COMMUNITY HEALTH NEEDS ASSESSMENT

Granite Falls Health

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 Yellow Medicine County residents, and additional information as pertinent to the process of a community health needs assessment.

Acknowledgements

The Granite Falls Health 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 a community forum. In addition, Granite Falls Health partnered with Countryside Public Health, (CPH) 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

Working Towards a Healthier Community

This Community Health Needs Assessment (CHNA) is a tool that is being used to analyze the health of a community, and to identify what resources are available for improving that health. This will allow Granite Falls Health (formerly Granite Falls Municipal Hospital & Manor) to see what resources, or lack thereof, impact the health of a region and to help identify additionally needed resources. The goal of this CHNA is to have an assessment and community improvement plan that is an asset for the community. This CHNA will be utilized as a planning tool to initiate strategic initiatives regarding services and support for local organizations in order to meet critical needs of the citizens of the community.

As a city-owned healthcare organization, Granite Falls Health's work in providing services that are directly correlated to the needs of our community is a central focus in how and why we operate. Decisions made within the facility are always made with the citizens of the community's best interest in mind and Granite Falls Health has a deep commitment to meeting the needs of all who need care and want to become a healthier self.

Granite Falls Health primarily serves the city of Granite Falls (56241) and secondarily the surrounding communities and areas to include Sacred Heart (56285), Clarkfield (56223), Cottonwood (56229), Montevideo (56265), Renville (56284), Wood Lake (56297), Maynard 56260), Echo (56237), Hanley Falls (56245), Belview (56214), Clara City (56222), Boyd (56218), and Watson (56295). Essentially, this service area is a 25-mile radius from the Granite Falls Health Facility.

Granite Falls Health offers care that respects patient choices, encourages participation, and recognizes the right to achieve personal health goals. Labeled as a level IV trauma center and a Comprehensive Advanced Life Support (CALS) designated hospital, Granite Falls Health offers superior local inpatient, outpatient, emergency care, ambulance and specialty services, radiology, mammography, obstetrics, and long-term care services in home care, nursing home, housing with services, and hospice care to people in and around the Granite Falls community.

It is Granite Falls Health's goal to demonstrate the commitment by dedicating capital, technology, and human resources with knowledge and expertise in the areas of healthcare delivery and community health issues that are important to rural healthcare and to the community. Lastly, it is our goal to demonstrate top quality of care by consistently striving to meet or exceed the needs and expectations of the citizens that we serve.

MISSION

Granite Falls Health exists to: Deliver compassionate care, promote healthy living, and to support people throughout their lives.

VISION

To be the healthcare home for people of the region, delivering the highest quality, customer services, and innovative care, throughout life.

VALUES

People:

Granite Falls Health will be the partner of choice for employees, physicians and communities.

Respect:

Providing personal, compassionate service recognizing the uniqueness and value of each individual while maintaining an environment that promotes fair, consistent and respectful treatment of employees.

Competency:

Assuring the highest level of care and quality provided by those skilled to deliver care, support care, and those who lead the organization.

Effectiveness:

Achieving the desired outcome of excellence in service focused to the organization and community by providing the needed assistance at the right time in the right way.

Compassion:

Being sensitive to the feelings and needs of others and demonstrating care and concern.

Responsiveness:

Readily reacting to the needs of the organization and community in order to provide personal, considerate, innovative, and effective customer service.

Partnership:

Working collaboratively with the community to assure a vibrant healthy economy, acting as a promoter for the community's health, well-being, and sustainability.

Financial Stewardship:

Granite Falls Health will achieve growth in our markets and maintain financial security.

A Retrospective Review

1. In 2016, Granite Falls Health participated in a Community Health Needs Assessment (CHNA) for Lincoln 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.granitefallshealth.com/about-us/your-health/. 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. The needs assessed from the 2016 CHNA include Unmet Mental Health needs, Senior care services, and access to services.

    a. Unmet Mental Health Needs: Based on the Granite Falls Health 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. Granite Falls Health has developed a closer relationship with Avera Marshall Behavior Health and has developed many best practices with their help. As a part of that work, Granite Falls Health has developed in the areas of ensuring appropriate resources, dedicated and adequate physical space, and staff competencies as it relates to mental health. They also continue to meet and collaborate with local agencies to be able to continue to offer safe and consistent mental health care.

    b. Senior Care Services: Granite Falls Health has implemented eLTC capabilities and were enhanced over the past year adding behavioral health services to its menu of options, further continuing to be responsive to our residents. These services are aiding in 24-hour access to healthcare professionals to aid in decreasing hospitalizations and ER visits from our long-term care facility.

c. Access to Services: Granite Falls Health has continued to provide transportation services to our residents by offering specialized transport vehicles staffed by a combination of volunteers and trained employees that are able to assist residents in obtaining continuous and consistent health care. Granite Falls Health has been active in the Accountable Care Organization and it has been going well for coordination of care. With this and other leveraged technologies on site (eLTC) and through our partnerships with other facilities and agencies, care coordination continues to be a strong focus.

Since the completion 2016 CHNA, Granite Falls Health has received requests for printed copies of the assessment. However, no written comments were received regarding that community health needs assessment or implementation plan.

The 2019 CHNA report is made widely available to the community through the Avera website and paper copy upon request.

Why a CHNA was conducted

The 2019 CHNA was conducted by Granite Falls Health 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 review 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 exist in our service offerings. As a significant employer within our Service Area, Granite Falls Health 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 Granite Falls Health 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 community health knowledge, the prevalence of chronic diseases, transportation and access to nutritional food. However, three major health and wellness priorities identified in the CHNA were addiction and mental health, access to cardiology services, and continued social support and community awareness.

Section 1: Demographics

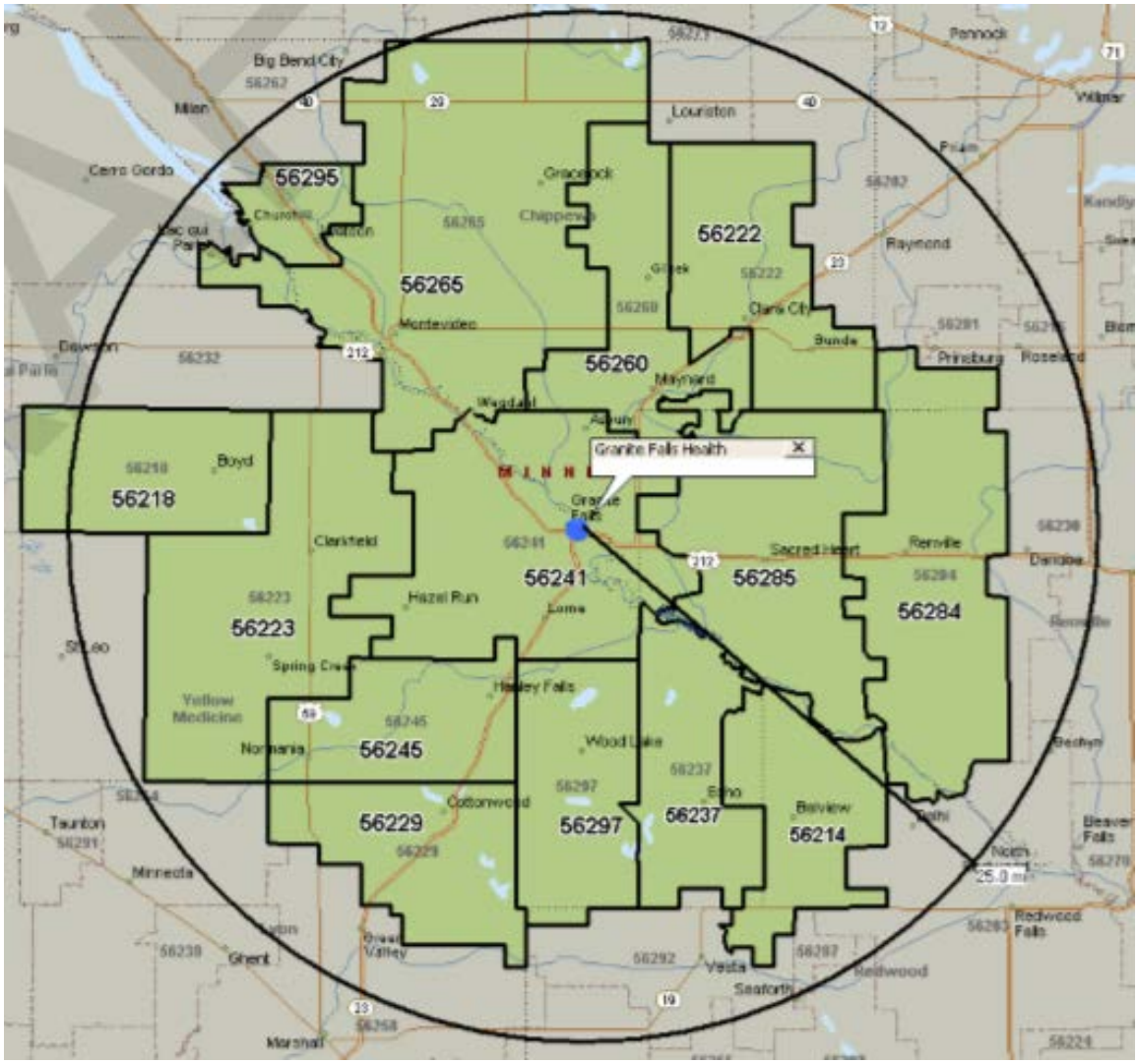
(Quantitative/Secondary Data Collection)

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) Additional information was utilized from other internal sources.

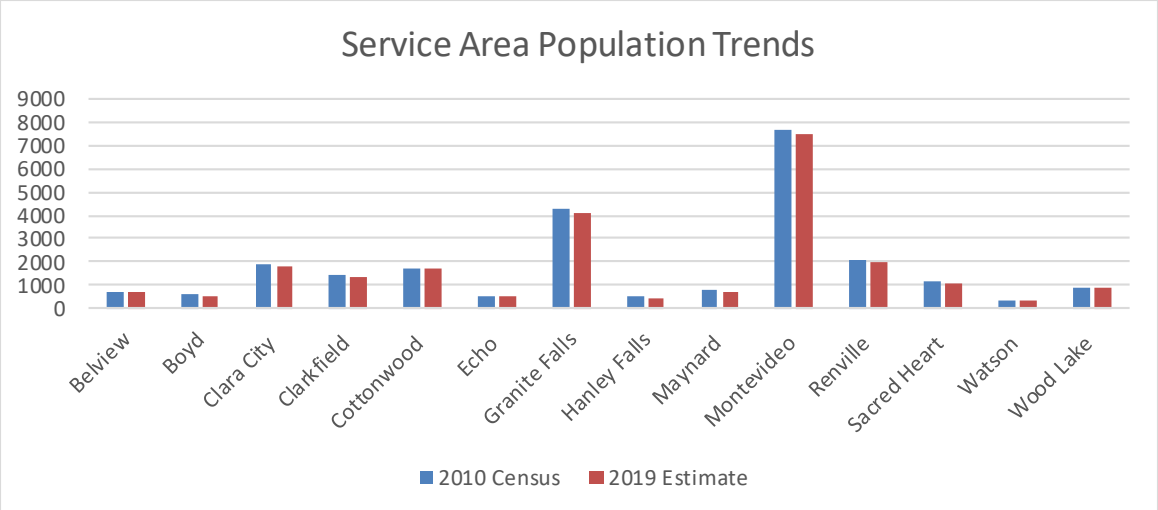
Definition of Community

Granite Falls Health serves communities in West-Central Minnesota and Southwest Minnesota, including all people, regardless of age, nationality, or economic status. For purposes of this report, the community is defined as Granite Falls and the zip code of 56241 (primary services area) and reflects the area from which the facility draws its patients and is represented in the data in this report from individuals who live and work in this area.

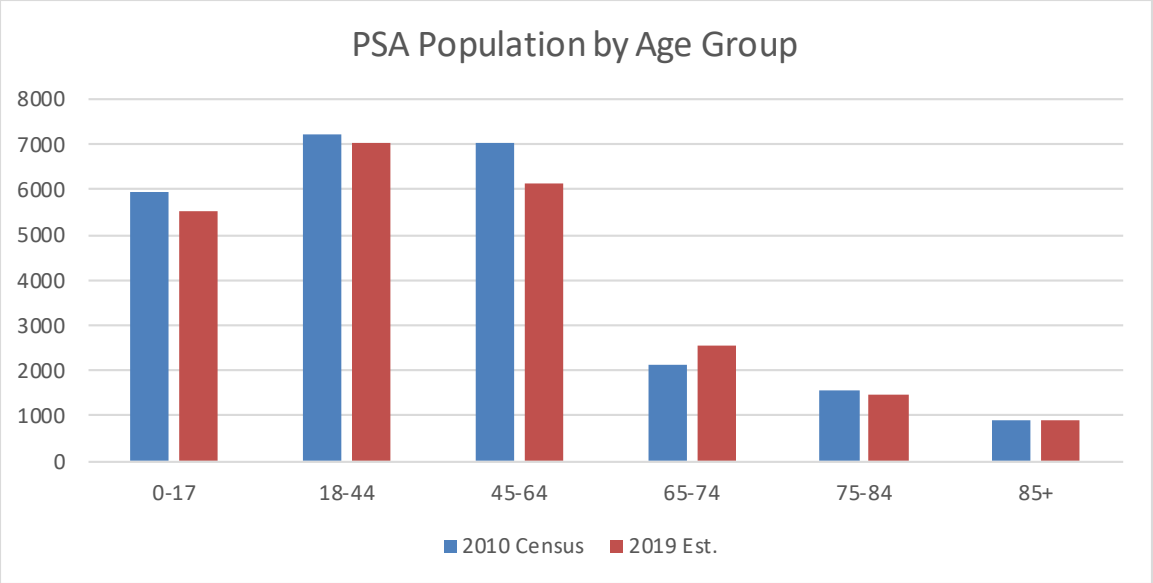
Demographics of Service Area



Granite Falls Health Primary Service Area Population by zip code



Source: Eide Bailly, 2019



Source: Eide Bailly, 2019

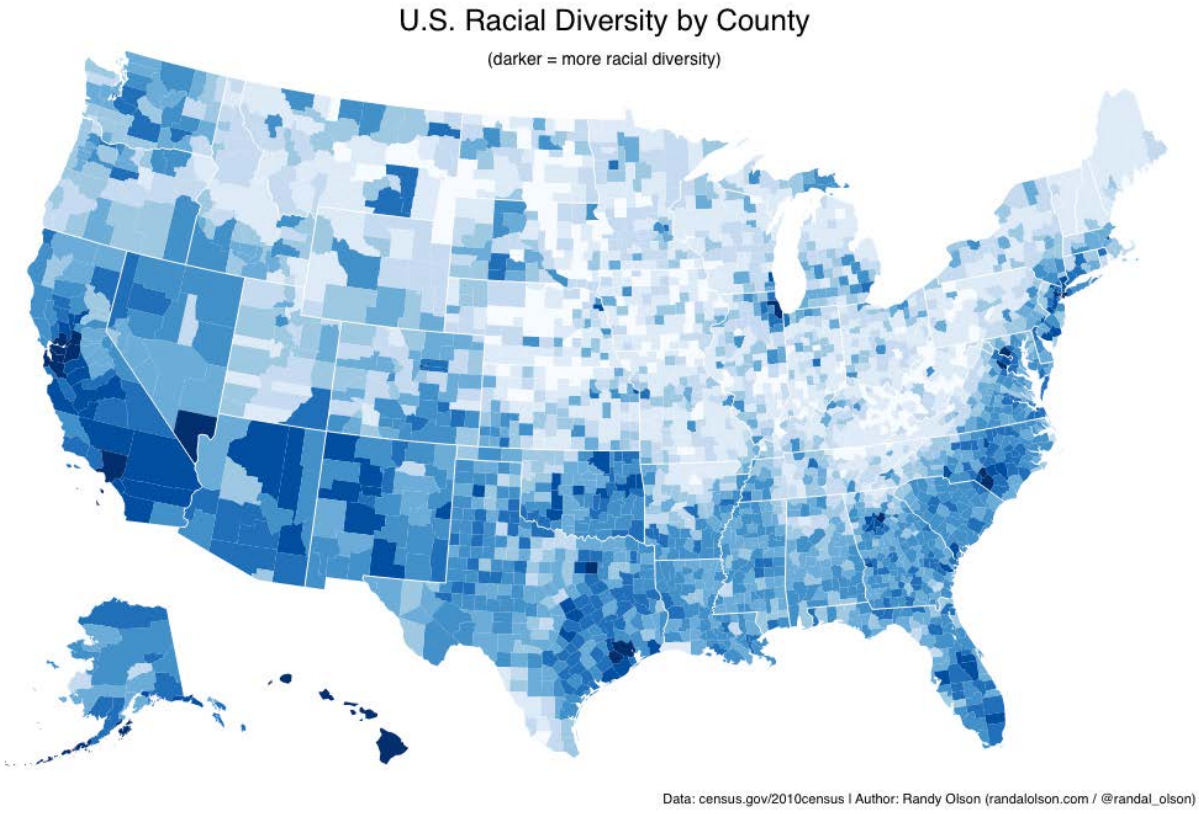
Rural Population Trends

- PSA estimated population for 2019 is 23,598. This has decreased approximately 2.8% since 2014.
- PSA population is projected to decline 0.8%from 2019 to 2024
- Zip code 56229 (Cottonwood) is the only PSA zip code with a projected population increase (1.5% in the next five years).
- All PSA age cohorts saw population decline from 2014 to 2019 except the age 65-74 cohort, which saw 10.2% growth.
- In the next five years, all cohorts will likely see flat trending or growth, with the exception of the age 45-64 group, which is projected to decline 11.1%
- The age 65-74 cohort is projected to grow 16% in the next five years.

Over the past decade the population in Granite Falls has slowly been declining. This can be attributed to decreasing business opportunities, different generations of people migrating towards the metropolitan areas for increased opportunity, and many other reasons. Most of this population is made up of those ages 45-84. It is fair to estimate the majority of the population will either retire and/or expire within the next 10-15 years. Most retired individuals keep a central home in Granite Falls, but many migrate to the southern states for the winter months to avoid the bitter cold temperatures and snowfall. As business opportunities continue to decrease in Granite Falls, the population follows.

Yellow Medicine County is predominantly white. However, there is a growing number of the population who are Native American and Hispanic. The chart below shows the racial diversity

by county in comparison to the United States, there is very little racial diversity in Yellow Medicine County. The light areas show the small number of racial diversity and the darker the color signifies more racial diversity.



Health Data

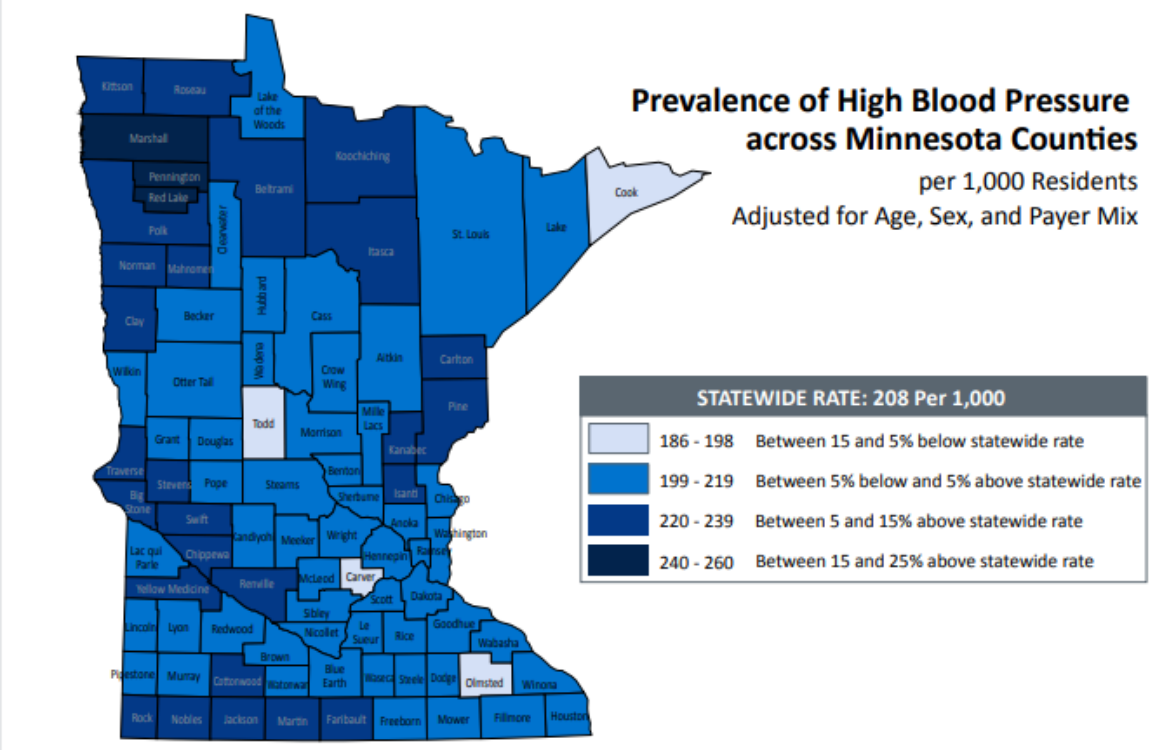
Chronic Disease

The most common chronic diseases in Granite Falls are diabetes and asthma. The prevalence of diabetes is 9.0% in comparison to the state of Minnesota at 5.8%. Both Yellow Medicine and Chippewa Counties show a significantly higher percentage than other counties in Minnesota. Diabetes being the most impressive increase than all other disease. Congestive heart failure is between 15 and 25% above the state average (Minnesota Department of Health, 2019). This is largely due to the Native American population, who have a higher incidence of hypertension and diabetes, coupled with the large obese population.

Leading causes of death for our area for all ages include cancer, heart disease and stroke. Motor vehicle accidents and suicides are close to follow. The number one cause is heart disease. In populations under the age of 75, cancer is the number one cause of death at 93.5% and heart disease follows with 49.2%. Unintentional injuries are the number three cause of death at 36.4%. In comparison to the state of Minnesota, Yellow Medicine County compares slightly higher by one-third percent, but the top three causes of death are consistent.

- The leading cause of death in Yellow Medicine County 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. (2015-2019).

- Cardiovascular disease comes in at a close second for leading cause of death in Yellow Medicine County and has a slightly higher rate of 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. Both Chippewa and Yellow Medicine county are between 5 and 15% above the state average for population affected by high blood pressure.



This Chart shows that Yellow Medicine and Chippewa Counties are between 5-15% above the statewide rate for prevalence of High Blood Pressure

(Source: https://www.health.state.mn.us/data/apcd/docs/20160127_chronicconditions.pdf)

Access to Care

- There is one primary care clinic: Granite Falls Health Clinic, an Avera affiliate. These providers also serve the 25-bed Granite Falls Health Hospital.
- Much of the population with chronic medical conditions and/or an acute treatable illness try to manage at home until the condition worsens or present to the emergency room.
- The clinic does offer an urgent care option on Saturdays as well as offering hours of operation after 5pm on Thursdays.
- Mental Health Professional Shortage: All of Southwest and West-Central Minnesota is underserved in mental health services. There is also a shortage of dentist, primary care, and specialty service providers.

Physical Activity / Eating Habits / Obesity

- Obesity is very prevalent in the service area. 36.9% of the population is considered obese, 35.4% are overweight, but not considered obese and only 27.7% of the population is considered not overweight. Over 2/3 of the total population is considered obese and/or overweight.
- It is important to address obesity as it relates to overall health moving forward with the Community Paramedic program.
- Tobacco use in our adult population shows 55% of our adult population has never smoked, 18% are current smokers, and 27% are former smokers. There is a higher percentage of smokers who are male 63% versus 35% female. (Countryside Public Health, 2015.)
- Fewer adults are getting the recommended 5 or more fruits and vegetables in the region as compared to the State of Minnesota.
- Fewer than 1 in 5 high school students meet the recommended servings of fruits and/or vegetables.
- Yellow Medicine County 9th grade students are considerably lower than the State of Minnesota in eating the recommended servings of fruits and/or vegetables.
- The table shows a large portion of the population in our area do not participate in physical activity and/or insufficient physical activity.

	Sufficient Activity	Insufficient Activity	No Activity
Countryside CHB	25.9	23.8	50.2
19-county region	29.7	24.1	46.2
Females	22.7	23.3	54
Males	29.1	24.4	46.5

Mental Health

- 9% of adults in the region experienced significant depressive symptoms in 2015. 4% 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.
- 30% of 9th grade students in the last 12 months feel significant problems with anxiety, nervousness, tension, fear or the feeling that something bad was going to happen. 12% of 9th graders have seriously considered attempting suicide.
- Mental health diagnosis continues to recur in the top ten reasons for emergency department visits.

Environmental Health & High-Risk Behaviors

- According to the chart below from Minnesota Department of Health, Minnesota, Yellow Medicine and Chippewa counties rank very high on childhood immunization rates. Although over 90% of our children and students are receiving vaccines as recommended, there remains a few percentages of children unvaccinated. This may be attributed to research and studies showing links between autism and immunizations and/or family beliefs.
- Adults and 9th graders smoking rates are increasing.
- Percent of birth mothers who smoke is higher versus state averages.
- Percent of students who engaged in binge drinking in the last year is higher compared to the State of Minnesota.
- Teen birth rate is higher compared to the State of Minnesota
- Rates of STD's are increasing at a higher rate compared to the State of Minnesota.
- Residential homes are at a higher risk for radon exposure compared to the State of Minnesota.

Advanced Aging Population

- Higher percent of people utilize nursing homes for care versus home & community care options.
- Long term care expenditures are higher than state average; home & community-based service expenditures 65+ is lower than the Minnesota average.

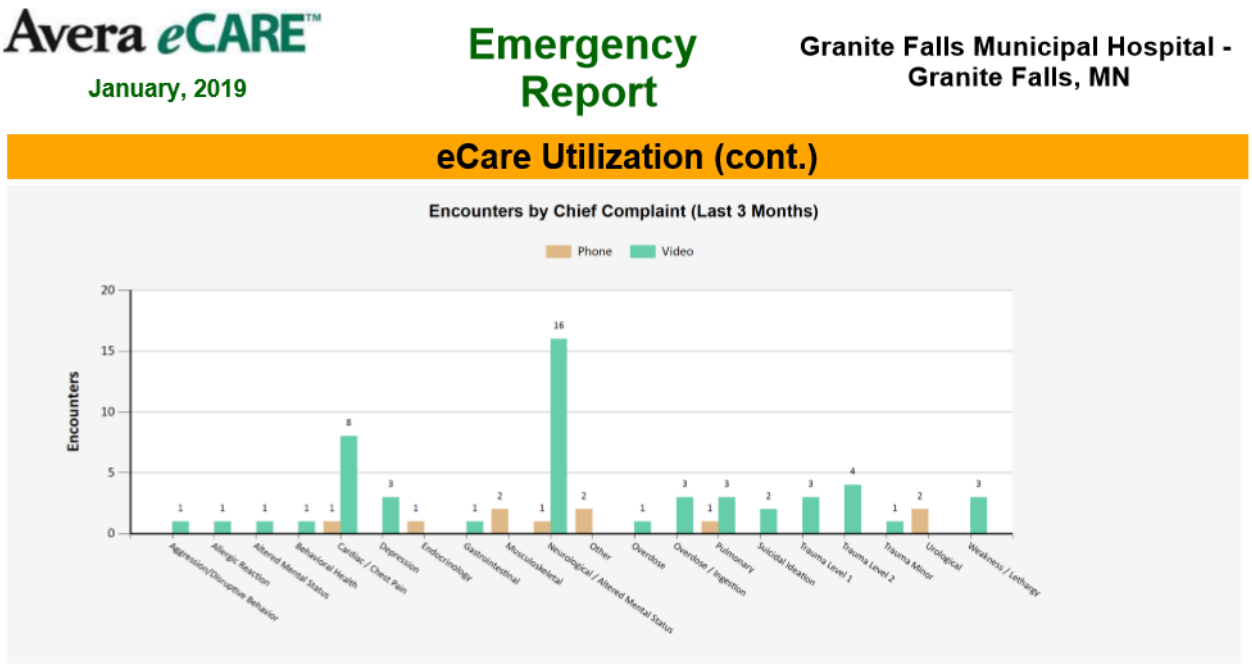
Hospital Data

Emergency Department Discharge Reason for Visit

In review of internal data sources, for January 1, 2019 – December 31, 2019, the top reasons for discharges from the Emergency Department included (graph includes 1st quarter 2019 below):

- Neurological/Altered Mental Status
- Cardiac/Chest Pain
- Abdominal Pain/Fatigue/Lethargy
- Trauma
- Mental Health/Depression/Suicide

(Avera eCare data, Granite Falls Health, 2019)



Top Diagnoses for Discharge from the Hospital

In 2019, the top diagnoses were:

- Pneumonia
- COPD
- Gastroenteritis
- Cellulitis
- Septicemia
- Diabetes

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

Community Resources Identified

Granite Falls and its surrounding communities have many valuable community assets that promote good health and a high quality of living for its residents. These assets include comprehensive healthcare 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:

Community Resources and Programs

The City of Granite Falls and Yellow Medicine County have multiple available community resources the public can turn to for education, continued care and/or assistance with filling any unmet needs. Granite Falls Health, Prairie Five, Western Mental Health, Countryside Public Health and Yellow Medicine County are just some of the facilities that collaborate in the area to improve the quality of life.

Hospital Resources

- Transition of Care/Home Care: This program offers skilled nursing available in the patient's own home. Nurses and staff work closely with patients to provide specialized care that best meets their needs. Many locations are available in the city of Granite Falls. Some facilities
- Outpatient services include:
    - Physical therapy/Occupational therapy – Both of these services provide treatment with goals to get back to normal activities of daily living and return to previous functional levels. These services can be part of a whole treatment plan for the patient involving all members of the healthcare team. Therapists will travel to some of the smaller surrounding communities and patients' homes to help ensure a more productive outcome.

- Speech therapy - Speech Therapy is available to homecare clients, Manor Residents, outpatients and hospital inpatients. Many patients in the community are seen due to previous CVA or brain injury. There are also services available for children to assist with stuttering, autism and language disorders. For children, having this service locally means less hours spent away from school and daily life.
- Cardiac rehab – Usually it takes 5-6 weeks of cardiac rehab to heal the heart after a heart attack. Both inpatient and outpatient services are available.
- Wound, Ostomy and Continence Nursing – Physicians may refer patients in the area to help with the healing process after severe injury, surgery or illness. Because wound care can be a daily visit, having a WOC nurse in the community hospital helps to reduce drive time and cost.
- Out-patient infusion and chemotherapy – The nurses that provide care in this unit have Oncology certification and training in chemotherapy and biotherapy in order to provide specialized care. The hospital added this department recently to help reduce time away from home during illness, travel arrangements and cost for the patient. It also provides a support system for the patient that is close to home. (Granite Falls Hospital, 2019).

Living At Home/Block Nurse Program

- The Living at Home/Block Nurse Program is a community program that draws upon the volunteer services of local residents to provide information, social and support services for their elderly neighbors to help them to remain independent in their homes.

Prairie Five

- Senior Nutrition Program/Meals on Wheels – This program functions almost entirely on community volunteers. The program promotes health through nutrition and reduction of social isolation by congregate dining. They also provide meal delivery and frozen meals for weekends and holidays.
- Energy Assistance – This program provides funds to eligible households to pay a portion of their home energy costs. Funds are also available to provide weatherization and energy related repairs. The program is designed to assist households with energy bills without eliminating responsibility for paying energy bills.
- Head Start Program – This program is income based and children are to attend class in a pre-school setting two to three days a week. They also have home visits with teachers one to two times a month. This program works with parents to ensure that the child has access to quality healthcare, including dental, vision, speech, hearing, nutritional, and

mental health screenings, physical exams and immunizations. The staff is also able to provide referrals to other community agencies as needed.

- Community Education – These classes and recreation activities are available year-round for area youth. Applications are available in many places including the school district, probation officers and family services. Guidelines for the program include being between ages of 14-21 and gross family income, unless the youth meets one or more of the following criteria. (Prairie five, 2014)
    - Recovering Chemically Dependent
    - In Foster Care
    - Emotionally or Physically Challenged
    - Current IEP on File with School
    - Eligible for/or receiving Food Stamps
    - MFIP Recipient (family)
    - Receiving Social Services and/or Group Home Services
    - Attending Alternative School
    - Currently on Probation
    - Pregnant or Parenting Youth
    - Limited English Speaking
    - Runaway Youth
    - Homeless Youth

Western Mental Health

- Adult Mental Health Rehabilitation/Community Support – This program uses resources to help patients learn to cope with stress, take medications correctly and build a social support system. The goal of both group and individual work is to reduce or prevent a relapse of mental health symptoms. Outpatient Psychiatry is also available through telehealth.
- Children Therapeutic Services and Support – The goal of this program is to help children build skills to learn to cope with stress. A practitioner will come to the home and work with children and families to help them improve on emotional, social, behavioral or academic abilities. Some of the patients that this program helps are children who are at risk for out of home placement.
- Mobile Crisis Unit – This service is available 24 hours a day, 7 days a week. They provide mental health services to adults, children and families who are experiencing a mental health crisis in their own home. These services can be over the phone, on site, short term ongoing support or crisis prevention planning. Services can be provided in your home, hospital, jail or other community locations. (Western Mental Health, 2009).

Project Turnabout

- Assisting community members and families as they navigate through addiction and recovery of drugs, alcohol, and gambling.
- Project Turnabout's continuum of treatment and recovery services is designed to provide the right combination of services to fit the needs of each of their patients. From prevention to detox, inpatient to outpatient treatment, transitional living and the post treatment system of care. (Project Turnabout, 2019)
- Their 24-hour Medical and Withdrawal Services provide a safe environment for all our patients. All while making treatment available to patients whose medical conditions may disqualify them from many programs. They are staffed around-the-clock by medical professionals (Project Turnabout, 2019)

Countryside Public Health

- Women, Infants, Children (WIC)
    - WIC provides nutritional information, infant and child feeding tips, breastfeeding counseling, referrals for health care and supplemental foods for women and children including: milk, cheese, eggs, juice, iron-fortified cereals, peanut butter, dried peas, beans and lentils, whole grain foods, fruits and vegetables, tuna and salmon for breastfeeding women. Infants receive the following: infant cereal, iron fortified formula, and infant fruits and vegetables. (Countryside, 2016).
    - Those eligible for WIC include: Those residents of the county who meet the program's liberal income guidelines including those who are pregnant, women breastfeeding, and an infant under 1 year of age, women who have a baby less than 6 months old, infants and children up to 5 years old, participation in Food Stamps, and/or Medical Assistance.

Yellow Medicine County

- Food Shelf
    - Yellow Medicine County food shelf is a food pantry that is open every Wednesday from 9am-3pm.
    - Serves the residents of Yellow Medicine County, including residents of Granite Falls residing in Chippewa County. Requires proof of current address for all members of the household. Visits to the food shelf are limited to once per month with the exception of extreme emergencies.
- City Bus-Heartland Express
    - The Heartland Express is the public transportation system governed by the City of Granite Falls serving local residents and visitors. It provides quick and convenient door to door transportation within the city limits of Granite Falls. Transportation hours are limited to Monday through Friday 8am-5pm. Each bus

is handicap accessible and driven by a city employed driver. This service is available to all people in the City of Granite Falls regardless of income or age. (Granite Falls, 2016).

- County Human and Social Services
    - Yellow Medicine County Adult Services provides services to individuals who may have issues related to aging/long term care and community-based services, physical and/or developmental disabilities, or adult protection. Services may include, but are not limited to, information and referral, long term care consultation and/or other screenings and assessments related to services, eligibility determinations, services access and funding, case management/care coordination, and adult protective services.
    - Foster Care for adults assists men and women, 18 years of age and older, who are unable to live alone but want to live in a family setting. They may have emotional, physical, developmental or mental health needs. They may attend school, work or day programs. The home can provide up to 24-hour supervision for 1 to 4 residents. Residents receive meals, support, supervision and some assistance with personal care and living skills as needed. Adult Foster Care homes are licensed by the State of Minnesota under Rule 203 and Statute 245A.
    - Case Management for Adult Mental Health provides case management services to adults with serious and persistent mental illness in Yellow Medicine County. Assistance is given in obtaining mental health, social services, financial assistance, medical, legal, vocational, housing, and other services designed to assist individuals to remain in the community. Some programs have income and documentation of disability requirements.
        - Mental Health Case Managers receive referrals from consumers, provider agencies, hospitals, medical clinics, mental health centers, Intensive Residential Treatment Services (IRTS), community individuals, and law enforcement. Case Managers are advocates for consumers and work to ensure that the consumers can live their lives as independently as possible. (Yellow Medicine County, 2016).

Section 2:

Data Assessment Analysis

(Qualitative/Primary Data)

For purposes of gaining pertinent information for this CHNA, community input was gathered from community leaders, hospital leaders, and members of a number of community service groups representing the broad interests of the community, including underserved populations. Through this process, individual interviews were conducted with key informants. The focus of these interviews was to learn more about the health concerns of the community.

Topics for these interviews included:

- What are the three most important 'health problems' in our community?
- What are the three most important factors for a healthy community?
- What is a community need you are more concerned about today that you were 3 years ago?

Key Themes from Interview Surveys

Major findings from the interviews included an assessment on the following factors that have been identified as a significant health need for the community. These factors included:

- **Mental Health** – Interviews revealed concerns over limited access to providers and long wait times for professional appointments, transportation issues, increases in the use of chemicals, suicide rates, bullying, and a general lack of coping skills. Also included in this is the overwhelming increase in addiction tendencies in both the young and older populations.
    - Pain management, reduction in opioid prescriptions/crisis- With a population that is now staying active longer, joints and backs are wearing out sooner than later. Interviews revealed that patients are wanting alternative pain management as appose to medication prescriptions, including opioids. The public is more aware than ever of the addictive tendencies of opioids and is wanting our healthcare community to provide alternative pain control means.
    - Breakdown of the family unit and family support- Much discussion was focused around the family dynamic and how healthy habits truly must start at the beginning – childhood. Lengthy discussions included linking young families to support and programs already offered in the community. Included in this was

access to affordable daycare services, new parent support, and affordable housing.

- **Cardiology care**- Considering that heart health in this community is at the top of ER admissions, and that heart related conditions are a leading cause of Clinic visits, it was not surprising to see this concern arise from interviews. Many community members have had to travel upwards of 45 miles or more to see a cardiologist.
- **Senior Care Services** – Interviews revealed that even though the community had a brand new, successful nursing home, there was a need for ample long-term care services, respite care, a full continuum of care, and caregiver services. Within that, there is a great need to address the growing number of dementia patients in the area that are currently being cared for by family members and loved ones in the setting of the home. Specifically, it was identified that there was a need for an assisted living, dementia unit or memory care program, and for additional education/trainings and support for caregivers.
- **Access to care and education of services already available**– Interviews revealed that even though there has been significant improvement in making sure our community has access to care, there are still areas for improvement. There still seems to be continual gaps in the lower income population receiving access to care. Care coordination among providers is also needing more improvement. There was extensive discussion on the gap of education on the services already available to our community. Other discussions discovered that there was a specialized need for elderly who are suffering from chronic diseases and dementia care coordination. Eliminating fragmentation, through a streamlined, team approach to care is necessary. Interviews also mentioned the need to address the nonexistence of specialty services, urgent care/walk-in clinic, and programs for the underserved populations in the community (i.e. Community Paramedic).

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 (including addiction and chemical dependency)
  - Social support
  - Aging problems (e.g., arthritis, hearing/vision loss, etc.)
  - Pain control (reduction in opioid prescriptions)
  - Obesity

- Family and home structure
- Lack of physical activity
- Alcohol-related illness and death
- Heart disease and stroke
- Diabetes
- Tobacco and e-cigarette use & exposure

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 Support and 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 crises 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.

- **Pain Management/Control**
  In coordination with our aging population and problems surrounding this, there has been an increasing concern for alternative pain control. The opioid crisis is still a growing concern, for both the young and old population. The public is demanding more options and alternatives to opioid prescriptions. One of these are injections specifically in the area of pain with long-lasting results further aiding in recovery of the injured person. This has cross-generational benefits and can lead to a higher quality of life.

- ***Family structure and dynamic***
  Participants noted continued gaps in home support of the youth of our communities. The concern mainly lies with parenting techniques, technology overload (i.e. screen time), and accountability of the younger population. Youth coping mechanism education and support is also needed.

- ***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. Home cooked meal assistance and education for families is also a need. The younger the person is to learn of healthy food choices, the better the long-term effects are.

- ***Tobacco and e-cigarette use & exposure***

  Emphasis must be placed on communication, education, and cessation.

- ***Addiction-related illness and death***

  Lack of access to services for the low-income population. A collective team approach is needed between health care provider, mental health provider, and social services. This will help those who are not aware of their disease to get treatment hopefully before the addiction becomes a crisis.

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. Today's population are wanting specialty care closer to home to reduce travel and aid in appropriate follow up and continuum of care.

Chronic disease prevention, management and accountability

- 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. Creating ways healthcare providers can encourage patient accountability for overall good health.

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 marketing 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 for families is needed to help teach young people about healthy choices. Earlier education will allow for a lifetime of better choices.

Section 3:
Community Health Needs Prioritization

Health Care Priorities

Identification of priority health needs was accomplished through a survey of local healthcare professionals and individual interviews of internal and community stakeholders of Granite Falls Health, including the Governance and Foundation Boards, the Granite Falls Health 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 Granite Falls Health.

Upon completion of the prioritization process, Granite Falls Health determined the following three community health priority needs:

- Improving Mental Health (including Addiction, Family, and Social Support)
- Advancing Cardiology Services
- Increasing Pain Management service access.

Prior to the CHNA Granite Falls Health was 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, Granite Falls Health 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. Granite Falls Health 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. With that being said, the implementation plan that will guide the overall strategy—is an extension of the kind of work Granite Falls Health carries out regularly to promote community health.

The proposed implementation strategy will be presented for discussion, consideration and approval to the Granite Falls Health Board of Directors prior to December 23, 2019

The 2019 CHNA report was approved
by the Granite Falls Health Board of Directors on December 23, 2019

Sources

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