# CentraCare Health – Melrose

## Community Health Needs Assessment Summary

2012-2013

CentraCare Health – Melrose takes pride in promoting community health and well-being. To that end, it recently conducted a **community health needs assessment** (CHNA) for its respective service area, located in Western Stearns County in the heart of Central Minnesota. CentraCare Health – Melrose serves nearly 10,000 people in and around Melrose, Minnesota and is part of an integrated health care delivery system known simply as CentraCare Health—a system recognized for being a leader in providing high-quality, comprehensive care throughout the region, and for living its mission:

***"CentraCare Health works to improve the health of every patient, every day."***

With over 270 employees, CentraCare Health – Melrose is committed to providing quality health care services in a hometown setting. It accomplishes this by offering a full range of health care services and by making available specialized care from visiting health professionals who provide outreach services on a regular basis. This convenient access allows patients to receive specialty care as needed while staying close to home. Adjacent to the hospital is a 75-bed skilled nursing facility and 42-unit apartment complex for seniors.

**CENTRACARE HEALTH – MELROSE SERVICES**

**CentraCare Health – Melrose Hospital**

- Ambulance
- Behavioral Health Services
- Cardiac Rehabilitation
- Chemotherapy
- Emergency Services
- Imaging Services
- Laboratory Services
- Obstetrics
- Rehabilitation
- Sleep Studies Program
- Surgical Services

**Visiting Physician Specializations**

- Allergy
- Audiology
- Cardiology
- Depression Care
- Gatroenterology
- General Surgery
- Neurology
- Obstetrics/Gynecology
- Oncology
- Opthalmology
- Orthopedics

**Visiting Physician Specializations (cont'd)**

- Podiatry
- Psychology
- Psychiatry
- Radiology
- Urology

**Pine Villa Care Center**

- Nursing Unit
- Alzheimer's Unit
- Adult Day Care

**Park View Center**

- Assisted living

# Taking the Pulse of the Community

In addition to high-quality inpatient and outpatient care, services are provided in the form of **community benefit programs**. These programs are developed in reaction to real and tangible needs in the community and are a fine example of how CentraCare Health and its affiliated hospitals utilize available resources and expertise to help address barriers to good health, particularly among underrepresented and underinsured populations.

CentraCare Health has an extensive history of checking the pulse of community health by identifying, prioritizing and responding to health needs as they emerge. A community health needs assessment, therefore, is a valuable and logical tool in guiding this line of work, further enabling the hospitals which operate under the system to assume a proactive stance towards community health improvement. Moreover, the process of conducting an assessment is an appropriate time for each hospital—and the community it serves—to reflect on the immense value of its contributions to the region's quality of life.

> **Community Health Needs Assessment (CHNA)**: a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon unmet community health needs.
>
> * Assessing & Addressing Community Health Needs, Catholic Health Association

CentraCare Health takes seriously the role it plays in promoting community health. To that end, it acknowledges the complexity and importance of conducting a thorough health assessment which accounts for the needs of the entire community. 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 hospitals' community benefit programs and likewise the health needs assessment.

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### A New Mandate

While it is common practice for the hospitals within CentraCare Health to assess the health needs of the communities they serve in order to determine community benefit planning and improve patient services, the recently enacted Patient Protection and Affordable Care Act mandates that all nonprofit, tax-exempt hospitals complete a CHNA at least every three years and adopt an implementation strategy (community benefit plan) to meet the existing health needs identified in the assessment. Compliance with this new regulation is reported to the Internal Revenue Service, which has issued guidelines on how assessments are to be documented.

Above all, a CHNA is an important first step in monitoring and improving community health, a goal CentraCare Health shares with various community organizations and stakeholders. The assessment process opens doors for greater collaboration among community partners by strengthening relationships and promoting a more efficient use of resources. These relationships are highly valued, as evident by CentraCare Health and its respective hospital's history of partnering with organizations and agencies such as the local United Way, county social services, Catholic Charities, area schools, public health departments, and many others.

### Roadmap

What follows is a summary of the assessment conducted by the CentraCare Health hospitals, beginning with an introduction to the assessment process and its basic components. The system-wide approach to the CHNA is outlined in the first section of this report, followed by a note on methodology. Then, the initial collection and analysis of secondary data is explained, along with strategies for community engagement and working with county public health. This is followed by a description of the community served by the hospital, including an overview of the community's assets. Next, a detailed account is given of the health priority areas which surfaced during the assessment and the prioritization process used to determine these needs. Lastly, a well-informed projection is made about the steps that will be taken to address (or in some cases continue to address) the identified needs. This leads nicely, then, to the supporting document which outlines the Implementation Strategy, or course of action (community benefit plan) for the immediate years ahead given what was learned from the assessment. When necessary, reference is made to items located in the appendices.

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## How the Assessment Was Conducted

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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 **four phases**, which were further broken down into a series of interconnected components. These phases are presented in Figure 1. Note that each phase represents a portion of a larger process that, although systematic in nature,

should not be interpreted as having occurred in strict chronological order; the complexity of the assessment process—and the unpredictability of its various components—necessitated a rather fluid movement between each phase. Indeed, the key to a thorough and comprehensive assessment is the ability to examine and re-examine each component of the process in light of what is learned along the way.

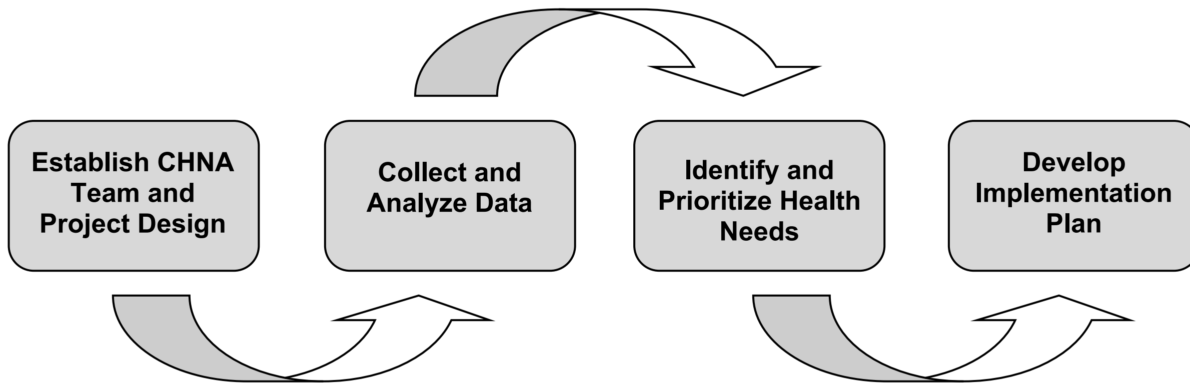


**Figure 1**: The CHNA four-phase process

## A System-wide Approach to the CHNA

**Establish CHNA Team and Project Design**

CentraCare Health - Melrose, like the other CentraCare Health hospitals, takes pride in its level of involvement in the community and its receptiveness to the community's health care needs. Therefore, the hospital felt it reasonable and appropriate that internal staff and leaders 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 Advisory Task Force 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. A list of Advisory Task Force members can be found in Table 1. This group consists of individuals from across the CentraCare Health system, which is indicative of the collaborative nature of the CHNA process and a testament, more generally, of the mutual support among the system's hospitals.

Hospital board members and executives were engaged in the assessment process at an early stage as well. It should be noted that, although a system-wide approach was adopted for parts of the CHNA, each hospital was ultimately responsible for identifying specific health needs in the community it serves and developing an implementation strategy (community benefit plan) to address these needs, all of which were reported (and can be found) in each hospital's respective CHNA summary.

**Table 1:** CHNA Advisory Task Force Members

| NAME | TITLE | AFFILIATION |
|---|---|---|
| Anita Arceneau | Specialist, Communications & Marketing | CCH – Long Prairie, Sauk Centre, Melrose |
| Melinda Bemis | Planning Coordinator | CentraCare Health |
| Craig Broman, MHA | President | St. Cloud Hospital - CCH |
| Diane Buschena-Brenna, RN | Administrator | CC Family Health Center |
| Delano Christianson | Administrator | CentraCare Health – Sauk Centre |
| Lori Eiynck | Planning Specialist | CentraCare Health |
| Tom Feldhege | Director of Finance | CentraCare Clinic |
| Gerry Gilbertson | Administrator | CentraCare Health – Melrose |
| Joseph Hellie, MHA | Director, Ambulatory Care | St. Cloud Hospital - CCH |
| Paul Knutson | Mission Development Specialist | CC Family Health Center |
| Mark Larkin | Executive Director | CentraCare Health Foundation |
| Mark Murphy | Vice President – Operations | CentraCare Clinic |
| Rosemond Sarpong Owens | Health Literacy/Cultural Competency Specialist | CentraCare Health |
| Kathy Parsons, MHA | Director, Managed Care | St. Cloud Hospital - CCH |
| Joni Pawelk | Director of Marketing | CentraCare Health - Monticello |
| Bret Reuter | Director, Mission & Spiritual Care | St. Cloud Hospital - CCH |
| Jodi Sanders | Reimbursement Specialist | St. Cloud Hospital - CCH |
| John Schnettler | Director, Marketing | CentraCare Health |
| Todd Steinke | Director | CentraCare Health Foundation |
| Dan Swenson | Administrator | CentraCare Health – Long Prairie |
| David Tilstra M.D. FACPE, FACMG, FAA | President | CentraCare Clinic |
| Sonja Zitur | Director of Accounting | St. Cloud Hospital - CCH |
| Kurtis Neu, Chelsea Schulte and Megan Osendorf | Student Interns – CHNA Project Staff | CentraCare Health – St. Cloud State University and Concordia College |
| David Borgert, MBA | Director, Community & Government Relations, CHNA Team Leader | CentraCare Health |

# A Note on Methodology

A key area of concern during the initial planning phase was the adoption of a proper and rigorous framework—or model—in which to approach the assessment process. For that reason, members of the CHNA Advisory Task Force conducted a thorough review of potential assessment models while keeping in mind effective strategies implemented by the hospital in the past and the purpose (see Figure 2.) and scope of this particular project.

The Catholic Health Association's (CHA) handbook titled *Assessing and Addressing Community Health Needs*, developed in partnership with VHA Inc. and the Healthy Communities Institute, was selected to serve as a guide in steering both the assessment process and the creation of this summary. *A Guide for Planning & Reporting Community Benefit,* another publication produced by CHA, was called upon during the planning and coordination of the CHNA's corresponding implementation strategy. Please be aware that although Catholic Health Association resources were heavily consulted, liberty was taken to freely interpret the information and make modifications as needed. Guidance also was found in material gathered from the Minnesota Department of Health's Web site.

**Figure 2**: The multi-level purpose of the CHNA

During this early phase of the assessment process special attention also was given to the appropriate use of resources and the potential for collaboration with community partners. These items, along with established data collection procedures and plans for community engagement, were plotted on a preliminary timeline with respect to the four overlapping phases of the assessment. A timeline can be found in Attachment A: Assessment Timeline.

## Creating a Snapshot of Community Health

**Collect and Analyze Data**

With the CHNA team established and the assessment model determined (and its components plotted accordingly on a timeline), the initial collection and analysis of data followed. A diagram of the data analysis cycle is presented in Figure 3. You will notice the diagram suggests the cycle may need to be repeated. Indeed, several rounds were made to ensure data accuracy and comprehensiveness. Before initiating the data analysis cycle, however, a set of criteria were developed to aid in the selection of health indicators for review, keeping in mind the need for eventual prioritization and the scope of the assessment. During the preliminary data-review process the following questions were considered:

- What health indicators stand out due to worsening trends and high rates of occurrence?
- Based on these indicators, where is the community doing worse, on average, compared to the county, the state and the nation?

These criteria made the task of collecting data manageable while at the same time ensuring a diverse range of health indicators were reviewed.

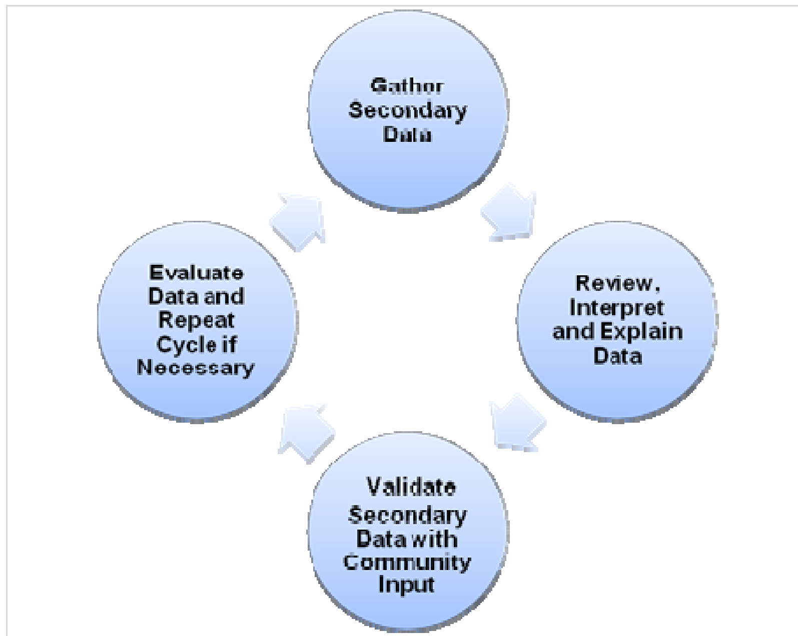


**Figure 3**: Data Analysis Cycle

## Key Secondary Data

The Minnesota Department of Health (MDH), in collaboration with Healthy Minnesota Partnership, recently published *The Health of Minnesota: 2012 Statewide Assessment*, a comprehensive overview of health factors and conditions throughout the state.[1] The data described in the statewide health assessment are organized into six categories or themes, including people and place; opportunity for health; healthy living; chronic disease and conditions; infectious disease; and lastly, injury and violence. MDH also has issued a list of health indicators to be used in conducting a community health assessment.[2] This comprehensive list of health indicators served as the basis from which secondary data were gathered and initial comparisons and trends were observed for the purpose of this CHNA. The following data sources, made available by the Minnesota Department of Health and referrenced in the indicator list, were consulted:

- Minnesota Statewide Health Assessment (2012)
- Minnesota State, County, and Community Vital Statistics Trend Report (1991-2010)
- Minnesota County Health Tables (2010-2011)
- Minnesota Student Survey (1998-2010)

Data also were obtained from local county public health departments, including their most recent health assessments and community reports. In addition, health-related information was collected from area nonprofit organizations which regularly conduct assessments and evaluations of the services they provide and their targeted demographics. Useful material was gathered from the

[1] To access an online PDF of *The Health of Minnesota: 2012 Statewide Assessment* visit www.health.state.mn.us/statewidehealthassessment/
[2] See Minnesota County-level Indicators for Community Health Assessment

local United Way, Catholic Charities, the Central Minnesota Council on Aging, and the Tri-County Action Program (Tri-CAP). These organizations support a broad range of constituents with diverse health-related needs; they represent demographics that are statistically more likely to encounter health-related barriers.

Findings from area nonprofit organizations and public health departments were supplemented by data from these online resources:

- Community Health Need Index (2012)
- County Health Rankings (2010-2013)
- Dartmouth Atlas of Health Care (2012)

These comparisons were weighed against national benchmarks set by Healthy People 2020, and were appraised in light of the framework established by Healthy Minnesota 2020.

**Healthy People 2020**: Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to: 1.) Encourage collaborations across communities and sectors; 2.) Empower individuals toward making informed health decisions; and 3.) Measure the impact of prevention activities.

*www.healthypeople.gov

### Key Primary Data

The secondary data described above established the groundwork for a series of discussions among community partners, public health departments, and medical boards and staff. Discussions of this sort produced valuable informatin that substantiated much of the findings from earlier rounds of secondary data analysis.

## Drawing on the Knowledge of the Community

Community members, including representatives of diverse groups with unique and challenging health-related needs, were encouraged to take part in a series of events including focus groups and key-informant interviews. CHNA Advisory Task Force members sought to include the voices of all persons in the community, especially those most impacted by health disparities, such as minorities and the uninsured.

Additionally, meetings were held with hospital physicians, medical boards, and public health experts. These individuals provided invaluable first-hand accounts of the current state of health in the community, the hospital's role in promoting overall wellness, and the gaps between specific health needs and the programs that currently exist to meet those needs. The conversations that took place with community partners validated

**The conversations that took place with community partners validated existing data, strengthened relationships...and promoted a more efficient use of resources.**

existing data, strengthened relationships between the hospital and community partners, and promoted a more efficient use of resources.

### Collaborating with Public Health Departments

A fine example of community collaboration is the newly formed consortium of county health departments and area hospitals known as the Central Region Data Group which, together, developed a behavioral health and opinion survey that was administered to residents throughout a five-county region in Central Minnesota. This collective endeavor brought together a sizable group of public health officials from various counties along with CentraCare Health representatives and staff (see Attachment B: Central Region Data Group Members).

Meetings among these groups were constructive and rewarding as each agency contributed valuable perspectives on the state of health in the region. This new initiative is a proactive and an innovative approach to working collectively towards population health and community benefit. The relationships that were established and/or strengthened as a result of this collaborative project will be sustained well into the future. CentraCare Health, on behalf of its affiliated hospitals, will work with county health officials to identify and respond to the health issues that surface as a result of the data generated from the survey, which will take place in fiscal year 2014.

### Gathering Community Input

As mentioned previously, conducting a health needs assessment is nothing new for CentraCare Health and its hospitals. In fact, this CHNA is an extension of the organization's ongoing mission to constantly assess the effectiveness of its services and identify areas for improvement. This, of course, requires considerable reflection and self-evaluation on the part of CentraCare Health and its affiliated hospitals and, perhaps more importantly, it presents opportunities to draw on the expert knowledge of community members in an effort to better meet their needs.

To that end, CentraCare Health has carried out a series of focus groups, key informant interviews and surveys, among other strategies for gathering community input (see Table 2). These community engagement activities are a fine example of how CentraCare Health reaches out to underrepresented groups to ensure their voices are heard. Again, the strategies outlined below are part of a larger ongoing process to better understand and serve the community.

**Table 2**: Strategies for community engagement and participation

| Strategy | Population |
|---|---|
| Interpreter Services | Nonnative English Speakers and Hearing Impaired |
| Hispanic Focus Group | Hispanic Community |
| African American Focus Group | African American Community |
| Deaf and Hard of Hearing Focus Group | Deaf and Hard of Hearing Community |
| Sudanese Focus Group | Sudanese Community |
| Community Health Survey | Five County Region |

| Consumer Survey | 14-county Service Area |
| --- | --- |
| Cultural Competency Assessment | CentraCare Staff |

# The Community Served by the Hospital

**Fast Facts**

City of Melrose

Population Size: 3,598

Population by Sex:

Male: 1,784

Female: 1,814

Population by Race / Ethnicity:

White: 3, 098

Black or African American: 33

American Indian & Alaskan Native: 7

Asian: 22

Hispanic or Latino (any race): 796

Stearns County

Average Household Income (2009)

$48,383

Students with Limited English Proficiency – Percent, School Year:

6.4%

Four-Year High School Graduation Rate per 100:

84

There is a strong correlation between the status of a community's health and the social, economic and environmental dynamics that define where people live—be it a specific neighborhood, an entire city, or a larger geographic area. The qualities that define these places—including variables such as crime rate, access to healthy food, social connectedness and many others—contribute significantly and in diverse ways to the overall health of an entire community, not to mention they can influence the rate at which healthcare systems are utilized and the specific services that are needed—from primary care checkups to emergency room visits and everything in between.

This is all the more reason why CentraCare Health puts forth special effort to understand the unique characteristics of the communities served by its affiliated hospitals and, likewise, why CHNA Advisory Task Force members devoted time and effort to evaluate these unique features during the early stages of the assessment process.

## People and Place

As a critical access hospital, CentraCare Health – Melrose serves the city of Melrose, Minnesota and immediate surrounding area (see Attachment C: Service Area Map). Located in Western Stearns County along the banks of the Sauk River, Melrose is predominantly an agricultural community with a total population of 3,598 at the time of the 2010 U.S. Census. The county of Stearns has a total population of 150,642 and has witnessed steady growth over the past decade, with a total percent change in population of 13.12% from the year 2000 to 2010. During this same timeframe the state

of Minnesota experienced a population growth of 7.81%.

### Growing Diversity

The racial and ethnic makeup of the city of Melrose is changing. The most pronounce change has occurred among the Hispanic population which now accounts for 22% of the total population. Compared to the rest of the county and to the state, this represents one of the largest ratios of a minority group—in this case Hispanics—compared to the overall population. Out of the 608 foreign born residents living in Melrose, 293 entered the country before 2000 and 315 entered 2000 or later. The most frequent world region of birth for foreign born residents in Melrose is Latin America, with 544, followed by Asia with 54.

These changing demographics are also evident by the fact that in Melrose nearly 1,080 people speak a language other than English at home and 738 speak English less than "very well". Of this group of people, 929 speak Spanish, 95 speak other Indo-European languages and 54 speak an Asian and/or Pacific Islander language. As concerns education and health care delivery, limited English proficiency poses unique challenges.

## Employment and Education

The local area economy is dependent on agriculture and livestock farming, though several large coroporate headquarters can also be found in the area, along with manufacturing industries.

The major employers in Melrose are the Jennie-O Turkey Plant, CentraCare Health System – Melrose and Melrose Dairy Proteins. The Jennie-O processing plant in Melrose brings new workers to the community, increasing the cultural diversity and vibrancy of the community. The city is home to a growing Hispanic population which now makes up 22% of the total population, one of the largest percentages in the state of Minnesota.

The average annual family income for the city has not changed significantly in the past decade and is $45,139.

The city has a strong educational system comprised of public and private elementary schools and public middle and high schools. It also provides an excellent Community Education program that includes activities and opportunities for community members of all ages.

## Community Assets

The city of Melrose and surrounding area is fortunate to have many valuable assets that contribute to the health and well-being of community members. These assets include a state-of-the-art health care facility; a strong educational system; supportive social service organizations; safe neighborhoods; many parks and opportunities for outdoor recreational activities, and an active arts and cultural scene. Figure 4 depicts the relationship between these diverse community assets and, when viewed together, they contribute to the community's quality of life. A list of these assets, though non-exhaustive, can be found in Attachment D: Community Assets.

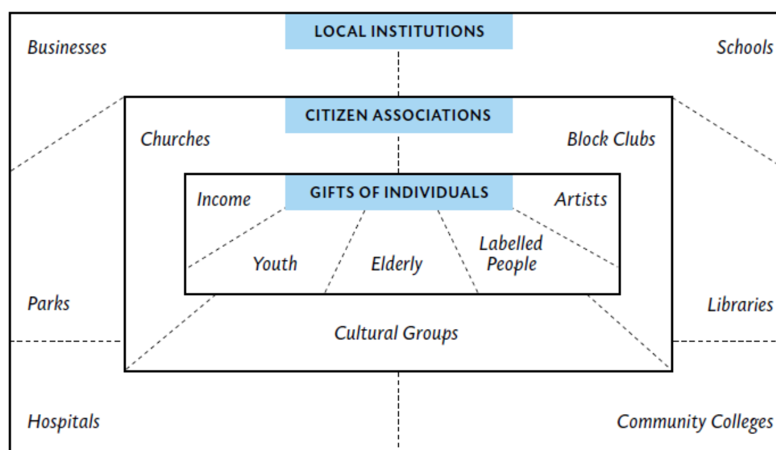


**Figure 4**: Community Assets Diagram, from *Assessing and Addressing Community Health Needs,* Catholic Health Association

# Health Needs Identified

**Identify and Prioritize Health Needs**

The primary data gathered from the fact-finding missions mentioned above lent credence to the identification, interpretation and prioritization of specific health needs in the community. Furthermore, information of this sort allowed for a more nuanced and holistic understanding of the secondary data and the interconnections, or relationships, between distinct health concerns. Given the purpose and scope of the assessment, tacking back and forth between secondary data and primary data, and between qualitative and quantitative data, was a particularly useful strategy in conducting a thorough wide-ranging health needs assessment.

## Prioritization Process

To prioritize the identified health needs, a set of criteria were developed by CHNA Advisory Task Force members. These five criteria were included in a ranking tool which can be found in Attachment E: Ranking Tool. The criteria that were used, and their corresponding descriptions, are listed below.

- **Community Impact**: size of issue; severity of condition; consequences of not doing something

- **Potential for Change**: known strategies to make a difference; adequate human resources and expertise available; adequate time for planning, implementation and evaluation

- **Economic Feasibility**: cost of internal resources and potential cost of external resources

- **Community Assets**: lack of existing programs addressing issue; inadequate programs that need support; need for collaboration

- **Value and Mission**: the health issue falls within the hospital's overall mission and core competencies

Each member of the CHNA Advisory Task Force ranked individual health needs based on the agreed upon criteria. The composite scores of the ranking exercise identified six health issues, or themes. The results of the prioritization process were shared with CHNA Advisory Task Force Members who discussed the results and how the outcomes would help inform the implementation strategy and community benefit planning.

The prioritization process revealed six community health issues:

- **Access to Primary Care**

- **Culturally Competent Care**

- **Heart Disease Morbidity and Mortality**

- **Linguistically Competent Care**

- **Mental Health Services**

- **Stroke Morbidity and Mortality**

Prior to the CHNA the hospital was, indeed, alert to these specific areas of need. The CHNA helped to validate these presumptions and raise greater awareness about the scale of the health concerns mentioned above. It also helped to validate efforts that have been ongoing and/or are currently underway to address these health needs.

It is important to realize that work in the area of community health is never "finished" that is, the health needs of the community are subject to change over time and require fresh and innovative approaches to satisfy unmet and emerging needs. Consequently, CentraCare Health has taken extra steps to ensure the assessment process is sustainable and can be updated for continued use.

It also is important to acknowledge that the assessment revealed gaps in information, including the lack of localized health disparity data concerning recent immigrants and non-English speaking minorities. Efforts will continue to be made to find sources of statistically reliable data on these populations. Because of the CHNA timeline (which is mandated by law) it was not possible to coordinate the assessment with the results of the community health survey developed by the Central Region Data Group. CentraCare Health and its hospitals will continue to work with county public health departments to respond collaboratively to the health needs that might emerge from the survey.

## Health Needs Priority Areas

As mentioned above, CentraCare Health takes seriously its role in ensuring the health and well-being of the community it serves. This responsibility brings with it the need to understand and react to persistent and emergent health needs. The CHNA brought into focus several priority health needs across the CentraCare Health system, including access to primary care, culturally competent care, heart disease morbidity and mortality, linguistically competent care, mental health services, and stroke morbidity and mortality.

### Access to Primary Care

Access to primary care encompasses a series of related concerns including: ratio of primary care physicians to residents; insurance status and the cost of care; transportation to and from medical facilities and other environmental barriers; and lack of knowledge of services in general.

The ratio of patients to primary care physicians for the state of Minnesota is 636:1, which is around the national benchmark of 631:1. Stearns County, with a ratio of 582:1, far exceeds the state average and national benchmark. This can be attributed to the presence of comprehensive and expansive health care systems in the area. There is a dramatic downturn in the number of physicians for the counties of Benton and Sherburne, however. The ratio of patients to primary care physicians is 1,646:1 in Sherburne County and even greater in Benton County with a ratio of 2494:1. These numbers are cause for concern. With so few primary care physicians, this means that obtaining preventative care services can be difficult, causing people to forego seeking these services altogether. Patients must wait for longer periods of time to see their physician, and on the other hand physicians are forced to take on more patients than should be expected. This is compounded by the fact that many people living in the St. Cloud hospital referral region do not have a usual source of care.

### Mental Health Services

On a somewhat related note, access to mental health services stands out as a priority issue as well, with the shortage of mental health professionals a central concern. The ratio of patients to mental health providers for the state of Minnesota is 1,306:1. Again, Stearns County surpasses the average with a ratio of 1,079:1, while Benton and Sherburne counties come up short with ratios of 4,987:1 and 3,965:1 respectfully. For Sherburne County, the number of adult mental health caseloads recorded by the county's department of health and human services has increased by a factor of 22 percent during a three year period. Surveys and focus groups conducted by Benton and Sherburne counties reveal that one of the top health-related community priorities identified by respondents is a lack of mental health services. This appears to be a multigenerational issue, and one that spans socio-economic variables.

### Culturally and Linguistically Competent Care

Considering the changing demographics of the community and the unique challenges this presents to health care organizations, a lack of cultural competency stands out as a top priority, especially language access services. A recent survey was conducted among care providers, which revealed several areas of concern, among them the fact that, although interpretive resources are accessible by telephone, currently there are no employed on-site interpreters (on-site interpreters are retained on contract). There has been a dramatic increase in linguistic diversity among patients and as a result it can be difficult for patients and their health care providers to communicate effectively; knowledge about medical issues can literally become lost in translation. Along with language services, sensitivity to cross-cultural understandings of health and medicine seems lacking, with a large number of health care providers reporting feeling less than well prepared to care for limited English speaking patients of foreign backgrounds.

### Heart Disease Morbidity / Mortality

Heart disease is among the top three leading causes of death for all counties, but is of particular concern for Benton County which, at number 84, is ranked among the 10 worst counties in the state according to the 2011 Burden Report. The age adjusted death rate (per 100,000 Pop.) from 2006 to 2010 was 181.6, a decrease from previous years (the rate has consistently decreased since 1991); however, this rate is still well above average compared to neighboring counties and the state average.

### Stroke Morbidity / Mortality

Stroke is among the leading causes of death among all counties served by CentraCare hospitals and again Benton County scores poorly compared to other counties in the region—it ranks 77 out of 87. In Benton County, the age adjusted death rate (per 100,000 Pop.) from 2006 to 2010 was 51.7. This number has consistently decreased since 1996, but is still well above the state average of 37.21. The age adjusted death rate for males is 52.40 and is 47.91 for females. The Health People 2020 target is 33.8. The county of Sherburne does not meet this target with a stroke mortality rate of 38.07.

## Next Steps

**Develop Implementation Plan**

The implementation strategy is a roadmap for how community benefit resources will be used to address the health needs identified through the CHNA. CentraCare Health has an extensive track record of identifying and testing promising practices for replication throughout the system by leveraging the expertise of staff and by working collaboratively with community partners. That being said, the implementation strategy—or better yet the action plan that will guide the overall strategy—is an extension of the kind of work CentraCare Health carries out regularly to promote community health.

The hospitals within the CentraCare Health system identified specific health needs related to the six health themes that emerged from the CHNA. To begin the process of developing an implementation strategy in response to each of these needs, select team members of the CHNA Advisory Task Force were assigned the responsibility of:

- Reviewing the existing community benefit programs
- Identifying what other community organizations are doing in regards to health priority areas
- Creating a work plan and ensure coordination across the entire health system
- Developing specific goals and metrics to monitor and measure progress and outcomes
- Communicating short-term and long-term results of the action plan with the community

## Publication

This assessment summary will be posted on the CentraCare Health Web site. A hard copy will be made available upon request. Information about the completion of the CHNA can be obtained by contacting the administrative department. CentraCare Health and its affiliated hospitals are committed to improving community health and will conduct another assessment in three years.

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