Glencoe Regional Health Services

2016 COMMUNITY HEALTH NEEDS ASSESSMENT

Dear Community:

On behalf of the medical staff and employees at Glencoe Regional Health Services, I would like to extend our sincere thanks for the opportunity to care for you, your friends and your family over the years. Our mission at Glencoe Regional Health Services is to provide high quality, convenient and personal health care to those we serve. We do so by providing comprehensive, evidence-based, cost-effective health care services and education. We collaborate with others to coordinate and improve the health of our communities, and commit our skills and resources to benefit the whole person through all stages of life.

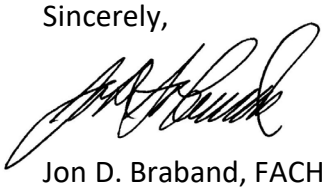
Glencoe Regional Health Services strives to be the health care provider of choice and employer of choice in our area. Our core values include:

- Compassion
- Authenticity
- Respect
- Excellence
- Service

To support the fulfillment of our mission and vision as a nonprofit hospital, as well as meet the requirements enacted by the 2010 Patient Protection and Affordable Care Act, Glencoe Regional Health Services has conducted a community health needs assessment (CHNA). A CHNA is essentially a review of current health activities, resources, initiatives, gaps and limitations to identify areas of improvement.

We are pleased to present you with the results of our 2016 CHNA. We invite your feedback and comments on our current CHNA, as your input will help guide and impact our next CNHA which will be undertaken again in three years.

Sincerely,



Jon D. Braband, FACHE
President and CEO

Executive Summary

Glencoe Regional Health Services (GRHS) is required to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy to meet the community health needs identified through the CHNA at least once every three years. The following document and past and future activities described therein serve to meet that requirement. The implementation strategy was approved by the Glencoe Regional Health Services Board of Directors on November 28, 2016. The majority of the hospital facility's CHNA process occurred in mid-2016, which was a collaborative process involving four hospitals, public health, other community service agencies and public bodies, plus community representatives. The process culminated in a workshop held on June 2, 2016. The highest-priority health needs for the community served by Glencoe Regional Health Services were identified as access to needed services and positively impacting overall individual behavioral choices.

The GRHS Board of Directors reviewed the health status statistics and trends for GRHS's service area. The Board also reviewed the ranked priorities as developed by the community forum process. (There were no community-supplied comments on the 2013 CHNA to take into consideration.) Based upon an analysis of GRHS's capabilities and capacity, it was determined to focus upon mental health as the key focus area to address during the next three years. The planned intervention to provide additional mental health counseling services will be monitored over time to determine the effectiveness of this planned intervention, and whether the community needs are being addressed in this area.

We truly believe this CHNA and associated implementation strategy will benefit community health, thus supporting Glencoe Regional Health Services' mission of providing comprehensive, high quality, cost effective, community-based, health care services to the residents of the communities we serve.

This Community Health Needs Assessment (CHNA) was conducted partially in response to the enactment of the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119(2010)), of Section 501(R) of the Internal Revenue Code. According to REG-106499-12, "Section 501(c)(3) requires a hospital organization to conduct a CHNA at least once every three years and adopt an Implementation strategy to meet the community health needs identified through the CHNA."

In addition this legal requirement, the CHNA and associated implementation strategy support the fulfillment of the mission of Glencoe Regional Health Services. It also supports a goal of GRHS to institute a functional health care home model to enhance the coordination and delivery of primary care services to patients in our service area.

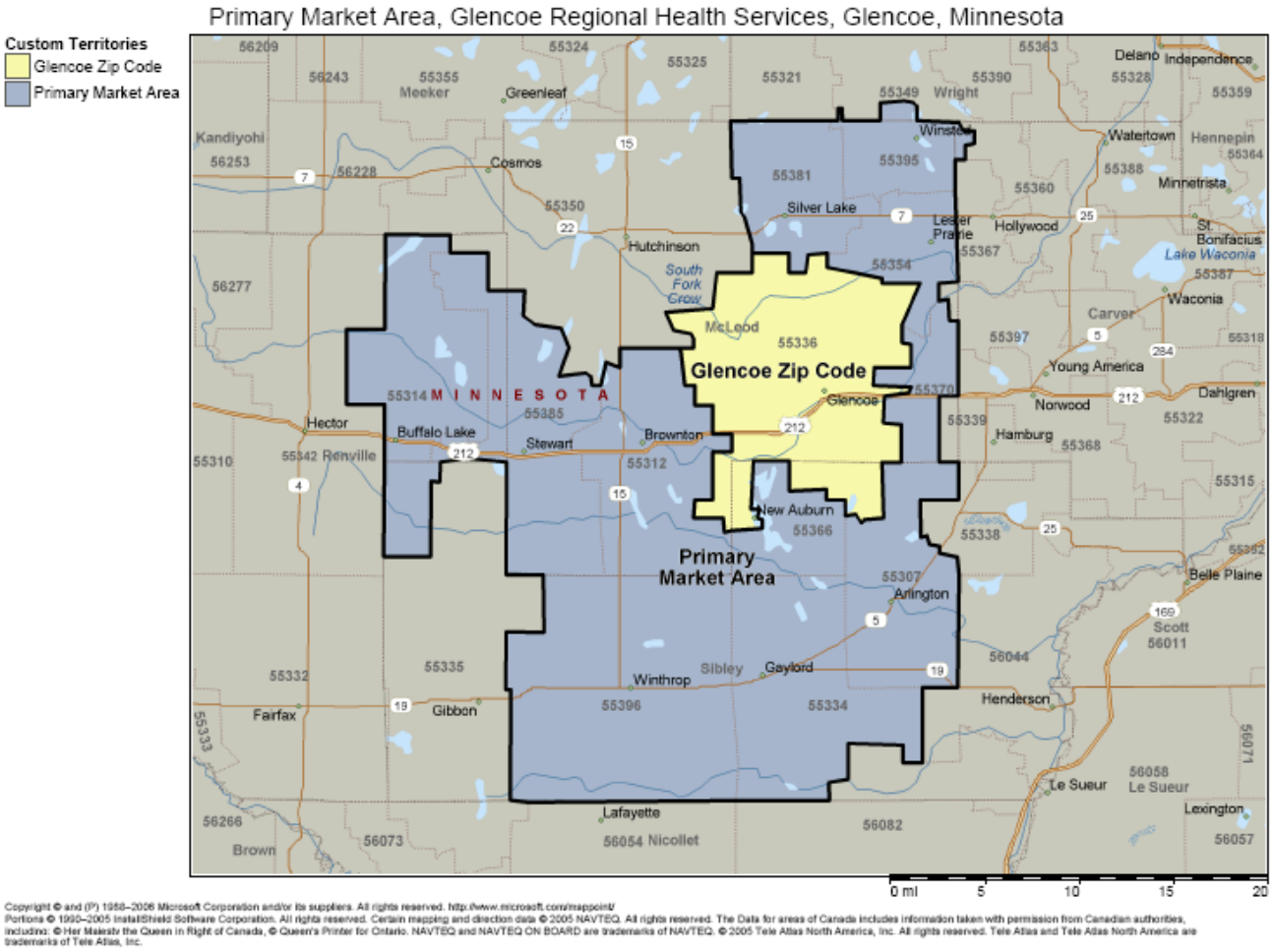
Comments on the CHNA and its accompanying implementation strategy can be emailed to GRHS at CHNA.Comments@grhsonline.org.

Community Served by the Hospital Facility

GRHS has determined its service area by reviewing patient origin over time, essentially looking at from where the majority of its patients come over time. This has been fairly stable over time, as noted in Table 1. For the purpose of this CHNA, the Primary Service area of Glencoe Regional Health Services has been determined to be McLeod County, from which approximately 74% of its patients come.

Table 1

Total Hospital Admissions			
City/Zip Code	**2014**	**2015**	**2016**
GLENCOE - 55336	36.34%	36.4%	39.0%
STEWART - 55385	2.50%	3.3%	2.8%
GAYLORD - 55334	8.27%	5.4%	5.3%
LESTER PRAIRIE - 55354	5.2%	7.3%	5.3%
BROWNTON - 55312	5.1%	3.3%	3.6%
HUTCHINSON - 55350	12.7%	11.5%	15.4%
ARLINGTON - 55307	4.2%	4.2%	2.6%
WINSTED - 55395	2.7%	4.1%	2.9%
SILVER LAKE - 55381	3.5%	3.9%	2.7%
PLATO - 55370	1.4%	1.3%	2.0%
NEW AUBURN - 55366	1.2%	1.3%	0.8%
NORWOOD-YOUNG AMERICA - 55368/55397	0.9%	1.9%	1.8%
GREEN ISLE - 55338	0.9%	1.0%	1.3%
HAMBURG - 55339	0.3%	1.0%	0.6%
BUFFALO LAKE - 55314	2.5%	2.4%	3.9%
OTHER	12.2%	11.9%	10.1%
McLeod County:	**69.44%**	**71.1%**	**73.7%**
Non-McLeod County:	30.7%	29.0%	27.5%
TOTAL	100.0%	100.0%	100.0%



Demographics

An evaluation of available demographic data shows that McLeod County is relatively more dense than Minnesota (73.6 persons per square mile versus 67.6 persons per square mile, respectively), but less dense than the U.S. as a whole (at 88.9 persons per square mile). McLeod County is slightly "older" than both Minnesota and the U.S., with the over-65 age group being 16.5% for McLeod County, 13.6% for Minnesota and 13.8% for the U.S. The proportion of families with children in McLeod County (30.9%) is relatively similar to Minnesota (31.1%) and the U.S. (32.3%). McLeod County is relatively less racially diverse, with 95.6% being categorized as White, compared to 85.2% in Minnesota and 73.8% in the U.S. McLeod County is relatively more ethnically diverse than Minnesota, with 5.1% categorized as Hispanic/Latino compared to Minnesota's 4.9%, but less than the U.S. average of 16.9%.

The McLeod County population is relatively less poor than Minnesota and the U.S. (with 7.8% being below the Federal Poverty Level in McLeod County, 11.5% in Minnesota, and 15.6% in the U.S.). Relatively fewer residents of McLeod County receive Medicaid than Minnesota as a whole or the U.S. (with 14.1%, 16.1% and 20.8% of the population on Medicaid, respectively). Residents of McLeod County are relatively higher rates of having health insurance than Minnesota or the U.S. (with the rates of uninsured at 7.4%, 7.9% and 16.4% respectively). The unemployment rate in McLeod County is about the same in McLeod County compared to Minnesota (3.5% versus 3.4%), but lower than the U.S. unemployment rate (at 4.9%).

Residents of McLeod County are relatively less educated than Minnesota, with the percent of population over 25 without a high school diploma of 8.6% (compared to Minnesota at 7.7%), but higher than the U.S. as a whole (with 13.7% in the U.S. without a high school diploma).

There is a relatively lower incidence of violent crime in McLeod County (131.5 incidents per 100,000 population) than Minnesota (237.9 per 100,000) or the U.S. (395.5 per 100,000).

Health Status

An evaluation of health status indicators shows that residents of McLeod County are relatively more physically active than Minnesota as a whole (20.4% reporting no leisure time physical activity, versus 18.2%, respectively), and more active than the U.S. population as a whole (21.8% reporting no leisure time physical activity). Fewer McLeod County residents report using tobacco products (13.6%) than Minnesota as a whole (16.3%) or the U.S. population (18.1%). McLeod County residents also have a relatively lower incidence of asthma (6.5%) than Minnesota (11.1%) or the U.S. (13.4%). Residents of McLeod County have slightly higher prevalence of diabetes as the State of Minnesota (7.7% and 7.1%, respectively), and less than the U.S. population (9.2%). Medicare-aged residents of McLeod County and Minnesota have similar prevalence rates of ischemic heart disease (20.7% and 19.4%, respectively), and less than the U.S. (27.0%). Heart disease mortality is slightly higher in McLeod County than Minnesota (age adjusted rates of 128.9 and 118.3 per 100,000 population, respectively), both of which are far less than the mortality rate for the U.S. (171.8 per 100,000). Relatively fewer residents in McLeod County have high blood pressure (17.0%) than Minnesota (21.9%) or the U.S. (28.2%).

McLeod County has relatively more teen births than the State of Minnesota as a whole (28.0 per 1,000 births, versus 23.8 per 1,000, respectively), but less than the U.S. rate (at 36.6 per 1,000). McLeod County has fewer babies born with low birth weights (5.2%) than Minnesota (6.5%) or the U.S. (8.2%). The infant mortality rate in McLeod County is much lower (2 in 1,000 live births) than Minnesota (5.2 per 1,000) or the U.S. (6.5 per 1,000).

McLeod County residents are relatively more obese (30.8% having Body Mass Index, or BMI, greater than 30) than the State of Minnesota (26.7%) or the U.S. (27.5%). Relatively more males in McLeod County are obese (33.5% with BMI > 30) than female (28.9%).

Overall, McLeod County residents self-report having "Fair" or "Poor" health at a lower rate (8.3%) than Minnesota (10.5%) or the U.S. (15.7%).

Sexually transmitted diseases are far less prevalent in McLeod County compared to Minnesota and the U.S. as a whole. HIV rates for McLeod County are 39.6 per 100,000, compared to 162.4 for Minnesota and 353.2 for the U.S. Gonorrhea in McLeod County is 5.6 per 100,000, while Minnesota is at 75.1 per 100,000, and the U.S. is at 110.7 per 100,000. Chlamydia in McLeod County is 192.1 per 100,000, while Minnesota is at 367.1 per 100,000, and the U.S. is at 456.1 per 100,000.

McLeod County has a relatively lower number of mental health providers (the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care, at 178.3 per 100,000 population in McLeod County) than Minnesota (204.8 per 100,000) or the U.S. (202.8 per 100,000). **This is a key issue in the development of our overall health goals in this process.**

Process and Methods Used to Conduct the Assessment

GRHS staff members participated in a collaborative workshop on June 2, 2016, which included representatives from Glencoe Regional Health Services, Hutchinson Health, Ridgeview Sibley Medical Center, Meeker Memorial Hospital, Meeker-McLeod-Sibley Public Health (MMS), Minnesota Department of Health, Glencoe-Silver Lake School District, Sibley East School District, the Depression and Bipolar Support Alliance of Mid-Minnesota, Tri-Valley Migrant Head Start, City of Hutchinson, Blue Cross/Blue Shield of Minnesota, University of Minnesota Extension Office, as well as unaffiliated community members. The objectives of the workshop were to get a better understanding of what creates health, to use population health data to generate what can be learned about community health and to recognize what could be done to improve the community's health.

Population data was given to participants using a health indicator prevalence comparison. The data was from ten different sources, with a large portion being from the MMS Community Health Survey and a large statewide survey from 2014. Both state and local survey data were analyzed to be representative of the entire population in each geography, analyzed using STATA, and the Minnesota Student Survey. The comparability of the data varied. Questions were sometimes asked differently between local and state surveys and different data collection modes were used. The indicator prevalence comparison also included additional demographic breakdowns by county,

age, gender, education level and income. The local MMS Community Health survey underrepresented the Hispanic/Latino population across the three counties. The data from the local survey was also self-reported and therefore subject to some biases such as exaggerated response and inaccurate recall. This comparison highlighted the areas where MMS ranked better than the MN rate, where there was notable difference between MMS and MN, and where MMS rate was worse than the MN rate. The data was organized by categories including behavior, access and outcomes.

During the overview of the MMS data presentation, the data highlighted as significant included elderly and child dependency ratio, exercise habits, binge drinking and access to healthcare, dental care and mental health care. Other important indicators were high rates in diabetes, heart disease, cholesterol and low rates in shingles vaccinations. After discussing the data, attendees made a list of over 20 health topics they deemed significant for the three counties. Then participants voted for the three topics they believed needed to be most prioritized.

The final prioritized list of topics based upon this rank ordering included:

- Access to care
- Obesity
- Choice/behavior/culture
- Mental health
- Senior health
- Binge drinking

Workshop participants then discussed what currently was being done to address each issue, what additional strategies could be used and what challenges needed to be faced on order to implement the strategies.

Summary discussion points for each topic included:

<u>Access to care</u>

- Getting transportation - current transportation not user friendly
- Dental services for children (in Meeker County especially)
- Dental care - not affordable for many
- Does everyone in the community know the information?
- Stigma regarding accessing services (especially mental health)
- Not enough mental health providers

Obesity

- Culturally acceptable to be obese
- School lunches not as healthy as could be
- Working with schools regarding physical activity
- How to motivate people
- High impact of technology on families at home

Choice/behavior/culture

- Resources - human and money
- Connecting the public
- How to get people to participate
- Maybe start at the workplace
- Lack of health insurance incentives?

Mental health

- Access to resources
- Getting people to the right level of care
- Break the stigma held by mental illness
- Bring the community together
- Huge lack of mental health providers
- Adequacy of insurance coverage

Senior health

- Focus culture on embracing aging
- Transportation to events and appointments for seniors
- Stigma for asking for help
    - Not taking advantage of the resources they quality for
- Understand barriers to access for healthcare
- Partner with resource organizations

Binge drinking

- Attitudes of adults
- The culture surrounding drinking
- Not a good understanding of what binge drinking is
- Not always seen as an issue
- Binge drinking is seen as accepted in certain situations
- No adverse stigma around having a DUI
- Community events centered on alcohol (ex. Winstock)

After this step, the workshop participants discussed next steps and where to focus the energy in moving forward. The discussion focused on two main areas – access to necessary service and education on improved individual choices/behavior.

Access to needed services

Throughout the session, a common theme at each table was transportation as a barrier and discussion was held if that is what needs to be focused on, especially in regards to access to healthcare. Another barrier to accessing healthcare could be a stigma held for individuals needing service.

Individual choice/behavior

It was evident that many health behaviors are based on the culture surrounding an individual. The Meeker-McLeod-Sibley Healthy Communities Leadership Team's prevention and wellness committee will look at how choice behavior meshes with the culture. From there, the subcommittee and partners can research ways to provide education and awareness to the community. For example, how can the culture around binge drinking be changed and how can awareness of community members on the effects of binge drinking be raised?

Board Adoption and Implementation Strategy

The Glencoe Regional Health Services Board of Directors reviewed the intake process and recommendations of the collaborative on November 28, 2016. Based upon an analysis of organizational capability, it was determined that the best impact could be made by addressing the mental health needs of the community (a highly significant need as determined by the focus group process). GRHS intends to address this community need by making more mental health counseling services available. The planned approach is to provide psychiatric services through a contracted third-party provider. The plan is to provide onsite mental health counselors in the Glencoe clinic setting, and access to psychiatrists, either onsite at the Glencoe clinic site, and/or via telemedicine. The planned start of this service is no later than July, 2017.

Regarding other top identified needs, it was determined that access and improved behavioral choices can be addressed on a per-patient basis during one-on-one encounters with GRHS medical providers. It was also determined that GRHS will evaluate avenues to collaborate with other community agencies to address these issues as these opportunities present themselves.

Making the CHNA Report Widely Available to the Public

This report will be available on the Glencoe Regional Health Services website: www.grhsonline.org. Paper copies are also available without charge upon request. Comments and suggestions are welcome. They may be submitted via email to CHNA.Comments@grhsonline.org or mailed to us at 1805 Hennepin Ave. N., Glencoe, MN 55336.