COMMUNITY HEALTH ASSESSMENT

Summary & Implementation Strategy

May 2018

Coteau des Prairies Health System

Coteau des Prairies HEALTH CARE SYSTEM

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EXECUTIVE SUMMARY

OVERVIEW

A community health needs assessment identifies and prioritizes the health needs of the community through collection of data and information to inform development of strategies to address priority health needs. A comprehensive assessment process gathers information using sound data collection methods and reflects the behaviors, beliefs, and demographics of community residents. A well-designed assessment will provide community planners, stakeholders, and partners with strong data to support local decision-making to address a healthy community environment. Moreover, multi-sector collaboration is integral to effectively understanding and addressing priority health needs, as well as integrate health equity into planning and practice.

To meet the requirements of the Patient Protection and Affordable Care Act and ensure that CDP Health System supports the community we serve, a community health needs assessment was conducted in collaboration with diverse partners and stakeholders. This process was implemented to understand the health issues that affect the community. Findings from the assessment informed development of a Community Health Improvement Plan, which support multi-sector collaborations, aligned to address priority health needs through evidence-based strategies. These efforts justify CDP's non-profit status and reinforces their guiding principles.

METHODOLOGY

CDP was awarded funding from the South Dakota Department of Health Office of Health Promotion and Chronic Disease Prevention to conduct a community health needs assessment to understand the health of the and identify priority health issues to improve population health in the CDP service area, including Roberts County, SD, Marshall County, SD, Day County, SD, Traverse County, MN, and Richland County, ND. The CDP service area also includes the Sisseton Wahpeton Oyate of the Lake Traverse Reservation. The process was guided by the DOH funding opportunity, as well as evidence-base practices for data collection.
CDP leadership convened a diverse sector of existing and new partners to support a community-driven process focused on comprehensive information gathering and data collection regarding local assets, gaps, and the health status of the service area. The CHNA process was guided by an established timeline which outlined steps and activities necessary to implement throughout the process. Methods to gather information and collect data included the following:

- **Partner, Stakeholder, and Community Members Focus Group:** B Consulting, LLC conducted two focus groups with members of the Stakeholder Committee and community members to understand priority health issues to address in the community survey. Findings from the focus groups were categorized into themes and supported development of the Community Health Survey.
- **Community Health Survey:** CDP leadership, project consultants, and B Consulting, LLC developed a survey to gather information from residents in the CDP service area regarding demographics, priority health issues, access to health care, substance use, mental and behavioral health and general health behaviors. The survey was disseminated electronically and paper copies throughout the service area through CDP partners and stakeholders, CDP clinics and hospitals, as well as at local events. A total of 202 surveys were completed and analyzed for key findings.

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- **Secondary Data Collection:** Comprehensive data was collected from valid and quality data sources on indicators that measure factors shown to affect health outcomes, including, mortality and morbidity, social determinants of health, maternal and child health, mental and behavioral health, health care resources, health behaviors, quality of life, clinical care, and measure relevant to the area tribal community.
- **Community Resource Inventory:** An inventory of available assets and resources, as well as gaps in those resources that support residents in the CDP service area to live, work, learn, and play healthy. The CDP Stakeholder Committee and CDP leadership supported information gathering, which supports understanding what the priority health issues are. Information was gathered regarding many resources, including health care providers and services, grocery stores available to support access to food, community coalitions, and neighborhood associations.

KEY FINDINGS

Community Health Survey and Focus Groups

Through this CHNA, the project partners attempted to survey key community leaders, stakeholders, and community members along with asking them to participate in the focus groups for determining the needs of the community. While many individuals participated, there are many community members who did not provide feedback through this assessment. The Community Health Survey (CHS) and focus groups asked for individual perceptions of community health issues and are subjective to individual experiences which may or may not be the current status of the community.

CHS included 28 questions that ranged from multiple-choice to open-ended questions along with several basic demographic questions, which took approximately ten minutes to complete. 202 individuals participated in the survey with an 87% completion rate. The ages of participants ranged from 18 to 75 plus years with an average age range of 45-54 and the majority identified as female (85%, N=150). There was very little diversity within the respondents as most identified as White (Caucasian, 77%, N=131) with Native American representing 28% (N=47) of the respondents. When respondents were asked to rate their community health, 66% (N=130) of the respondents stated their community had fair to poor health, but 71% (N=142) reported their own health state as good to very good health. However, the average number of days the respondent reported to having fair or poor physical health in the last 30 days was nearly 7 days. The survey also identified that the top five health conditions were: high blood pressure, depression, high cholesterol, anxiety, and arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia. The top preventative services accessed in last year included: Flu shot-67% (N=123), Blood Pressure Screening-56% (N=103), Dental Screening-46% (N=65), Blood Sugar Screening-36% (N=67), Cholesterol Screening-36% (N=67). The primary reasons for not accessing preventative services were that the screening was not necessary (40.46%, N=70) and Doctor Hasn't Suggested (29%, N=50). This indicates the need to educate the community on the benefits of preventive health care and maintenance along with reminding medical professionals to reinforce the education and benefits.

Additionally, 70% of respondents indicated they would access after-hour care on nights and weekends if it was available at a walk-in or urgent care clinic. The survey also indicated that nearly 60% of the respondents rated their mental health as fair to poor during the last 30 days with having an average of 12 days of feeling fair or poor and only 17% stated they needed treatment. However, near 40% of those individuals who stated they

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needed treatment were not able to access treatment due to no availability of treatment or thought they could handle it by themselves. Given these numbers, CDP catchment area would greatly benefit from additional mental health services.

While this community health needs assessment is comprehensive, it cannot measure all aspects of health in the CDP catchment area, nor can it adequately represent all possible populations of interest. Because of these information gaps, the ability to assess all the community health needs are limited in some ways. Both the quantitative (CH survey) and qualitative data (focus groups) have limitations, and, as a result, should not be used to confirm or deny a specific health issue within the area.

Secondary Data Collection

Secondary data research highlighted progress moving in the wrong direction to support healthy communities. Obesity and related risk factors continue to challenge the CDP service are with poor physical activity and nutrition behaviors, poor access to physical activity opportunity, and healthy foods for all residents of the service area. In addition, the food insecurity rate continues to increase in adults and children, as well as those who are ineligible for assistance with accessing food through programs such as SNAP or WIC.

Health behavior including sextually transmitted diseases (Chlamydia), tobacco use in pregnant mothers, utilization of preventative services and screenings for diseases, such as colon cancer, heart disease, etc., and alcohol impaired driving, contribute to poor disease and mortality rates. Specifically, the CDP service area has a high age-adjusted colon cancer incidence rate and a low percentage of adults age 50+ who have had a sigmoidoscopy/colonoscopy within the past 10 years.

Access to primary care physicians continues to be a challenge, and there are increasing rates of uninsured populations in the CDP services area, including 18-64 year old's, Native Americans, and children under 18 years of age.

Mental and behavioral health issues continue to affect the service with increasing rates of suicide in the Roberts County, SD area in people under the age of 25 and in American Indians. An increasing percentage of the Medicare population is reporting depression, as well as a higher percentage of adults aged 18 or older who self-report they receive insufficient social and emotional support.

PRIORITY HEALTH ISSUES AND IMPLEMENTATION STRATEGIES

CDP leadership and key partners convened for an action planning session to review data findings and determined priority issues that should be addressed in the CDP service area over the next three years. Priorities were identified based on current efforts underway to address the community's health issues, capacity of CDPHCS and partners to address issues, significance of the health issues, and to build on CDPHCS' prior work to address population health in the CDPHCS service area. Six priority issues along with strategies were identified with obesity and chronic disease management (e.g., heart disease, diabetes) identified as the number one priority.

- **Priority 1: Obesity and Chronic Disease Management**

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CDP will research development of Case Management Program for CDP patients to set strategy to improve the care of patients with chronic disease diagnosis and obesity. In addition, CDP will promote patient education programs to patients, the community and partners that focus on the chronic disease management, fruit and vegetable consumption, as well as breastfeeding to support healthy mothers and babies. Specifically, program such as the Better Choices, Better Health chronic disease management program will be promoted within the CDP service area. This program is available throughout South Dakota and currently there are trained facilitators in the CDP service area, available to host and facilitate these trainings. Patient education programs will also focus on the consumption of fruits and vegetables, such as the Pick It, Try It, Like It campaign. In addition, we will work with local partners, such as the WIC office to provide patient education to improve adoption of breastfeeding practices.

CDP will create and promote a wellness committee for health enrichment of the CDP staff, as well as develop a staffing plan, budget and design for a patient advocacy program that supports the strategies to address obesity and chronic disease management. CDPHCS has requested consultant to conduct a Readiness Assessment and provide operational expertise and assistance to implement strategies that will improve Chronic Disease Management performance within the evidence-based clinical practices and outcomes related to these chronic conditions.

- **Priority 2: Behavioral and Mental Health**
  CDP will continue to enhance the work outlined in the 2012 Implementation Plan and continue to implement a dual approach to address mental health issues in the CDP service area, focused on 1) creating and promoting an active place program for individuals afflicted by mental health issues and 2) partner with local law enforcement and mental health care providers to address and refine the mental health hold process to lessen wait time and increase access to care. We will work with health care providers to enhance screening of patients for mental health issues. We will also explore strategies to educate community members and patients life coping skills, as well as how to engage parents with their children more and be aware of any mental health issues their children may be facing.

- **Priority 3: Alcohol, Drug, and Substance Use/Abuse**
  Establish and foster partnerships with local community groups, including the SWO Tribal Health Board and Indian Health Service, to address the chronic issue of alcohol and drug use/abuse in the surrounding community. Specifically, CDP aims to target its prevention and at-risk behavior education towards youth via partnership with area school districts, both public and private, reinforce existing messaging mediums and expand programming. In addition, CDP plans to create consistent and direct messaging to patients and community members about active referral services for adults with chronic alcohol abuse issues. Educational resources will be given to health providers to foster an environment that is supportive of care practices and referrals for patients who are affected by this illness.

  In an effort to best coordinate these services, both inpatient and within the community, CDP will utilize the patient advocacy program in response to medical care close to home. The active placement program, an evaluation tool to access the needs of patients, described above in addressing mental health care would also be utilized here as well, wherein CDP could ultimately be in

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a position to improve the quality of services available in the community and increase access to those services for individuals with alcohol addiction.

- **Priority 4: Suicide Prevention**
  CDP will continue to enhance the activities outline in the 2012 Implementation Plan focused on suicide prevention including: continue to collaborate with existing community partners to increase awareness of suicide and prevention strategies. Existing partnerships, such as the Aliive Roberts County Coalition, are important to maintain in order to identify new partners and stakeholders to support suicide prevention efforts. CDP will explore strategies to integrate routine suicide screenings into care and educate health care providers to increase their level of comfort and understanding to assess suicide risk with patients. CDP will explore partnership opportunities with SWO and organizations who can support a "Zero Suicide Model" for suicide prevention.

- **Priority 5: Preventative Services**
  Secondary data and findings from the community survey found higher rates of chronic diseases in CDP service area, as well as not accessing preventive services to address and/or prevent chronic diseases. Efforts will focus on promotion of preventative services and encouraging providers to refer patients to preventative services. In addition, CDP will work with local partners, such as local health service agency and Sisseton Wahpeton Oyate tribe to advocate for preventative services and expand current efforts conducted in the community, which are focused on screenings for color cancer.

- **Priority 6: Access to care/telehealth to patients**
  Data from the CHNA highlight the challenge for patients in the CDP service area to access care, including physicians and geographic distance to CDP services. CDP will develop and execute a tactical plan for recruitment of family practice providers. In addition, will explore options for reducing barriers to accessing care by extending hours of operation, including after hours, extended hours, weekend, and a walk-in clinic. Physician recruitment will continue for family practice physicians.