COMMUNITY HEALTH NEEDS
ASSESSMENT

AVERA MARSHALL REGIONAL MEDICAL CENTER

2019
The information in this report is compiled from many sources, including state and county statistical information, data from other organizations and agencies, group studies of Lyon County residents, and additional information as pertinent to the process of a community health needs assessment.

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. In addition, Avera Marshall partnered with the Southwest Health and Human Services, (SWHHS) 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 recognizes the importance of responding to the changing community needs, and monitors changes that can impact health care.

Avera Marshall is committed to meeting the needs of all who need care regardless of their ability to pay. The mission of serving individuals and communities is central so a community needs assessment is a natural extension of collecting and studying information pertinent to health care delivery.

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 78th 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

1) In 2016, 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 https://www.avera.org/about/community-health-needs-assessments/. In that 2016 Needs Assessment, community health priorities were identified and recommendations were implemented to address priority needs. As part of the 2019 Community Health Needs Assessment process, a retrospective review of the 2016 CHNA and Implementation plan was conducted. Based on the Avera Marshall Board of Directors’ recommendation, the 2016 community health needs assessment and implementation plan focused on providing access to a full spectrum of mental health services and providing a collaborative care model involving primary care, mid-level mental health professionals, and qualified community agencies; providing access to a full spectrum of
Elder Care Services with partnerships with clinics, health providers, public health, employers, schools, civic leaders, police/fire and regional elder care services providers; optimize access and coordination of care throughout the continuum and to accomplish shared goals within and across care settings through enhanced access to care services with a consistent care team approach. In response to the prioritized need and recommendation, implementation of Cognitive Behavioral Therapy, a form of psychotherapy that treats problems and boosts happiness by modifying dysfunctional emotions, behaviors, and thoughts in the inpatient behavioral health unit was established, including adding an additional provider to the Avera Medical Group Psychiatry clinic to address on-going needs within the community. Avera Marshall continues to work with area schools to implement and reinforce concussion protocols. An adult and geriatric nurse practitioner (ANP/GNP) was added to staff to address continuum of care needs to the elderly. A Memory Care Clinic was established September 2017 as an outpatient clinic at Avera Marshall to support those with memory loss throughout their journey. It is meant to help with diagnosis, medication education, and referrals to community support as well as discussion about future care choices. It currently is held weekly on Thursdays at Avera Marshall. In addition, to help address the 2016 priorities and goals from the 2016 CHNA the following took place: Mental Health:

a) Additional telemedicine resources provided for Behavioral health
b) Additional social worker added to the staff to support after hours behavioral health concerns and on call social worker created 24/7/365
c) Consolidation of behavioral health transitions to social worker on call
d) Recruitment of on staff chaplain
e) Recognized in efforts in Zero Suicide, a national effort to reduce suicide, standardize staff education, and consistently address means reduction with patients
f) Won MHA patient safety award last year for zero suicide work.
g) Partnerships with mental health agencies to provide mental health expertise in primary care area

2) Eldercare and Memory Care Services:
   a. Additional resources added to support local schools with concussion management and healthy student choices

3) Coordination of Care
   a. Resources added to care coordination and collaboration of such with emergency services
   b. Recruitment of additional specialty physicians in cancer care, ENT, surgery, and primary care

Since the completion 2016 CHNA, 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 2019 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, and reviews of local level surveys and studies.

The 2019 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 fits 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 2019 CHNA identified many areas of community health and wellness needs, including, access to care, access to healthy food options, access to transportation, prevalence of chronic diseases such as diabetes and cardiovascular disease, in addition to aging problems and tobacco and e-cigarette use. Three major health and wellness priorities identified in the CHNA are mental health problems, obesity and tobacco and e-cigarette use and exposure.
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.
Rural Population Trends

Overall, population has been on the decline in all five identified counties. From 2017, Lyon County had a loss of 0.1% population.

Although a high percentage of the population remains white, Lyon County experienced an increase in racial diversity from 1990 to 2010. As a whole, the service area counties experienced a shift in the distribution of populations going from 98.6 percent white in 1990 to 89.7% white in 2017.

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 (2017 Data).
## Primary Service Area, Lyon County, Minnesota

### Population

<table>
<thead>
<tr>
<th>Category</th>
<th>Lyon County</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population, 2017</td>
<td>25,831</td>
<td>5,679,718</td>
</tr>
<tr>
<td>Persons under 5 years, percent, 2017</td>
<td>7.3%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Persons under 18 years, percent, 2017</td>
<td>25.1%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Persons 65 years and over, percent, 2017</td>
<td>15.2%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Female persons, percent, 2017</td>
<td>50.0%</td>
<td>50.2%</td>
</tr>
<tr>
<td>White alone, percent, 2017</td>
<td>89.7%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Black or African American alone, percent, 2017</td>
<td>3.6%</td>
<td>6.5%</td>
</tr>
<tr>
<td>American Indian/Alaska Native alone percent, 2017</td>
<td>0.7%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander alone, percent</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Two or More Races, percent</td>
<td>1.6%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Hispanic or Latino, percent</td>
<td>6.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Foreign born persons, percent, 2010-2014</td>
<td>6.4%</td>
<td>8.2%</td>
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</tbody>
</table>

### People Characteristics

<table>
<thead>
<tr>
<th>Category</th>
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<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school graduate or higher, percent of Persons age 25 +, 2013-2017</td>
<td>92.4%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Bachelor’s degree or higher, percent of persons age 25+, 2013-2017</td>
<td>26.5%</td>
<td>34.8%</td>
</tr>
<tr>
<td>Persons in poverty, percent</td>
<td>12.2%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Veterans, 2013-2017</td>
<td>1,246</td>
<td>319,438</td>
</tr>
<tr>
<td>With a disability, under age 65 years, percent, 2010-2014</td>
<td>6.3%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Persons without health insurance under age 65 years, percent</td>
<td>5.3%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Language other than English spoken at home, percent of people’s age 5 years+, 2013-2017</td>
<td>10.2%</td>
<td>11.3%</td>
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</tbody>
</table>

### Housing

<table>
<thead>
<tr>
<th>Category</th>
<th>Lyon County</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Units, July 1, 2017 (v2017)</td>
<td>11,259</td>
<td>2,437,711</td>
</tr>
<tr>
<td>Home ownership rate, 2013-2017</td>
<td>68.2%</td>
<td>71.6%</td>
</tr>
<tr>
<td>Building Permits, 2017</td>
<td>44</td>
<td>21,953</td>
</tr>
<tr>
<td>Median value of owner-occupied housing units, 2013-2017</td>
<td>$135,900</td>
<td>$199,700</td>
</tr>
<tr>
<td>Median selected monthly mortgage, 2013-2017</td>
<td>$1,148</td>
<td>$1506</td>
</tr>
<tr>
<td>Median gross monthly rent, 2013-2017</td>
<td>$621</td>
<td>$906</td>
</tr>
<tr>
<td>Households, 2013-2017</td>
<td>10,060</td>
<td>2,153,202</td>
</tr>
<tr>
<td>Persons per household, 2013-2017</td>
<td>2.44</td>
<td>2.49</td>
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</table>

### Business

<table>
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<th>Category</th>
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<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private nonfarm establishments, 2016</td>
<td>807</td>
<td>150,115</td>
</tr>
<tr>
<td>Private nonfarm employment, 2016</td>
<td>12,785</td>
<td>2,661,627</td>
</tr>
<tr>
<td>Total number of firms, 2012</td>
<td>1,983</td>
<td>489,494</td>
</tr>
</tbody>
</table>
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: 7.8 percent of Minnesota adults are diagnosed with diabetes (Type 1 or Type II). One in ten people have diabetes and don’t know it. (2017)

- Asthma hospitalization rates are higher in the identified counties than the state rates. In 2015 the hospitalization average for the five identified counties is 16.6 {per 10,000 visits}

- The first leading cause of death in the identified counties is cancer. Breast cancer is the leading new cancer diagnosis. Lung and bronchus 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. State of Minnesota hospitalizations is 15.9 per 10,000 compared to the identified counties is 16.4 per 10,000.

- 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. (County Health tables 2013-2017).

- Lyon County sexually transmitted infections lower than Minnesota average, however the number of cases for Lyon County in 2016 is over half the total number of cases for Minnesota which is 66% of the total for Minnesota, and a 49% increase from 2015 to 2016.

**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. (2016)

**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. The obesity rate in Minnesota is 28.4 percent (2017).

- Lyon County had a higher rate of obese adults compared to the State of Minnesota. Lyon County had 30 percent of adults reporting a BMI of 30 or more versus Minnesota with a 28 percent obesity rate. (2019 County Health Rankings used data from 2015 for this measure.)

- Physical activity is increasing in adults, with 77.6 percent getting some exercise 3 times per week in 2017 which is 3.4 percent less than the 81 percent Minnesota average.

- 9th grade students in Lyon County who chose to eat vegetables 2 or more times daily are 15 percent lower for males and 24 percent higher for females than the State of Minnesota rate. (21 percent respectively)

**Mental Health**

- Ten percent of adults in the identified counties experienced frequent mental distress which is the same frequency as the State of Minnesota in 2017. 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.

- 28 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.

- An estimated 50% of all Americans are diagnosed with a mental illness or disorder at some point in their lifetimes. Mental illnesses are the third most common cause of hospitalization for those 18-44 years old, and adults living with serious mental illness die on average 25 years earlier than others. (CDC.gov, 2018)

**Environmental Health & High Risk Behaviors**

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

- Binge drinking among 9th graders is higher than Minnesota in the identified counties. 9 percent of Lyon County 9th graders binge drink compared to 8 percent 9th graders in the State of Minnesota (2016).

- Teen birth rate is lower in Murray and Lincoln Counties, higher in Lyon, Pipestone and Redwood Counties than the State of Minnesota. The average for the 5 identified counties is .4 teen births lower than the State of Minnesota (2018 & 2019 data)

**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 (2015 – 2019).
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 2018 were:

- Major Joint Replacement or Reattachment of Lower Extremity W/O MCC
- Psychoses
- Septicemia or Severe Sepsis W/O MV 96+ Hours W MCC
- Simple Pneumonia Pleurisy W CC
- Esophagitis, Gastroent Misc Digest Disorders W/O MCC
- Disorders of Personality Impulse Control
- Major Joint/Limb Reattachment Procedure of Upper extremities
- Kidney Urinary Tract Infections W/O MCC
- Pulmonary Edema Respiratory Failure
- Misc disorders of nutrition, metabolism, fluid/electrolytes W/O MCC
- G.I. Hemorrhage W/O CC/MCC
- G.I. Hemorrhage W CC

Emergency Department Discharge Reason for visit

In review of internal data sources, for fiscal year 2018 the top reasons for discharges from the Emergency Department included:

- Other Chest Pain
- Viral Intestinal Infection Unspecified
- Acute Upper Respiratory Infection Unspecified
- Noninfective Gastroenteritis and Colitis Unspecified
- Dehydration
- Suicidal Ideations
- Syncope and Collapse
- Flu Due to Unidentified Influenza Virus W OTI RESP Manifest
- Viral Infection Unspecified
- Low Back Pain
- Nausea with Vomiting Unspecified
- Lobar Pneumonia Unspecified Organism
- Constipation Unspecified
- Laceration WO Foreign Body of OTH Part of Head INIT ENCNTR
- Sepsis Unspecified Organism
Avera Marshall Regional Center’s Emergency Department (ED)

In fiscal year 2018, there were 7,399 visits to the Avera Marshall Emergency Department, almost a two percent decrease from the previous fiscal year.

Top Diagnoses for Discharge from the Hospital

In 2018, the top diagnoses were:

- POSTTERM PREGNANCY
- MAJOR DEPRESSV DISORDER RECURRENT SEVERE WO PSYCH FEATURES
- MATERNAL CARE FOR LOW TRANSVERSE SCAR FROM PREV CESAREAN DEL
- UNILATERAL PRIMARY OSTEOARTHRITIS RIGHT KNEE
- UNILATERAL PRIMARY OSTEOARTHRITIS LEFT KNEE
- MAJOR DEPRESSIVE DISORDER RECURRENT MODERATE
Avera Marshall Regional Center’s Inpatient Volume Comparison

In fiscal year 2018, there were 2,580 total discharges from Avera Marshall Regional Medical Center, an increase of 2.8 percent from fiscal year 2017.
Avera Marshall Regional Center’s Outpatient Data

In fiscal year 2018, there were 58,372 total outpatient visits, an increase of almost 2.23 percent from fiscal year 2017.
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

Greater MN Family Services

Southwest Health and Human Services

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

Western Mental Health:

- Emotional and Behavioral Counseling Services
- 24/7 Crisis Services
- Medication Management
- Adult Mental Health Rehabilitation Services
- Community Support Program
- Children’s Program
  - Children’s Therapeutic Services
  - Family Community Support
- Outpatient Therapy Services
- Group Therapies
- Psychiatry

United Community Action Partnership:

- Heating Assistance
- Housing Assistance
- Food Pantry
- Social Services
- Transportation Services
New Horizons Crisis Center:

- Domestic Abuse

Goodwill

- Clothing Assistance (must qualify through United Community Action Partnership)

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.

Health Care Provider Resources

- In 2019 County Health Rankings reveals the ratio of population to primary care physicians is 1280:1 for Lyon County and 1120:1 for Minnesota. The ratio of population to mental health providers in Lyon County is 660:1 compared to the Minnesota statistic of 430:1. The ratio of population to dentists in Lyon County is 2,150:1 compared to Minnesota statistic of 1410:1.

- 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. Lincoln and Lyon Counties have a combined 5 MUA. Additionally physicians (including Psychiatrists) who furnish care in a critical access hospital (CAH) located in a geographic base mental health HPSA are eligible for a 10 percent bonus payment for outpatient professional services furnished to a Medicaid beneficiary.
Section 2:

Data Assessment Analysis

(Qualitative/Primary Data)

For purposes of gaining primary information for this community health needs assessment, individual interviews were conducted and a Quality of Life Survey was done. Southwest Health and Human Services (SWHHS), in collaboration with Avera Marshall, partnered to conduct a Quality of Life Community Survey. The survey was made available by Survey Monkey. Paper copies were also available at the Southwest Health and Human Services offices in Marshall and Ivanhoe. The survey was made available to the Community Leadership Team with Partners from Southwest Regional Development Commission (SWRDC), Southwest Health & Human Services (SWHHS), Statewide Health Improvement Partnership (SHIP), Minnesota River Area Agency on Aging (MNRAAA), University of Minnesota Extension, Southwest Minnesota State University (SMSU), Esther’s Kitchen, United Community Action Partnership (UCAP), Karen Organization of Marshall, Child Care & Nutrition, Open Door, Hy-Vee, Ace of Southwest Minnesota, Southwestern Minnesota Opportunity Council (SMOC) and Marshall Community Education. 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 Leadership Team included:
- Community leaders from towns in the surrounding counties
- Public health representatives from Southwest Health & Human Services
- Educators
• Business leaders
• Americorp Health Vista
• Aging services
• Avera Marshall Board Representatives (Foundation & Governing)
• Physicians
• Faith Leaders
• Minority Representatives

The same conversation questions were posed for each interview and Quality of Life Survey conducted:

1. What do you think are the three MOST Important “health problems” in your community?
2. What do you think are the three MOST Important factors for a “healthy community?”
3. What is a community need you are more concerned about today that you were 3 years ago?

Key Themes from Interviews and Quality of Life Surveys

• *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 often about life style choices and 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 participant interview 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.

• *A Shared Responsibility*
  Interview participants 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, while emphasizing the role played by the social determinants of health is a major part of making a community whole.

- **Safe & Clean**
  Interview 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 & Robust Education**
  Survey participants of the community recognized stability in economic and population bases, and a sense of pride in the educational experience offered by public and parochial schools. The participants identified the importance of a financially stable community with highly reputable schools and overall academic experience. Capital improvements for communities add benefit, such as parks and bike trails.

- **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 do you think are the three MOST Important “health problems” in your community?

- The 10 Most Important “health problems” in your community”:
  - Mental health problems
What do you think are the three MOST Important factors for a “healthy community”?

➢ The 10 Most Important factors for a “healthy community”:
  ◦ Access to Health Care (physical and mental)
  ◦ Good Jobs and Healthy Economy
  ◦ Good Schools
  ◦ Low Crime/Safe Neighborhoods
  ◦ Access to Healthy Food Options
  ◦ Affordable Housing
  ◦ Youth & Family Activities (e.g. parks & recreation)
  ◦ Good Place to Raise Children
  ◦ Clean Environment
  ◦ Religious or Spiritual Value

What is a community need you are more concerned about today than you were 3 years ago?

• Mental Health Issues
  Mental health issues are increasing in our community, 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.

- **Aging problems (e.g., arthritis, hearing/vision loss, etc.) & Alzheimer’s Disease**
  Aging problems and Alzheimer’s disease are increasing with the aging population in the community and 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/Alzheimer’s 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. Special attention was given to the need for dementia care coordination and for the elderly who are suffering with chronic diseases.

- **Drug-related illness and death**
  Participants noted continued gaps in care coordination among providers, case managers, and language service providers. A more streamlined, less fragmented, team approach to care is necessary. There is a lack of access to services for the low-income population.

- **Obesity**
  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.

- **Tobacco and e-cigarette use & exposure**
  Emphasis must be placed on communication and education.
What do you think are the MOST important factors for a “healthy community”?

**Access to Health Care (physical and mental)**
- 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. Natural options for treatment of illnesses.

**Good Jobs, Good Schools and Healthy Economy**
- 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 message for health and wellness in our communities. Lobbying state and local government for advocacy and financial support of health and wellness programs.

**Access to Healthy Food Options**
- Access to healthy food options that are affordable. Education on healthy food options.
Section 3: 
Community Health Needs 
Prioritization

Health Care Priorities

Identification of priority health needs was accomplished through a Quality of Life Survey and Individual Interviews 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
- Obesity/Diabetes
- Tobacco and e-cigarette use and exposure

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, 2019.

The 2019 CHNA report was presented and approved by the Avera Marshall Board of Directors on June 24, 2019.
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