CHI Oakes Hospital

Oakes, North Dakota

Community Health Needs Assessment

June 30, 2016

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Introduction

Oakes Community Hospital, dba CHI Oakes Hospital (CHIOH), is a 20-bed critical access hospital providing various inpatient and outpatient services to approximately 14,000 people in southeastern North Dakota. It is also a 24-Hour Emergency Level V Trauma Center. The hospital is part of a larger values-based organization, Catholic Health Initiatives (CHI).

CHI Oakes Hospital is ranked highly in the entire CHI system in the categories “likely to recommend” and “overall satisfaction.”

The medical staff consists of providers that are multi-specialists in family practice, internal medicine, cardiology, sports medicine, and geriatrics. There are also a number of specialists on the courtesy staff that provide services such as cataract and orthopedic care. The physicians partner with the highly trained nursing staff to provide excellent patient care. The hospital offers safety focused, quality healthcare in a progressive environment. CHI Oakes Hospital has a dynamic nursing team with excellent skills. All nurses receive ACLS Certification and cross training for all areas of the hospital.

The purpose of conducting a community health needs assessment (CHNA) is to describe the health of local people, identify areas for health improvement, identify use of local health care services, determine factors that contribute to health issues, identify and prioritize community needs, and help health care leaders identify potential action to address the community’s health care needs. A health needs assessment benefits the community by collecting timely input from the local community, providing an analysis of secondary data related to health-related behaviors, conditions, risks, and outcomes, compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan, and engaging community members about the future of health care. Completion of a CHNA and implementation plan every three years is also a requirement for non-profit hospitals in compliance with the IRS requirements described in section 501(r)(3) of the Internal Revenue Code.

Methods

CHNA Process

The following outline explains the process for conducting the CHNA. Each process is described in more detail throughout the report.

1. Formation of a CHNA advisory committee

2. Definition of the community served by the hospital facility

    a. Demographics of the community
    b. Existing health care facilities and resources

3. Data collection and analysis

    a. Primary data
    b. Secondary data

4. Identification and prioritization of community health needs and services to meet community health needs

5. Adoption of goals and implementation strategy to respond to prioritized needs in collaboration with community partners

6. Dissemination of priorities and implementation strategy to the public.

CHNA Advisory Committee

The CHNA Advisory Committee was formed by Leadership at CHIOH. The Committee was tasked with completing the objectives outlined by the IRS CHNA requirements. The Committee consisted of the following members:

- Becki Thompson, Market President
- Julie Entzminger, Foundation Director/Human Resources
- Renee Seyer, Programs Coordinator/Public Relations
- Karla Hoelscher, Project Consultant

Community Served Determination

The service area for CHIOH was created with input from the CHIOH CHNA Advisory Committee. The definition includes Dickey County.

Primary Data Collection

In March of 2016, a community survey was distributed to local organizations within Dickey County. The online link was also presented to healthcare professionals for their participation. The questions were developed to capture input regarding health needs in the community. This survey was also made available at a community event co-sponsored by the Oakes Public School with access at the community computer lab.

The survey that was conducted online and by paper copy can be found in Appendix 8.

Respondents were asked to prioritize and rank health issues, access issues, and service availability within the community.

In March thru May of 2016, key participants were asked a series of questions designed by the Advisory Committee. These individuals were identified by the CHNA Advisory Committee from within the organizations listed in Appendix 1, based on their qualifications to represent the broad interests of the community served. Generally, the interviewees included persons with special knowledge or expertise in public health and persons who represent the medically underserved and vulnerable populations. Interviewees were contacted and asked to participate in the key informational interviews in addition to the online survey.

These questions were developed from a variety of nationally accepted health improvement models and tailored by the Committee to uncover the health needs that may exist within the CHIOH community. Interview questions and resulting feedback can be found in Appendix 2. Responses were recorded and later condensed into common themes.

Secondary Data Collection

Secondary data was collected from a variety of local, county, and state sources to present a community profile, birth and death characteristics, access to health care, chronic diseases, social issues, and other demographic characteristics. Data was collected and presented at the county level and wherever possible, compared to the State of North Dakota and the Nation.

The secondary data collected for this analysis was collected from the following sources:

- ESRI Business Information Solutions, 2015 (Based on US Census Data)
- County Health Rankings
- North Dakota Job Service Labor Market Information Center
- North Dakota Census Office, 2016

This report presents a summary that highlights the data findings, presents key priorities identified through the CHNA, and CHIOH Board-Approved implementation plan.

Information Gaps

There were no major gaps in information for this community health needs assessment because quantitative information for demographic and health status were available at the county level. That said, to the extent that health status differs significantly by zip code within the county, health information was not available at that granularity.

Community/Demographic Profile

Population

The population for the CHIOH service area is expected to decrease over the next five years, by 83 people. North Dakota is expected to grow by approximately 2.4%. Population is expected to rise nationally by over 4%.

2015 and 2020 Population

	2015	2020	% Change (2015-2020)	Change (2015-2020)
Dickey County	**5,119**	**5,036**	**-1.6%**	**-83**
North Dakota	**750,458**	**845,284**	**2.4%**	**94,846**
USA	**321,370,000**	**334,500,000**	**4.08%**	**13,130,000**

ESRI Business Information Solutions, 2015
North Dakota Census Office, 2016

Population by Age

Population was grouped into major age categories for comparison. In general, Dickey County has a significantly older population than North Dakota and the Nation. The service area population is expected to continue aging over the next five years. This will likely cause a rise in health care utilization as older populations tend to utilize health care services at a higher rate. Health needs will also continue to shift toward disease categories that tend to present at an older age.

Population by Race and Ethnicity

CHIOH's service area is predominantly white, equating to roughly 93% of the total population. The Hispanic population, which is included in 'some other race alone,' makes up 3.4% of the population in Dickey County. It is important for CHIOH to continue outreach with this subpopulation to ensure that the health needs of all population groups within the County are being met.

County Health Rankings, 2016

Income

Income data was analyzed for Dickey County and compared to the state of North Dakota and the Nation. 2014 census data reveals that Median and Average household income for Dickey County is lower than the State and the Nation.

Job Service North Dakota Labor Market Information Center, 2016

**Additional Demographic and Population data available in Appendix 6

Secondary Data Results

The County Health Rankings display health rankings of nearly every county in the nation and illustrate that much of what affects health occurs outside of the doctor's office. The rankings help counties understand what factors influence how healthy residents are and how long they will live. The rankings look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, unemployment, limited access to healthy foods, air and water quality, income, and rates of smoking, obesity, and teen births.

Overall, Dickey County ranked 4th of 49 in the state for health outcomes based on the data collected by County Health Rankings.

County Health Rankings, 2016

Birth Statistics

Low birth rates in a community are often associated with poor health of the mothers. Low birth rates can lead to higher incidences of fetal mortality, inhibited growth and cognitive developments, as well as chronic disease in later life; and is generally a predictor of newborn health and survival. Low birth weight percentages in Dickey County of 5% are lower than in North Dakota and the Nation, which are both at 6%.

Teen birth rates were also analyzed for Dickey County and compared to North Dakota and the Nation. Teen birth rates in Dickey County are lower than North Dakota national levels. That said, the percentage of children in poverty in Dickey County is higher than in North Dakota and National levels. This is an important group as poverty among children can often be associated with many negative health consequences throughout childhood. Dickey County also shows 21% with limited access to healthy foods and 7% with food insecurity.

County Health Rankings, 2016

Insurance

Individuals without health insurance often forego care due to high cost, which can lead to a higher prevalence of chronic conditions. The goal of the Affordable Care Act is to lower the rate of uninsured and thereby reduce the negative health consequences stemming from lack of affordable health insurance. The uninsured rate in Dickey County is higher than North Dakota, which is in line with the national benchmark. Because the Medicare-eligible population in Dickey County is higher than North Dakota and the Nation, this means that the rate of uninsured in the 0-64 population range may be even higher than the uninsured rate numbers reflect.

County Health Rankings, 2016

General Population Health

One measure of health among the community included in the County Health Rankings Nationwide study is reported general well-being. Reported general health of “poor or fair health” in Dickey County was lower than North Dakota, and in line with the Nation. North Dakota, however, is higher than the Nation. What this means is that the population in Dickey County considers themselves to be slightly healthier in general, and this trend is moving in a positive direction.

A similar self-reported measure is “poor physical health days,” which refer to days in which an individual does not feel well enough to perform daily physical tasks. Rates in Dickey County are below North Dakota and the Nation. This is a positive indication as people in Dickey County are reporting feeling better physically.

A third measure of general health of the population is the percentage of adult obesity. Nationally, the rate has been around 25% of the population. In North Dakota, the percentage of adults who are obese has remained at 30%, the same as 2013, but higher than the 27% reported in 2010. The percentage is slightly higher in Dickey County, at 33% for 2016, up from 29% in 2013, and 28% in 2011. The health ramifications stemming from obesity are significant. The trend in North Dakota and Dickey County is alarming, and represents a major health factor that should be addressed further in the coming years.

Another indicator, “Poor mental health days,” refers to the number of days in the previous 30 days when a person indicates their activities are limited due to mental health difficulties. The reported days in Dickey County are lower than North Dakota and the Nation. They have been falling consistently over the past four years which is a positive indication. Mental health has come into the spotlight nationally as an area where continued focus and improvement efforts are warranted; however, this remains a significant area of concern as needs within the county and state exceed available resources.

County Health Rankings, 2016

Adult Smoking

Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birth weight and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs.

The percentage of adults that report smoking in Dickey County has remained flat at approximately 16%, which is slightly below North Dakota’s rates but above the national benchmark rate of 14%.

County Health Rankings, 2016

Preventable Hospital Stays

Hospitalization for diagnoses treatable in outpatient settings suggests that the quality of care provided in those outpatient settings was less than ideal. The measure may also represent a tendency to overuse hospitals as a main source of care. Rates for Dickey County have declined since 2010, to 49 per 1,000 Medicare enrollees. This is above the national benchmark and below the North Dakota rates.

County Health Rankings, 2016

Screening

Screening for potential health issues is a major indicator of future health needs within a community.

Diabetes screening rates in Dickey County have fluctuated between 90%-100% over the past five years. This is higher than North Dakota and at the National Benchmark, which is a very positive indication.

Mammography screening had declined precipitously in Dickey County from 82% in 2011 down to 67% in 2013, but has seen an increase to 76% in 2016. This is above the National Benchmark rate of 71% and the North Dakota rate of 68%. This downward trend should be explored in the coming years. This screening need has been the focus of grant dollars to increase awareness and provide free screenings for the uninsured.

County Health Rankings, 2016

Summary of Key Findings and Prioritized Needs

The following issues were identified through the interview and survey process described in the primary data collection section (in no particular order):

1. High cost of health care
2. Mental health: Adults & Children
3. Cancer
4. Alcohol and substance abuse
5. Maintaining enough health care and EMS workers
6. Aging population & lack of health care resources in the future
7. Financial viability of the hospital
8. Obesity
9. Focus on wellness/prevention of disease – availability of exercise facilities
10. Domestic violence & child abuse
11. Crime & community violence
12. Heart disease
13. Lack of affordable housing and assisted living facilities

The health needs were prioritized by the CHNA Advisory Committee. The criteria used to prioritize the health needs can be found in Appendix 3. The criteria measures were established by the Committee, drawing from recommendations from the National Rural Health Association.

Existing Health Care and Other Facilities and Resources

A complete list of health care and other facilities and resources available within the community to meet the identified health care needs, including location and description of services, can be found in Appendix 4.

Implementation Plan

Once the health needs were prioritized by the CHNA Advisory Committee, the final step in the CHNA process involved developing an implementation strategy. The purpose of the implementation strategy is to develop a clear set of goals to respond to the priorities identified through the CHNA. The implementation strategy should include a written plan that addresses each of the community health needs identified through the CHNA, describe how the hospital plans to meet the health needs, and identify health needs the hospital does not intend to meet and why.

The CHNA Advisory Committee developed the implementation strategy. The committee addressed the following implementation strategy components within each priority identified:

1. Objectives/Strategy
2. Tactics (How)
3. Programs/Resources to Commit
4. Impact of Programs/Resources on Health Need
5. Accountable Parties
6. Partnerships/Collaboration

The detailed implementation strategy for each priority can be found in Appendix 5. In summary, the following priorities were addressed through the implementation strategy:

1. High cost of health care
2. Mental health – Adults & Children
3. Maintaining enough health care & EMS workers
4. Obesity
5. Focus on wellness/prevention of disease – availability of exercise facilities

The implementation strategy detail for each priority located in Appendix 5 provides supporting tactics, programs/resources, accountable parties, and potential partnerships/collaboration for each strategy.

References

ESRI Business Information Solutions, 2015

North Dakota Census Office, 2016

County Health Rankings – see Appendix 6

North Dakota Job Service Labor Market Information Center Report – see Appendix 7