COMMUNITY HEALTH NEEDS ASSESSMENT

AVERA MARSHALL REGIONAL MEDICAL CENTER

2016

Acknowledgements

The Avera Marshall Regional Medical Center Community Health Needs Assessment (CHNA) was conducted in collaboration and partnership with community members, community organizations, stakeholders from local public health and internal stakeholders. These partners assisted in the development and analysis of assessment information through a series of data collection processes and multiple community forums. In addition, Avera Marshall partnered with the Southwest Initiative Foundation, (SWIF) and the associated consultant services of Andrea Fox Jensen to provide a more comprehensive look into the social determinants of health and wellness in the communities we serve.

We extend our gratitude to the community forum participants who willingly participated in discussions about the health and wellness of our community and to the many individuals who were instrumental in the CHNA process.

Executive Summary

Compelled to Care for our Community

As a faith-based health care organization in the Catholic Christian tradition, Avera Marshall Regional Medical Center's work of providing services that reflect the needs of our community is central to our identity. While governed by laws and regulations for non-profit tax-exempt hospitals to provide services to those in need, we are ultimately compelled by a desire to extend the healing ministry of Jesus. Our mission and core values call us to make a positive impact in the lives and health of persons and communities.

Avera Marshall is committed to meeting the needs of all who need care regardless of their ability to pay.

In a spirit of charity and justice, Avera exists in response to God's calling for a healing ministry to the sick, the elderly and the oppressed, and to provide healthcare services to all persons in need, without regard to the consideration of age, race, sex, creed, national origin or ability to pay... Avera is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. Consistent with its mission to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values, Avera strives to ensure that the financial capacity of people who need health services does not prevent them from seeking or receiving care. (Avera Fiscal Policy #605 Financial Assistance and Billing Practices)

Avera Marshall is in its 75th year of serving the surrounding communities of Lyon County in Southwest Minnesota. From a community hospital that first opened in 1950 to the regional medical center it is today, the steadfast commitment to delivering quality health care to individuals and communities remains strong and at the center of all decisions.

The last decade in particular has brought many changes to the rural health care arena, including changes in reimbursements and insurance, legislative impacts, increased competitive forces, changes in economic status for consumers and the need for partnerships in many areas. Finding ways to lessen gaps in services, be competitively positioned and finding purchasing savings have challenged existing business models.

The quest to be the best health care provider possible has been at the forefront of tough decisions. Avera Marshall has maintained core services, strengthened sophistication through technology and recruited skilled professionals for its team. Avera Marshall continues to have significant impact on the local economy, through jobs, visitors, and overall commerce. Successful recruitment of physician specialists has brought a surge of credibility and access that has not been available to the region before. These successes are built on the premise of continuing to fulfill the mission, vision and values of the organization.

Mission

Avera is a health ministry rooted in the Gospel. Our mission is to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values.

Vision

Avera Marshall will be the leading provider of high quality health care services for the region.

Ministry: Avera Marshall participates in the healing ministry of Jesus.

People: Avera Marshall will be the partner of choice for employees, physicians and communities.

Service: Avera Marshall will exceed the expectations of our customers.

Quality: Avera Marshall will lead the industry in clinical performance and innovative care delivery redesign.

Financial Stewardship: Avera Marshall will achieve growth in our markets and maintain financial security.

Core Values

In caring together for life, the Avera Marshall community is guided by these Gospel values:

Compassion

The compassion of Jesus, especially for the poor and the sick of body and spirit, shapes the manner in which health care is delivered by Avera's employees, physicians, administrators, volunteers and sponsors. Compassionate caring is expressed through sensitive listening and responding, understanding, support, patience and healing touch.

Hospitality

The encounters of Jesus with each person were typified by openness and mutuality. A welcoming presence, attentiveness to needs and a gracious manner seasoned with a sense of humor are expressions of hospitality in and by the Avera community.

Stewardship

Threaded through the mission of Jesus was the restoration of all the world to right relationship with its Creator. In that same spirit and mission, the members of Avera treat persons, organizational power and earth's resources with justice and responsibility. Respect, truth and integrity are foundational to right relationships among those who serve and those who are served.

A Retrospective Review

In 2013, Avera Marshall Regional Medical Center participated in a Community Health Needs Assessment (CHNA) for Lyon County area to identify community perceptions of health concerns, barriers to access, gaps in service, health education, prevention services, vulnerable populations and social concerns. At that time, a plan was developed for addressing needs within the community. The full report can be viewed at http://www.avera.org. In that 2013 Needs Assessment, community health priorities were identified and recommendations were implemented to address priority needs. As part of the 2016 Community Health Needs Assessment process, a retrospective review of the 2013 CHNA and Implementation plan was conducted. Based on the Avera Marshall Board of Directors' recommendation, the 2013 community health needs assessment and implementation plan focused on providing additional cancer related services to our community. In response to the prioritized need and recommendation, the Avera Cancer Institute Marshall (ACIM) was opened in January of 2015 and began offering comprehensive cancer services, including radiation treatment to the residents of Lyon County and the surrounding regions. Since its inception, ACIM has provided local, high quality cancer treatment to over 200 patients. In addition, Avera Marshall successfully recruited specialty physicians and spearheaded conversations with local mental

health providers. Avera Marshall participated in the Avera Behavior Health Service Line and intentionally recruited therapists in response to the identified needs in the 2103 CHNA.

Since the completion 2013 CNHA , Avera Marshall has received requests for printed copies of the assessment. However, no written comments were received regarding that community health needs assessment or implementation plan.

Why a CHNA was conducted

The 2016 CHNA was conducted by Avera Marshall Regional Medical Center to identify community health needs and to inform development of an implementation strategy to address identified priority needs. The hospital's assessment of community health needs also responds to regulatory requirements. Federal regulations require that tax-exempt hospital facilities conduct a CHNA every three years and develop an implementation strategy that addresses priority community health needs, treatment and/or promote health and healing as a response to identified community needs. The CHNA process included an in-depth review of national, state and local data, key stakeholder forums, and reviews of local level surveys and studies.

The 2016 CHNA represents an approach to gathering information that can impact health care delivery by identifying unmet health care needs and strengthening existing services. The assessment fit well with our mission and was a strategic way to look carefully at what gaps there are in our service offerings. As a large employer within our Regional Service Area, Avera Marshall is proud of being a wise steward of our resources, including financial, people and community resources. 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 socioeconomic status, access to healthy food, social connectedness, education 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 Avera Marshall puts forth special effort to understand the unique characteristics of the communities served by the hospital and clinics.

The 2016 CHNA identified many areas of community health and wellness needs, including, access to care, prevalence of chronic diseases such as diabetes and cardiovascular disease, in

addition to dental care and access to nutritional foods. Three major health and wellness priorities identified in the CHNA are mental wellness, elder care and dementia care, and coordinated care.

Section 1: Demographics

(Quantitative/Secondary Data Collection)

A thorough secondary data review was conducted with publicly available data on the demographics and health indicators for our community. The primary data sources included the U.S. Census Bureau, County Health Tables and other documents available through the Minnesota Department of Health, the Minnesota Department of Human Services, *The County Health Rankings* (through the University of Wisconsin) and the Minnesota Student Survey. Additional information was utilized from other internal sources.

Definition of Community

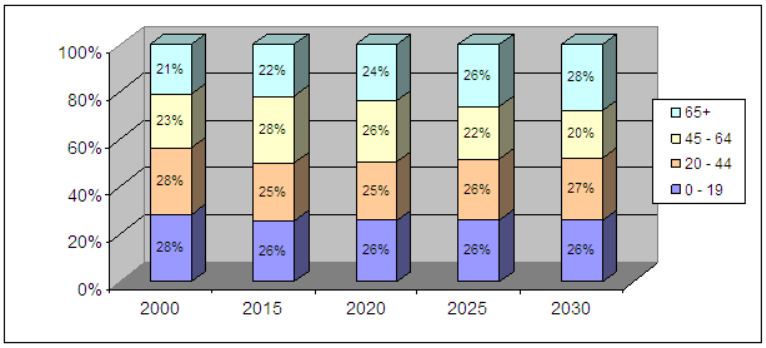
Avera Marshall serves southwest Minnesota, including all people, regardless of age, nationality or economic status. For purposes of this report, community is defined as Lyon County (Primary Service Area) and four surrounding counties of Lincoln, Redwood, Pipestone and Murray, as (Secondary). The cities in Lyon County include Marshall, Minneota, Ghent, Taunton, Lynd, Russell, Cottonwood, Tracy, Balaton and Garvin. Marshall is the county seat with the largest share of population, with the other communities considered micro-communities functioning as their own municipalities.

There is also a large rural community consisting of agricultural and livestock farmers, plus rural dwellers. The major employers in Marshall are The Schwan Food Company, US Bank, Avera Marshall, Southwest Minnesota State University, and Hy-Vee.

Avera Marshall Discharge data information indicates the majority of those served are Lyon County residents (by zip code), however a growing number of discharges also include residents from Lincoln, Redwood, Pipestone and Murray Counties.

Demographics of Service Area

Avera Marshall Primary Service Area Population by Age Group Projections



Source: U.S. Census Bureau (2010 data); Woods & Poole Economics, CEDDS 2011, (2015, 2020, 2025 & 2030 Projection)

Rural Population Trends

Overall, population has been on the decline in four of the five identified counties. From 2004 – 2014, Lyon County is the only county within the service area counties with a population gain. Demographic projections for these counties show that the trend will continue with Lyon County gaining population through 2040, (25,400 in 2000 growing to 28,000 by 2040) with the rest of the counties decreasing in population.

Although a high percentage of the population remains white, Lyon County experienced a **500%** increase in the populations of color from 1990 to 2010. As a whole, the service area counties experienced a shift in the distribution of populations of color from 98.6 percent white in 1990 to 91.6 percent white in 2012.

Demographics for the identified counties show that the population is continuing to get older. From 2000 to 2012, there was a sharp increase of 3,870 people in the 50 -69 age groups. In

four of the five identified counties, the percent of the population 65 and over is higher than the State of Minnesota average.

Primary Service Area, Lyon County, Minnesota

Population	**Lyon County**	**Minnesota**
Population, 2014	25,665	5,489,594
Persons under 5 years, percent, 2014	7.2%	6.4%
Persons under 18 years, percent, 2014	24.8%	23.5%
Persons 65 years and over, percent, 2014	14.4%	14.3%
Female persons, percent, 2014	50.4%	50.4%
White alone, percent, 2014	86.3%	85.3%
Black or African American alone, percent, 2014	2.5%	5.2%
American Indian/Alaska Native alone percent, 2014	0.7%	1.1%
Asian alone, percent, 2014	3.3%	4.0%
Hispanic or Latino origin, percent, 2010	6.4%	4.7%
Foreign born persons, percent, 2010-2014	5.6%	7.0%

People Characteristics	**Lyon County**	**Minnesota**
High school graduate or higher, percent of Persons age 25 +, 2010-2014	92.4%	86.3%
Bachelor's degree or higher, percent of persons age 25+, 2010-2014	27.2%	31.4%
Median household income (in 2014 dollars) 2010-2014	$51,182	$60,828
Persons in poverty, percent	12.3%	11.5%
Veterans, 2010-2014	1,455	355,366
With a disability, under age 65 years, percent, 2010-2014	7.2%	8.5
Persons without health insurance under age 65 years, percent	9.6%	12%
Language other than English spoken at home, percent, of people's age 5 years+, 2010-2014	10.4%	10.9%

Housing	**Lyon County**	**Minnesota**
Housing Units, 2014	11,181	2,347,201
Home ownership rate, 2010-2014	67.5%	64.4%
Building Permits, 2014	36	16,990
Median value of owner-occupied housing units, 2010-2014	$134,700	$185,200
Median selected monthly mortgage, 2014	$1,179	$1526
Median gross monthly rent	$609	$835

Households, 2010-2014	10,076	2,115,337
Persons per household, 2010-2014	2.43	2.48
Business	**Lyon County**	**Minnesota**
Private nonfarm establishments, 2013	798	146,354
Private nonfarm employment, 2009	12,571	2,518,268
Total number of firms, 2007	2,302	496,657
Retail Sales, 2007 ($1000)	378,877	71,384,103
Geography	**Lyon County**	**Minnesota**
Land area in square miles, 2010	714.56	79,626.74
Persons per square mile, 2010	36.2	66.6

Source: United States Census Bureau Quick Facts Data derived from; Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits

Health Data

Chronic Disease

- Chronic diseases account for seven of every 10 deaths in the United States. They are among the most prevalent, costly, and preventable health problems. Examples of chronic diseases include cancer, heart disease, stroke, obesity, arthritis, and diabetes. Healthy lifestyles can reduce the risk for developing chronic disease. Chronic disease is higher in the identified counties than the State of Minnesota.

- Diabetes is notably higher than the state average in the identified counties. Age-adjusted estimates of the percentage of adults with diagnosed Type II Diabetes is highest (7.1 percent) in Lyon County compared to both surrounding counties and compared to the Minnesota state average (6.1 percent)

- Asthma hospitalization rates are higher in the identified counties than the state rates. In more populated areas (Redwood and Lyon) – number of asthma related ER visits increased from 2008 -2013 (20.5 to 27.1 and 20.2 to 24.6 respectively {per 10,000 visits})

- The second leading cause of death in the identified counties is cancer. Prostate cancer is the leading new cancer diagnosis. Breast cancer is the 2nd leading new cancer diagnosis. Lung cancer is the leading cause of death by cancer type.

- Higher rate of COPD hospitalizations in the identified counties compared to the State of Minnesota.

- Cardiovascular disease is the leading cause of death in the identified counties; each county has a slightly higher rate in heart attacks and heart disease than the State of Minnesota. Stroke mortality rates have declined over the past 10 years, but are still higher than the state average. Over 30 percent of adults in the identified counties have a diagnosis of high blood pressure. Over 30 percent of adults in the identified counties have a diagnosis of high blood cholesterol.

Access to Care

- All five counties are underserved in mental health services. There is also a shortage of dentist and primary care physician providers in the identified counties.

Physical Activity / Eating Habits / Obesity

- The rate of obesity (BMI of 30 or more) continues to rise in every racial and ethnic population in the identified counties, as well as among children, adolescents, and adults, in both males and females.

- In 2014, Lyon County had a higher rate of obese adults compared to the State of Minnesota.

- Physical activity is increasing in adults, with 54 percent getting some exercise 3 times per week in 2014 vs. 41 percet in 2004.

- 9th grade students in the identified counties who eat vegetables 2 or more times daily are lower than the State of Minnesota rate. (20 percent vs. 21 percent respectively)

Mental Health

- Eight percent of adults in the identified counties experienced significant depressive symptoms in 2012. Three percent of adults had symptoms of serious psychological distress (although these groups are not mutually exclusive) Individuals with serious mental illnesses were more likely to experience homelessness, lack of insurance coverage, and less social support.

- 33 percent of 9th grade students in the identified counties in the last 12 months feel significant problems with anxiety, nervousness, tension, fear or the feeling that something bad was going to happen. 15 percent of 9th grade students in the identified counties have seriously considered attempting suicide.

- Mental Health diagnosis continues to recur in the top 10 reasons for emergency department visits in Lyon County.

Environmental Health & High Risk Behaviors

- Adults and 9th graders smoking rates are decreasing in Lyon County (higher in Lincoln and Pipestone counties).

- Percent of birth mothers who smoke is higher in the five counties area versus state averages.

- Binge drinking in 9th graders who engaged in last 2 weeks is higher than Minnesota in the identified counties.

- Teen Birth rate is higher in the identified counties than the State of Minnesota in 2008-2012.

Advanced Aging Population

- Higher percent of people utilize nursing homes for care versus home & community care options in the identified counties.

- In the identified counties long term care expenditures are higher than state average; home & community based service expenditures 65+ is lower than Minnesota average.

Hospital Data

Medicare discharge data

According to The Medicare Provider Analysis and Review file, the top MS-DRG diagnosis of Medicare beneficiaries admitted to Avera Marshall for fiscal year 2015 were:

- Psychoses
- Major joint replacement
- Simple pneumonia and pleurisy
- Heart failure and shock
- Nutritional or metabolic disorder
- Hip and femur procedures except major joint
- Kidney and urinary tract infections
- Chronic obstructive pulmonary disease
- Esophagitis, gastrointestinal and misc. digestive disorders
- Cardiac arrhythmia and conduction disorders

Emergency Department Discharge Reason for visit

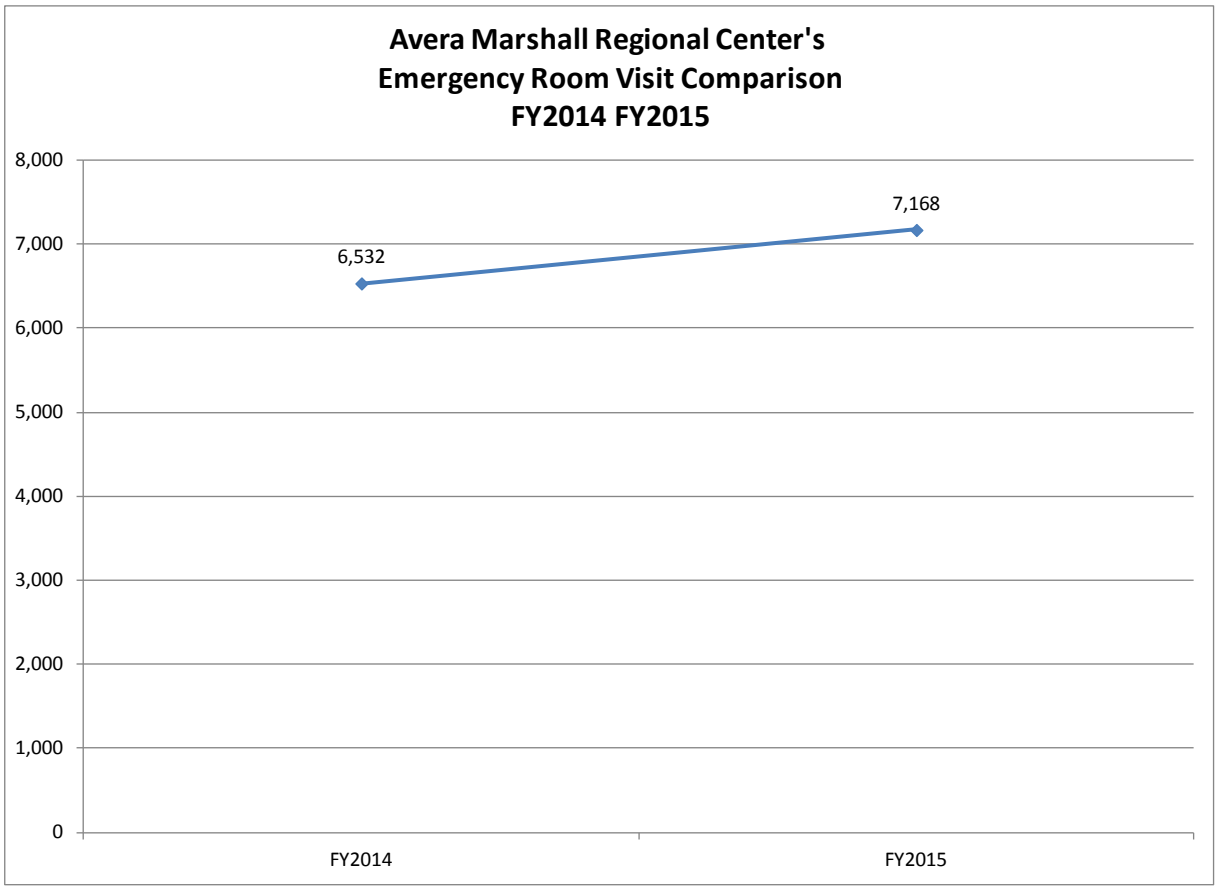
In review of internal data sources, for January 1 2015 – December 31, 2015 the top reasons for discharges from the Emergency Department included:

- Abdominal pain
- Ear infections
- Chest pain
- Stomach flu
- Fever
- Headache
- Urinary tract infection
- Back pain
- Severe reoccurring depression (mental health issues recur in the top 50 reasons)
- Dental problems

**This data is not significantly different from a review of the previous years, with the same reasons bringing people to the ER*

Avera Marshall Regional Center's Emergency Department (ED)

In fiscal year 2015, there were 7,168 visits to the Avera Marshall Emergency Department, almost a nine percent increase from the previous fiscal year.



Top Diagnoses for Discharge from the Hospital

In 2015, the top diagnoses were:

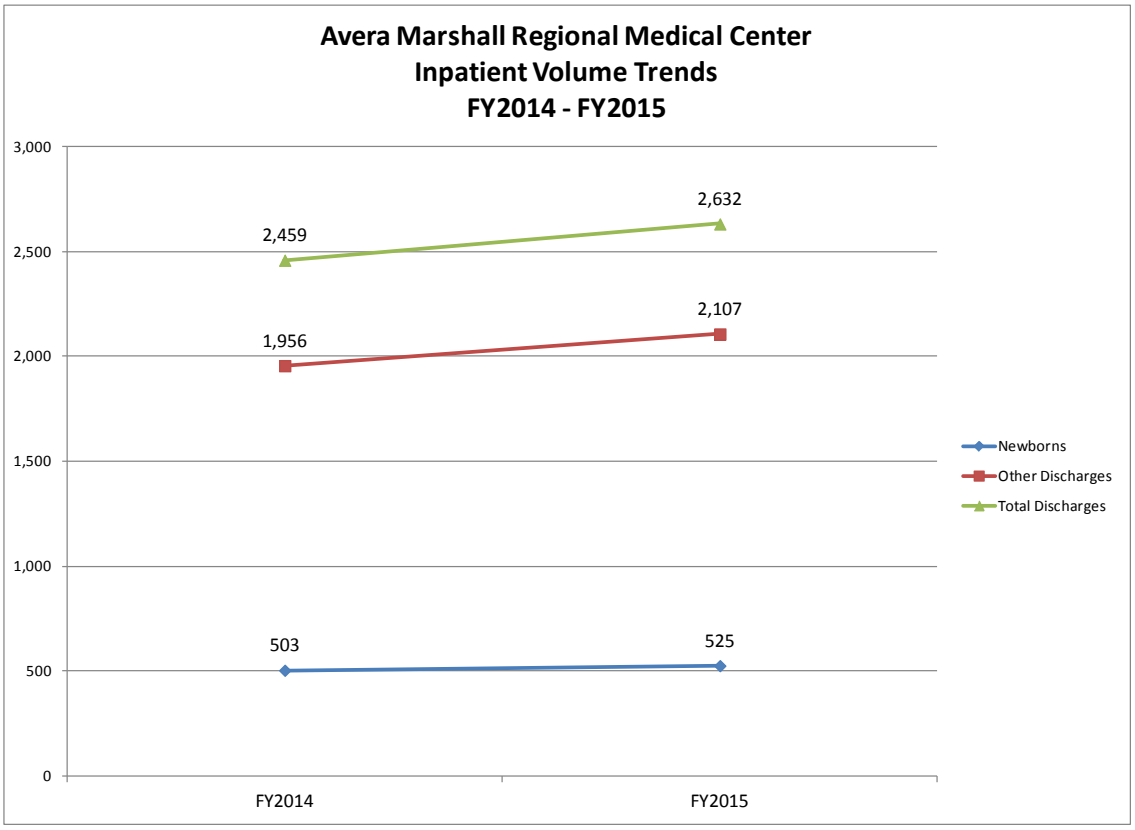
- Single live births
- Pneumonia
- Mental health issues
- Repeat Cesarean delivery
- Osteoarthritis

The information on discharges illustrated disease prevalence in heart disease, heart failure and pneumonia in addition to mental health issues.

**This data is not significantly different from a review of previous years.*

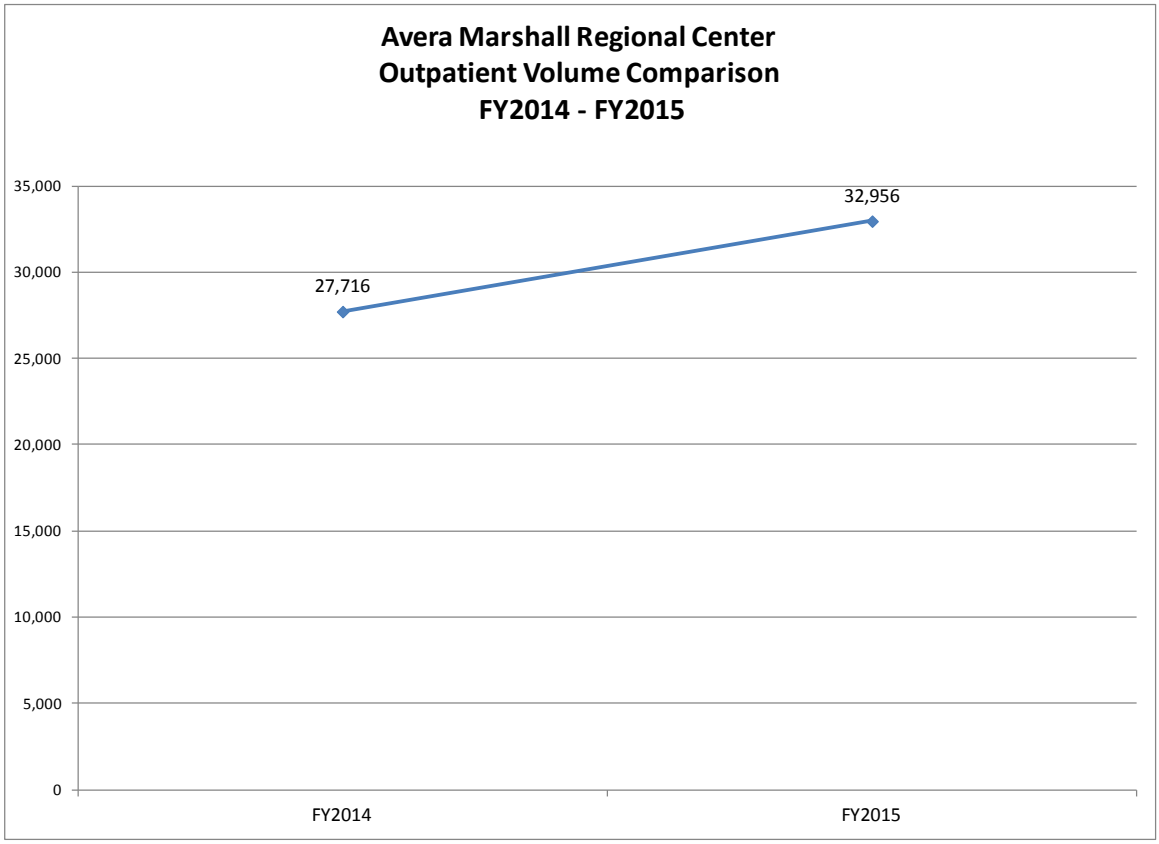
Avera Marshall Regional Center's Inpatient Volume Comparison

In fiscal year 2015, there were 2,632 total discharges from Avera Marshall Regional Medical Center, an increase of six percent from fiscal year 2014.



Avera Marshall Regional Center's Outpatient Data

In fiscal year 2015, there were 32,956 total outpatient visits, an increase of almost 16 percent from fiscal year 2014.



Community Resources Identified

Lyon County and the surrounding communities have many valuable community assets that promote good health and a high quality of living for its residents. These assets include comprehensive health care resources; 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. A non-exhaustive list is below.

Avera Marshall Regional Medical Center

Avera Tyler

Affiliated Community Medical Center

Southwest Health and Human Services

- Food Assistance
- Cash Assistance
- Medical Assistance
- Teenage Pregnancy

Western Mental Health:

- Emotional and Behavioral Counseling Services

Western Community Action:

- Heating Assistance
- Housing Assistance
- Food Pantry
- Social Services
- Transportation Services

New Horizons Crisis Center:

- Domestic Abuse

Goodwill

- Clothing Assistance (must qualify through Welfare of Western Community Action)

Esther's Kitchen (Presbyterian Church)
Ruby's Pantry

- Prepared meals
- Food pantry

SWCIL (SW Center for Independent Living)

- Assistance for independent living skills, paying bills, applications, etc.

Children's Crisis Response Service

- Behavioral, emotional, or psychiatric crisis

Health Care Provider Resources

- In 2015 County health rankings reveals the ratio of population to primary care physicians is 1419:1 for Lyon County and 1113:1 for Minnesota. The number of population to mental health providers in Lyon County is 2276.1 compared to the Minnesota statistic of 1306.1.

- There are portions of Lyon County that are deemed a Health Professional Shortage Area (HSPA) or Medically Underserved Area (MUA) from the Minnesota Department of Health. This includes psychiatry services and some primary care. A portion of Lyon County is also a designated rural area where primary care physicians are eligible for the Minnesota Health Professional Loan Forgiveness Program.

Section 2:
Data Assessment Analysis

(Qualitative/Primary Data)

For purposes of gaining primary information for this community health needs assessment, two community forums were conducted. A select group of community individuals were invited to participate in one of two facilitated forums, and selected based on their community involvement and their occupational roles. Many of these individuals have a significant stake within their occupations for the general, overall health of the service area. Special attention was taken throughout the primary data collection process to ensure the hospital's assessment took into account input from persons who represent the broad interests of the community including those with special knowledge or expertise in public health. Invitations were sent via email or in-person to the selected community members including representatives from education, local government, religious, social service and other nonprofit organizations in the community. There was intentional outreach to representatives from the medically underserved, and minority populations to ensure vulnerable populations were included. All potential participants were told that their feedback was important in representing the many roles they might play in the community: as a worker, neighbor and citizen.

Community forum groups included:

- Community leaders from towns in the surrounding counties
- Public health representatives from Southwest Health & Human Services
- Educators
- Business leaders
- Law enforcement
- Aging services
- Avera Marshall Board Representatives (Foundation & Governing)
- Physicians
- Faith Leaders
- Minority Representatives

The two community forums were held on November 19th, 2015 and December 11th, 2015 at the Marshall-Lyon County Library.

The same conversation questions were posed for each forum conducted:

1. When we say "health and wellness in our community, what do we want it to mean?
2. What is a community need that you are even more concerned about today than you might have been a few years ago?
3. What is a major chance to advance health and wellness that can only be achieved through shared effort?

Key Themes from Community Forum Groups

When we say "health and wellness in our community, what do we want it to mean?

- ***Holistic***
  Key themes included care for the whole person, in the right setting, where people live, learn, work and play. Health in our community is more than physical health, but also includes mental and spiritual health and must be considered in our schools, work places, churches, and homes.

- ***Coordinated Health Care***
  A prominent theme that surfaced during focus group discussion was the necessity of a collaborative, coordinated health care experience. Ideal collaboration would span the full breadth of the health care continuum. Participants envision a collaborative health care system in which institutions, community resources, and physicians not only communicate but work together to provide a well coordinated experience for patients and families.
- ***Active Support Systems***
  The groups identified a need for support teams and support systems to assist in navigating the health care systems and reaching the appropriate resources, promoting an equity of care.

- ***A Shared Responsibility***
  Groups mentioned the opportunity to lift up community organizations that come together to form a shared vision of responsibility for the well being of the individual

community member. Properly allocating resources to maintain and improve the health of an entire identified population of community residents, emphasizing the role played by the social determinants of health.

- ***Safe & Clean***
  Participants felt cleanliness, vibrancy and safety are closely associated with health and wellness in our communities. It was noted that a relationship exists between crime and health, as safety concerns cause stress leading to subsequent emotional, mental and physical issues and disparities beginning in childhood and throughout adult life.

- ***Economic vitality***
  Focus groups recognized business growth, stable population base, and a sense of regionalization, with Marshall as the hub. The groups identified the importance of a financially stable and highly employable population includes a generational mix of families and seniors. Capital improvements for communities add benefit, such as parks and bike trails.

- ***Acceptance & Ease across Cultures***
  Health and Wellness invites healthy relationships among the growing diverse cultures and ethnicities in our communities.

- ***Equal Care & Access to Care***
  Health and Wellness must be available for everyone. This means eliminating health care disparities, where access and quality of care in our communities does not differ by socioeconomic status, gender, race or ethnicity.

- ***Well Informed Community***
  A community that is knowledgeable about the many aspects of health and wellness will foster a greater likelihood of healthy behaviors, and healthy lifestyle choices.

What is a community need that you are even more concerned about today than you might have been a few years ago?

- ***Mental Health Issues***

  Forum groups noted that mental health issues are increasing in our communality, and some suggested that our community is on the verge of a mental health crisis. Although mental health crisis' are handled relatively well in our community, a more proactive, early diagnosis with a systematic approach is needed. Minority populations are very unlikely to seek and receive mental health services. Between the stigma associated with mental illness and inadequate screening by primary care practitioners, identification is often missed. The lack of local mental health providers and lack of available resources for mental health wellness was identified as a major concern during most of the groups. Too few psychiatrists serve the area. Raising awareness during annual physicals and accepting mental health to be equally important as physical health can start the changes towards better mental health. The school districts in our communities are seeing not only students, but parents are also affected by poor mental health which is harmful to the overall wellness of the family unit.

- ***Elder Care & Dementia Care***

  Focus groups mentioned the need for ample and quality long-term care, respite care, continuum of care, and caregiver services were all noted by participants as important. Addressing the growing number of dementia patients that are currently being cared for by family members and loved ones in the home setting. Participants acknowledged that though these needs were not immediate for everyone, they will impact each person at some point in their lifetime. Participants mentioned the need for a memory care program.

- ***Coordination of Care***

  Participants noted continued gaps in care coordination among providers, case managers, and language service providers. Special attention was given to the need for dementia care coordination and for the elderly who are suffering with chronic diseases. A more streamlined, less fragmented, team approach to care is necessary.

- ***Limited Access to Healthy Food***

  Access to healthy food continues to be an issue for many populations in our communities**.** There are opportunities to increase the availability of affordable, nutritious food in our communities, including increased nutritional information and how to prepare / cook healthy meals.

- ***Immigrant Integration***

  Groups suggested much work is necessary to successfully integrate immigrants in building secure, vibrant and cohesive communities, fostering respect and incorporation of differences with an appreciation of diversity. Emphasis must be placed on communication, education, equal treatment and opportunity and social and cultural interaction.

- ***Dental and Oral Health***

  Lack of access to dental services for the low-income population and many dentists don't accept Medicaid patients. One of the top health issues among children is prevalence of cavities. More children and adults need an annual dental exam.

What is a major chance to advance health and wellness in our community that can only be achieved through shared effort?

Access to care

- Primary and specialty care for underserved populations, insurance coverage and shared awareness of disparities in care due to language and cultural differences, transportation, and more.

Chronic disease prevention and management

- Community-based approaches to create the conditions for health and wellness and begin to reverse the growing incidence of chronic disease.

Educational Efforts

- Educational resources and methods to improve community awareness of the many aspects of the determinants of health and wellness. Education on healthy choices and promoting a balance between individual and community accountability in health and wellness.

Collaborative strategies

- Effective partnerships based on healthy community principles to achieve real advances in community health while creating a shared accountability for the health and wellness of our communities. Leveraging key community organizations in both the public and private sector. Promotion of consistent marketing message for health and wellness in

our communities. Lobbying state and local government for advocacy and financial support of health and wellness programs.

Shared Understanding of Measurement

- Logic models, indicators, and collaborative assessments to help establish goals, understand out-comes, and communicate progress.

Section 3:
Community Health Needs Prioritization

Health Care Priorities

Identification of priority health needs was accomplished through a facilitated forum of internal stakeholders of Avera Marshall, including the Governance and Foundation Boards, the Avera Medical Group Marshall Leadership Council and the Administrative Council. Supported with the primary and secondary community health and wellness data obtained through the CHNA process, the forum participants were invited to prioritize community health and wellness needs based upon community impact, potential for change, economic feasibility, community assets and alignment with the mission and values of Avera Marshall Regional Medical Center.

Upon completion of the prioritization process, Avera Marshall Regional Medical Center determined the following three community health priority needs:

- Mental Health
- Eldercare and Memory Care Services
- Coordination of Care through Health Teams

Prior to the CHNA, Avera Marshall 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. This process also helped to validate efforts that have been ongoing and/or are currently underway to address these health needs. It is significant to consider 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 new and innovative approaches to satisfy unmet and emerging needs. Consequently, Avera Marshall has taken extra steps to ensure the assessment process is sustainable and expansive.

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. Avera Marshall has an extensive track record of identifying and testing promising practices for replication throughout the service area 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 Avera Marshall carries out regularly to promote community health.

The proposed implementation strategy will be presented for discussion, consideration and approval to the Avera Marshall Board of Directors prior to November 15, 2016.

The 2016 CHNA report was presented and approved by the Avera Marshall Board of Directors on May 16th, 2016.

Sources

United States Census Bureau. www.census.gov

County Health Rankings & Roadmap. The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Avera Marshall Discharge Data. Avera Marshall, Marshall, MN.

Avera Marshall Emergency Room Data. Avera Marshall, Marshall, MN.

Minnesota Department of Health. St. Paul, MN.
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