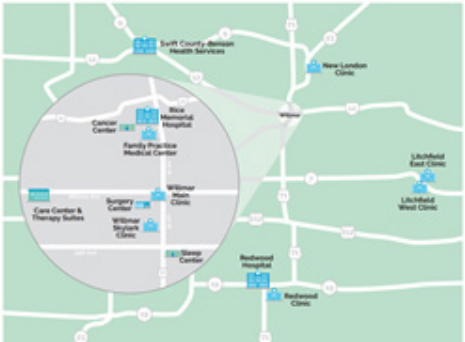

Figure 2. Carris Health Service Area

- Regional Cancer Center
- Regional Dental Clinic
- Sleep Center
- Rehabilitation Center
- Outpatient Surgery Center
- 8 Hospice Offices (Appleton, Benson, Dawson, Granite Falls, Montevideo, Ortonville/Graceville, Redwood Falls, Willmar)

Figure 3. Carris Health Primary Service Area Zip Codes

Zip Code	City	Service Area
56201	Willmar	Primary
56288	Spicer	Primary
56273	New London	Primary
56215	Benson	Primary
56209	Atwater	Primary
56222	Clara City	Primary
56282	Raymond	Primary
56251	Kandiyohi	Primary
56271	Murdock	Primary
56252	Kerkhoven	Primary
56279	Pennock	Primary

Methodology

An internal review of performance and outcome data using various reporting and data collection tools, in addition to the incorporation of community conversations led by the local health department supported the identification of the top health priorities that were determined to have the largest impact and potential for improvement on population health. These priority areas are as follows: Obesity, Depression, Tobacco, Diabetes, Opioid Use, and Cancer. Furthermore, the CHNA working committee elected to prioritize the strategies in which it would focus its efforts on during FY2019.

Initial Prioritization

In order to prioritize the health indicators that were identified, the CHNA Working Group evaluated a set of four ranking criteria to align priorities with community health objectives. The criteria that were used, and their corresponding description are listed below:

- Mission Relevancy: the health issue falls within the hospital's overall mission and core competencies
- Community Impact: the prevalence and severity of the health issue
- Resource Availability: the availability of Carris Health's time, human, and strategic resources necessary to address the issue
- Estimated Expense: the expense (both internal and external) of addressing the issue

The prioritization process itself was divided into the two stages. The first stage consisted in rating each health indicator according to mission relevancy alone. Each CHNA Working Group member was asked to respond, "Is each respective course of action relevant to Carris Health's mission and core competencies?" After a review of the responses to the survey, 6 priority areas were selected. The second stage of the process consisted in the prioritization of the 6 high priority areas according to community impact, resource availability, and estimated expenses.

These top six priority areas were reviewed in comparison to data gathered by Carris Health's on going, collaborative effort with Kandiyohi Public Health to complete their Health Needs Assessment. No data from the County Health Assessment contradicted the choice of the priorities from the Carris Health Community Health Needs Assessments. The collaboration between Carris Health and Kandiyohi Public Health strengthened the collective impact that

this group of health professionals recognize is needed in order to have sustainable impact on population health improvement.

Finally, the ranked issues were presented to Carris Health's operating committees, boards, medical staffs and leadership group for feedback and clarification. An Action Plan was developed to address the top priority health concerns that were identified by the CHNA working committee.

Priority Area: Obesity	
Goal: Kandiyohi and Renville counties will implement policies and processes that decrease the percentage of adults with BMI >= 30.	
ACTION PLAN	
Activity	**Anticipated Outcome or Result**
BMI EHR documentation/education workflow	Education, Support, Options for Weight Loss
Bariatric surgical education sessions	Group Education for Surgical Services
Pre-diabetes referral- track based on BMI	Screening and Prevention
BMI Weight Management Plan	Education and Awareness of available resources
Bariatric Data Monitoring Program	
ReYou Community Wellness Program	Community resource for wellness and prevention, public information
Well Child Participatory Guidance	Patients learn to identify risk and compilations as a result of physical inactivity and understand the importance of PA in child development
Vision 2040 Community Wellness Projects	Community resource for wellness and prevention
Foot Lake 4 Annual Event	Community event to support local physical activity resources
RESOURCES	
CDC: Overweight & Obesity	Overweight & Obesity | CDC Prevention Strategies & Guidelines | Overweight & Obesity | CDC
National Institutes of Health – Obesity	Obesity Health Problem, Healthy Weight Basics, NHLBI, NIH
Community Tool Box ~ Tools and Resources For building healthier communities ~	Community Tool Box

Priority Area: Depression	
Goal: Kandiyohi and Renville counties will implement policies and process to identify residents with depression and increase access to assistance.	
ACTION PLAN	
Activity	**Anticipated Outcome or Result**
PHQ-9 recheck 6 months after elevated- EHR task	Research-based guidelines with the goal of achieving a score of 8 or less to demonstrate effective remission
PHQ-2 screening, then PHQ-9 primary care visits	Standardized Care which will lead to early identification and management leading to minimizing risk of patients going untreated
BHH transition from medical home	Improved Access to BH provider. Resource for staff in screening and follow up care
ED Depression Screening Workflow	Standardized Care for early detection of depression
Woodland Centers/WMH After Hours Triage	Improve Access to BH provider
Willmar Cancer Center Screening Workflow	Team approach to treating depression – Improved management Through Collaboration, improve all aspects of cancer care
RESOURCES	
US Department of Health and Human Services Behavioral Health	Behavioral Health
Healthy People 2020	Mental Health and Mental Disorders | Healthy People 2020

Priority Area: Tobacco	
Goal: Kandiyohi and Renville counties will implement policies and process to decrease the percentage of adults who smoke.	
ACTION PLAN	
Activity	**Anticipated Outcome or Result**
Screening- every visit , tobacco user- education workflow	Standardization of care-Education, Screening, Awareness
PHARMD- referrals for tobacco cessation- medication and/or counseling – Willmar	Education, Support and Medication Therapy to successfully quit smoking
Patient Access to Quit Plan Resources	Education, Support and Programming options for Tobacco Cessation
Clinical Summary Resource Information	Patient Education/Awareness of Resources
Inpatient Screening Workflow and Referral Process	
Registry Monitoring for Patients with Chronic Conditions	Identification of patients with chronic condition likely to benefit from tobacco cessation outreach
RESOURCES	
CDC: Smoking & Tobacco Use	CDC - Fact Sheet - Quitting Smoking - Smoking & Tobacco Use
The guide to Community Preventive Services "What Works to Promote Health"	The Community Guide - Reducing Tobacco Use and Secondhand Smoke Exposure

Priority Area: Diabetes	
Goal: Kandiyohi and Renville counties will implement policies and processes that decrease the burden of diabetes and improve the well-being of those living with diabetes.	
ACTION PLAN	
Activity	**Anticipated Outcome or Result**
Pre-diabetes program referral	Standardized Care which will lead to decreased complications and improved blood sugar control
Registry/panel management	Identify and effectively manage diabetic patients attributed to clinic population
Kandiyohi Diabetes Coalition	Improve community engagement by connecting local resources and creating learning opportunities about available resources
Focus Project for Diabetic OB patients	
RESOURCES	
American Diabetes Association Diabetes Pro – Professional Resources Online	American Diabetes Association
CDC: Preventing Diabetes	Preventing Diabetes | Basics | Diabetes | CDC
The Guide to Community Preventive Services: Diabetes Prevention and Control	The Community Guide

Priority Area: Opioid Use	
Goal: Kandiyohi and Renville counties will implement processes that will decrease opioid dependence.	
ACTION PLAN	
Activity	**Anticipated Outcome or Result**
Education for prescribers on alternative meds to take the place of opioids.	Decreased number of opioid prescriptions overall and for high risk patients.
Enhancement of electronic health record to include monitoring of prescribing activity and electronic prompts for those prescribing opioids.	Key information available at time prescription documented.
Patient education including risks of opioid use and means of harm reduction. Brochure and 1:1 available.	Increased patient awareness of risks and alternative forms of treatment.
Controlled Substance Care Team	Leadership of community-wide task force. Review of prescribing practices. Medical treatment of opioid dependence. Partner with Lower Sioux Community to provide increased access to education and treatment.
RESOURCES	
Dr. Kurt DeVine & Dr. Heather Bell, Rural Opioid Program, Family Medical Center - Little Falls, MN	www.chistgabriels.com
Opioid Misuse in Rural America United States Department of Agriculture	www.usda.gov
Rural Opioid Federal Interagency Working Group Resource Guide	https://blog.ed.gov/2018/11/rural-opioid-federal-interagency

Priority Area: Cancer	
Goal: Via screening and health education, Kandiyohi and Renville counties will increase awareness of risk factors and the need for early intervention when diagnosed as well as available resources for care and support.	
ACTION PLAN	
Activity	**Anticipated Outcome or Result**
Member of MNCORC – MN Cancer Care Network	Through collaboration, improve all aspects of cancer care.
Colorectal Cancer Screening using Cologuard	Increase the number of patients screened for colon cancer.
Survivorship Program – Wide range of programs and services that enhance life throughout the cancer experience	Connect patients/former patients to resources and support.
You Are Not Alone support group	Trained volunteers facilitate discussion for this group of individuals diagnosed with cancer – any age, any stage
Girls' Night Out: Breast Cancer Screening	Increase number of women obtaining mammograms
Participant in the MN Department of Health Sage screening program. Provides free office visits for breast and cervical exams as well as screening mammograms and Pap smears for those eligible.	Screening and prevention.
RESOURCES	
American Cancer Society	American Cancer Society Information and Resources for Cancer: Breast, Lung, Colon, Prostate, Skin
National Cancer Institute – Cancer Prevention Overview for Health Professionals	Comprehensive Cancer Information – National Cancer Institute
CDC – National Comprehensive Cancer Control Program	CDC – Ongoing Work – National Comprehensive Cancer Control Program