



# Perham Health Community Health Needs Assessment & Action Plan

IMPLEMENTATION 2019-2022



SANFORD

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# EXECUTIVE SUMMARY

Perham Health is a public, non-profit, critical access healthcare organization located in Perham, Minnesota. This report represents the current community health needs assessment (CHNA) for Perham Health.

Every three years, Perham Health identifies and analyzes health priorities in the community, and creates an action plan to address identified needs. The CHNA process is conducted in partnership with a variety of community stakeholders. To understand the top needs of the community, Perham Health works with these stakeholders to identify resources and develop a plan that leverages resources to improve the health of the community.

Information collection began in early 2018. Community members and stakeholders were surveyed and data was collected to identify the perceived needs of the community.

In 2019, Perham Health hosted a community stakeholder meeting to identify the biggest needs in the community and ascertain achievable solutions to those needs in order to develop the 2019-2022 action plan. This plan includes the following goals, each of which is supported by multiple objectives and will be implemented through a variety of strategies.

## **1). MENTAL HEALTH**

To provide education regarding the importance of mental health for individuals, to help reduce stigma, and increase awareness of the prevalence of mental health issues and available resources.

## **2). HEALTHY LIFESTYLE**

To promote healthy lifestyles within the community by developing a community health coalition to spearhead community health initiatives.



# INTRODUCTION

Perham Health's mission is dedicated to health and wellness throughout life. To ensure Perham Health is addressing the health needs of the community, Perham Health conducts a community health needs assessment (CHNA) every three years to identify and analyze health priorities in the community, and creates an action plan.

Through this process, Perham Health aims to:

- Better understand the health status and needs of the communities Perham Health serves, by considering the most recent health and demographic data as well as gathering direct input from community members.
- Gather perspectives from individuals representing the interests of the community.
- Identify community resources and organizations with whom Perham Health can collaborate in supporting the priority areas for that community.
- Create a strategic action plan based on information gathered through the needs assessment.

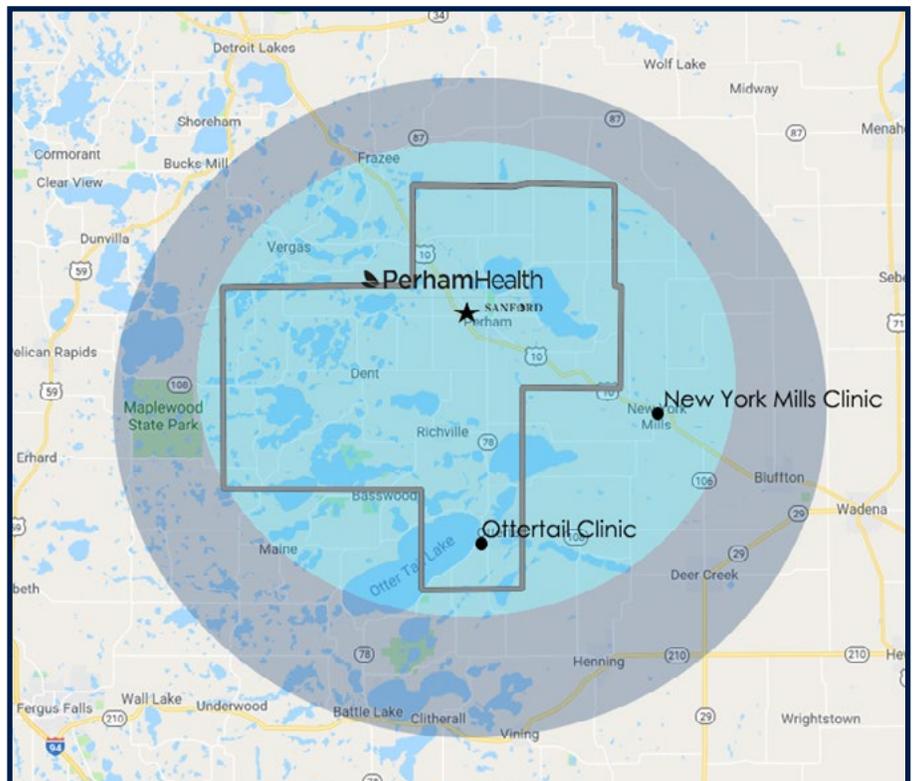
The purpose of this report is two-fold. First, to highlight the activities Perham Health conducted during 2016-2019 to address the needs emphasized in the 2016 CHNA. Second, to share the significant findings of the 2018 CHNA and Perham Health's plan to address the identified needs over the next three years.

## **PERHAM HEALTH DESCRIPTION**

Perham Health is a health system headquartered in the city of Perham (population of 3,300) in west-central Minnesota. The organization serves as a regional provider of quality healthcare focusing on Patient- and Family-Centered Care. Since the hospital's founding in 1902, Perham Health has remained committed to three core principles: healing, health, and hospitality.

As a public, non-profit, healthcare organization, Perham Health is owned and governed by 10 townships and three cities within a geographic area known as a "hospital district." The hospital district encompasses an area covering approximately 180 square miles, with an estimated population of 15,000 residents. The current operation of the Perham Hospital District consists of the board of trustees retaining the governance role while Sanford Health upholds the management role.

The configuration of Perham Health is unique in that it is one of a few health care systems that provides a full continuum of care - from birth to death - under one umbrella with a staff of 600 employees. In 2012, Perham Health completed construction of a state-of-the-art, 120,000 square foot, 25-bed critical access hospital. Some facility features include a family birth center, two operating suites, an endoscopy



**FIGURE 1 DISPLAYS THE PERHAM HEALTH HOSPITAL DISTRICT (OUTLINED IN GRAY), AND THE PRIMARY (LIGHT BLUE CIRCLE) AND SECONDARY (NAVY CIRCLE) SERVICE AREAS.**

suite, level IV emergency department, imaging/radiology, laboratory, durable medical equipment, therapy center, and pharmacy. In addition to emergency and acute services, Perham Health offers a wide array of ancillary services through its three clinics in Perham, Ottertail, and New York Mills, Minnesota. The Perham Health system also includes a 96-bed skilled nursing facility, memory care assisted living, home care services, adult day services, acute-care rehabilitation, and senior housing. In addition, Perham Health also upholds management agreements with the local ambulance service (Perham Area EMS) and a city-owned Housing and Urban Development housing building (St. James Manor).

## **COMMUNITY PROFILE POPULATION SERVED**

Perham is a small, yet vibrant, community with a strong entrepreneurial spirit located in the heart of Minnesota's lake country. The community provides numerous employment opportunities and attracts new residents readily, thanks to a wide variety of recreational activities and a relaxed, resort-like lifestyle.

According to census data, the population in the hospital district's primary service area has increased by approximately 10% since 2000. The Minnesota State Demographic Center projects a continuation of this growth pattern, estimating another 3-5% population increase for Otter Tail County by 2020.

Perham offers a vast number of job opportunities in the agriculture, manufacturing, and tourism industries. Health care, education, and social service jobs are also areas of job growth for the Perham area. Employment in Perham grew by 13.6% in the past five years, resulting in approximately 3,886 jobs available within the city of Perham.<sup>1</sup> All of these factors influence Perham Health's services and its healthcare impact as more people, particularly ethnically diverse populations, move to the community for jobs.

The tourist population comprises a large cohort of people served by Perham Health. With Perham nestled in the heart of lakes country, there can be an influx of around 30,000 people vacationing in the area at any given time during the summer months. This population influx increases Perham Health's patient numbers, especially in the emergency department.

The elderly population (65 and older) is another population that continues to increase at staggering rates. According to the Minnesota Demographic Center, 33% of Otter Tail County's citizens are 65 or older. This percentage is projected to increase to 39% by 2030.<sup>2</sup> This means the number of people turning 65 has eclipsed the population aged 5-17 for the first time in history. Due to increased longevity, this population requires the highest level of support to maintain their health, independence, and quality of life. These trends affect community services and resources, further impacting health care, workforce needs, and revenue sources.

<sup>1</sup> Progressive Perham, Community & Economic Profile, 2019

<http://www.progressiveperham.com/wp-content/uploads/2019/04/Community-Profile-1.pdf>

<sup>2</sup> Face Aging MN, Otter Tail County Population, 2019

<https://faceagingmn.org/minnesota-population-aging-map/?county=otter-tail>

# REVIEW OF 2016 CHNA ACTION PLAN

The 2016 Perham Health CHNA identified three areas of focus: physical health, mental health, and aging population. Based on these identified areas of need, Perham Health identified initiatives that lead to improvement of services in these deficit areas. Perham Health leadership appointed strategic teams to lead coordinated efforts to improve the areas of concern across both the health system and partnerships across the community. The following describes the initiatives and outcomes.

## **DIABETES PREVENTION PROGRAM**

Due to overwhelmingly high obesity rates across the community, Perham Health opted to focus on pre-diabetes and implementing the Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program (DPP). Over the past three years, the medical community has turned its attention to educating those they serve about prediabetes. Prediabetes is considered the precursor to a diagnosis of Type 2 diabetes, where one's blood sugar levels are higher than normal, but not quite high enough to be diagnosed as Type 2 diabetes.<sup>3</sup>

As a new focus in the medical community, Perham Health made several changes in treatment of obesity in its clinics. The Perham Health obesity team worked on identifying individuals with prediabetes, workflows on how to connect obese patients to resources, and added staff, such as an RN diabetes educator, to help support patients with an obesity diagnosis. One of the most significant areas of focus for the team was becoming a CDC-accredited Diabetes Prevention Program site. This yearlong course welcomes participants "with prediabetes or at risk for Type 2 diabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of Type 2 diabetes and improve their overall health."<sup>4</sup>

Perham Health has held 17 free DPP courses and helped 108 participants lose a total of 3,559.80 pounds (an average weight loss of 32.96% per participant).

## **3 GOOD THINGS**

Mental health was identified as a considerable concern in the community and an unknown area for many community members. Due to the difficulty in providing new mental health services in a rural area, Perham Health opted to take an "upstream" (preventative) approach to address mental health challenges the community faces. The upstream approach that Perham Health's mental health team decided to focus on was promoting a "Three Good Things" campaign. Three Good Things (3GT) is a daily practice to help one tune into positive experiences; taking a moment to reflect on three good things that one experienced that particular day.

The mental health team took a multi-faceted approach to encourage 3GT throughout the community. The team created a logo, brochure, magnets, notepads, and social media page as tools to help spread the practice. With materials in hand, the team permeated the community, working to educate community members about the 3GT practice and how it promotes mental health. The team participated in radio interviews, met with businesses, interviewed with local newspapers, staffed booths at health fairs, presented to community organizations, and helped the local schools educate youth about the practice.

After full implementation, 3GT became a buzz in the community.



<sup>3</sup> Centers for Disease Control and Prevention, Prediabetes: Your Chance to Prevent Type 2 Diabetes, May 30, 2019 <https://www.cdc.gov/diabetes/basics/prediabetes.html>

<sup>4</sup> Centers for Disease Control and Prevention, What Is the National DPP?, December 11, 2018 <https://www.cdc.gov/diabetes/prevention/what-is-dpp.htm>

The logo was seen in areas all around town, and stories were shared about how 3GT had helped individuals get through difficult times. The Three Good Things campaign has been embraced as a common practice and has made an impact in the community.

## **BREAKING BARRIERS**

Breaking Barriers is a movement designed by Perham Health's mental health team to bring awareness and education to the mental health crises and suicide epidemic that plagues the community. Through this movement, the mental health team hosted a variety of educational opportunities for community members.

First, the team hosted two Mental Health First Aid (MHFA) trainings. This training is an 8-hour course that teaches attendees to identify, understand, and respond to signs of mental illness and substance use disorders.<sup>5</sup> At the time of this report, 60 people have been trained in MHFA. These trainings have spurred a drive amongst the 60 trainees to educate the entire community in mental health, providing community members the tools to handle mental illness. Some trainees have become certified trainers for MHFA and Perham Health is fundraising to expand mental health education in the community.

Second, Perham Health hosted speakers from the Strub Caulkins Center for Suicide Research<sup>6</sup> who informed on the prevalence of suicide in the community and educated on how to prevent suicide through the *suicideTALK*<sup>7</sup> program. In the wake of a difficult time for the community, this Breaking Barriers event brought together mental health resources available throughout the area and spurred a conversation about mental health.

## **ADVANCED CARE PLANNING**

Advanced care planning (ACP) is the meeting of a trained facilitator, an individual, and his/her loved ones. The purpose of ACP is to assist in identifying end-of-life wishes and discussion of how much healthcare intervention one wants to receive. Including loved ones in the discussion is needed, should they have to speak on the individual's behalf should he/she not be able to speak for him/herself. Perham Health has recognized the value this service brings to the community and has invested in developing an ACP program.

Although health care directives have been law for nearly 30 years, confusion remains about this legal document, and many people lack a form of directive. The ACP program brought a new, streamlined process to implementing advance care directives, about which the community needed to be educated. Therefore, the Perham Health ACP team put together a multi-session community education event to educate about ACP and the importance of having a directive. The event was a great success, with more than 100 people in attendance. Patients continue to call to schedule ACP appointments.

Over the past three years, the ACP team has made great strides in making ACP a standard of care for Perham Health. Perham Health has trained six people in facilitating ACP and developed a process to get a notarized ACP document entered into the patient's electronic health record. Since the program's inception, Perham Health has seen an increase in the number of patients requesting assistance in completing their health care directives.

## **PERHAM HEALTH SPECIFIC ACTIVITIES**

The following activities were developed and implemented by Perham Health to better serve the community as identified by the needs listed in the 2016 CHNA:

### **MENTAL HEALTH**

#### **Psychiatry**

In addition to the clinical psychologist on staff, Perham Health added a full-time psychiatrist. This expands Perham Health's ability to treat mental and behavioral illness through prescription management.

<sup>5</sup> Mental Health First Aid, 2019 <https://www.mentalhealthfirstaid.org/>

<sup>6</sup> Strub Caulkins Center for Suicide Research, 2019 <http://www.suicideresearch.org/>

<sup>7</sup> LivingWorks, suicideTALK: suicide awareness, March 2018 <https://spcch.org/wp-content/uploads/2018/06/suicideTALK-info-sheet.pdf>

### Integrated Behavioral Health Therapy

Perham Health has incorporated the use of telehealth to bring integrated behavioral health therapy to patients over age 12 in a mental health crisis or patients who a primary care provider feels would benefit from a rapid consult. The integrated health therapist (IHT) is a master's level social worker who provides patient-centered care and focuses on assisting the primary care medical team in identifying, triaging, and effectively helping patients manage behavioral health problems or psychosocial comorbidities of medical disease. The IHT also works to ensure interface between primary care and specialty, as well as community-based, services. The IHT sees a patient via video for up to five visits, then transitions the patient to more appropriate resources.

### Mobile Mental Health Crisis Response

Perham Health has developed a partnership with the Mobile Mental Health Crisis Response Team to help patients who access the Perham Health emergency department (ED) during a mental health crisis. Mobile mental health services are short-term, face-to-face services designed to restore a person's functioning level to pre-crisis levels. Through the partnership, trained mental health providers come into the emergency department and work with patients to de-escalate a situation or problem and to help them develop individualized strategies for their future concerns.

### Management of Aggressive Behavior (MOAB) Training

Incidence of violence in healthcare facilities continues to rise. In an effort to keep those who work, visit, and seek care at Perham Health safe, Perham Health has trained staff in management of aggressive behavior (MOAB). MOAB presents principles, techniques, and skills for recognizing, reducing, and managing violent and aggressive behavior. The program also provides humane and compassionate methods to deal with aggressive people.

### Safe Room

Internal statistics indicate the number of mental/behavioral patients utilizing the Perham Health ED when seeking crisis intervention has increased 5%-10% per year. This is a result of the lack of mental/behavioral health resources across the state of Minnesota. With little to no preventative care, mental/behavioral health patients often fall subject to a mental/behavioral health crisis, which leads them to the ED to seek help. Despite Perham Health's best efforts to keep patients and staff safe, incidents continue to rise and the current treatment rooms become more and more unsafe to use when caring for these patients. In an effort to provide safe care, Perham Health remodeled the ED to incorporate a safe room. The safe room includes features such as an outward opening, locking door, closed camera systems, and all medical equipment safely stored, to allow mental/behavioral patients to be boarded in a safe, comfortable environment during their stay, until a safe discharge plan is in place.

## PHYSICAL HEALTH

### Community Paramedic

Community paramedic service is an innovative solution dedicated to providing high-quality follow-up care and preventative services in the comfort of a patient's home when they may have limited access to healthcare. This service compliments the specialized services available in a home care model or physician office. The community paramedic provides care and communicates health status or concerns back to the referring provider to ensure quality of care and appropriate oversight. Furthermore, the community paramedic works with public health officials to provide preventative services throughout the community.

### Coordination of Care

In partnership with Stratis Health<sup>8</sup>, Perham Health was a part of the statewide initiative to reduce the rate at which patients were readmitted to the hospital within 30 days of being discharged. Perham Health collaborated with a variety of local agencies that play a role in the discharge process of Perham Health patients. Some of the participants included Otter Tail County Public Health and Human Services, Hospice of the Red River Valley, LB Homes and Hospice, community paramedic, area assisted living, and representation from all Perham Health patient care departments.

Together, this group implemented multiple programs which played a role in reducing readmissions in Perham.

<sup>8</sup> Stratis Health, Coordination of Care, 2019 <http://www.stratishealth.org/providers/care.html>

Some of the projects include:

- Daily care team rounding with patients to communicate daily goals and plan for discharge with the entire care team taking care of that patient.
- Universal congestive heart failure and chronic obstructive pulmonary disease (COPD) education materials that all partners use with patients.
- Communication plans between nursing homes, home care agencies, and the hospital to help ensure discharge plans are carried out as intended.

### Integrated Health Partnership

In 2017, Perham Health partnered with the Minnesota Department of Human Services to care for Medicaid members in a fee-for-service payment model. The goal of such partnerships is to hold healthcare organizations accountable for the total cost of care and quality of services provided to this population. Perham Health focuses its efforts on preventing unnecessary emergency department visits and helping patients develop relationships with a primary care provider to ensure they have continuity of care.

### Medical Home

To help patients coordinate their care within the complicated healthcare system, Perham Health implemented an accredited Primary Care Medical Home at both the Perham and New York Mills clinics. Registered Nurse case managers work with high-risk patients on a monthly basis, focusing on care coordination, access to care, and effective collaboration between the primary care clinician, interdisciplinary team, and patient. At any given time, Perham Health serves approximately 125-150 patients through this program.

As an extension of the medical home program, Perham Health has obstetric RN case managers who work with every expecting family from their pregnancy confirmation appointment until their baby is one year old. The OB RN case managers offer education every trimester and are available to answer any questions new parents may have about their journey. On average, the case managers see approximately 150 families a year.

### Baby Friendly

Perham Health has pursued becoming a Baby-Friendly designated facility. The Baby-Friendly Hospital Initiative (BFHI) is a global program launched in 1991 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. The BFHI assists hospitals in giving all mothers the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies or feeding formula safely, and certifies hospitals meeting these stringent criteria. Becoming a Baby-Friendly facility is a comprehensive, detailed and thorough journey toward excellence in providing evidence-based, maternity care with the goal of achieving optimal infant feeding outcomes and mother/baby bonding. Perham Health is in the final stages of the accreditation process and hopes to receive Baby-Friendly accreditation by the end of 2019.

### Worksite Wellness

With over 600 people employed by Perham Health, Perham Health recognized the need to create a workplace culture and environment that supports healthy behaviors. As a result, Perham Health developed the Live Well team, which implements change and develops programs to support employees to live a healthy life at work and at home. Through the program, a variety of initiatives has been implemented to educate and promote wellness. Examples include encouragement of healthy diets by way of reducing access to sugar-sweetened beverages, offering free fruit, clear food labeling programs, promotion of an active lifestyle through the fitness challenges, breastfeeding support, education on all aspects of wellness through lunch and learn seminars, and collaboration with weight loss programs such as the Diabetes Prevention Program and Weight Watchers.

## AGING POPULATION

### Northwinds

In response to the need for housing for those diagnosed with Alzheimer's and/or dementia, but are not quite ready for nursing home care, Perham Health opened a 13-bed memory care assisted living center. Northwinds is specially designed to provide comfort and security in a supporting environment for those in need of memory care. Structured and stimulating activities are delivered by staff members trained specifically on caring for those with memory impairment. Professional caregivers are on-site and available 24-hours a day with a licensed nurse available for staff consult 24-hours a day, seven days a week. Located on the Perham Living campus, Northwinds provides an alternative for people living with Alzheimer's disease and related dementias.

### The Connection

Perham Health was awarded a grant to host community planning sessions to develop a program to help keep seniors in their homes longer and safer in the wake of the ever-growing senior population. Because of the community planning sessions and the award of an implementation grant, Perham Health, along with partners from Otter Tail County Human Services, the community, and Blue Cross Blue Shield of Minnesota, were able to carry out the implementation of The Connection to help address the needs that seniors are facing in the community.

The Connection provides a local point of contact – a one-stop referral center – for all senior services offered in Perham and the surrounding area. People looking for services to help meet the needs of an aging family member, friend, neighbor or even themselves, are often given a variety of phone numbers and websites, making it a challenge to sort through all the information. A community resource navigator is available to introduce those in need to agencies that offer services and provides follow-up to verify that needs were met.

### Financial Support for Perham Living

Nursing home closures in rural communities have been occurring across the state for the last several years. Nursing homes are expensive to run, highly regulated, and hard to staff. When a nursing home closes, it is a massive loss for a small community. Jobs are lost, the economy is affected, and residents have to move away from their beloved home community. Perham Living is no different from these rural facilities feeling the financial pressures from the broken aging services system. The only way Perham Living can keep its doors open is from the support it receives from being connected to a more extensive healthcare system. Perham Health recognizes the benefit the nursing home brings to the community. Therefore, Perham Health subsidizes the nursing home to keep the doors open.

# 2019 CHNA PROCESS & METHODS

To uncover the most significant health needs of the community that Perham Health serves, Perham Health utilized a multifaceted approach that sought out both the opinion of constituents and assessed the current data available about the community. Perham Health implemented a team to oversee the process of collecting the information necessary to help its leadership decide on the areas of focus.

TIMING	STEPS
December 2017 – January 2018	<p><b>COMMUNITY SURVEYS DISTRIBUTED</b></p> <p>Online community stakeholder and resident surveys distributed via local newspapers, website, social media, and email</p>
February – December 2018	<p><b>DATA COLLECTION &amp; REVIEW</b></p> <p>Data from the community surveys and secondary data collection collected and reviewed to identify areas of concern</p>
January – February 2019	<p><b>PLAN COMMUNITY STAKEHOLDER MEETING</b></p> <p>Using the data, a community stakeholder meeting took place to share the data and facilitate a discussion about where the area(s) of focus should be</p>
February 11, 2019	<p><b>GATHER COMMUNITY STAKEHOLDER INPUT</b></p> <p>Community stakeholders reviewed data and discussed area(s) of focus</p>
March – August 2019	<p><b>PRIORITIZE NEEDS AND PREPARE REPORT</b></p> <p>Perham Health leadership used the data and summary of inputs from the community stakeholder meeting to determine priority needs and write a report to share findings</p>
September 2019	<p><b>SEEK FINAL APPROVAL</b></p> <p>The final CHNA report goes to the Perham Hospital District Board of Trustees for approval and adoption</p>

## **DATA COLLECTION & REVIEW**

Data from both community surveys and secondary data sources was collected to help narrow down areas of focus to identify priority health need in the community.

## **COMMUNITY SURVEYS**

In partnership with Otter Tail County Public Health, Sanford Health, and the Center for Social Research (CSR) at North Dakota State University, Perham Health surveyed community residents and stakeholders to capture the perceived health needs of the community. Between December 2017 and January 2018, online surveys and those distributed via local newspapers, website, social media, and email, were collected. The resident survey tool focused on respondent’s health and the stakeholder survey concentrated on the stakeholder’s perceived concerns for the community specific to economic well-being, transportation, children and youth, the aging population, safety, health care and wellness, mental health, and substance abuse. A total of 174 stakeholders and 221 community residents participated in the survey.

## SECONDARY DATA COLLECTION

Perham Health used the most recent secondary data available via the CHNA toolkit—a free, web-based platform hosted by Community Commons—as well as additional national, state and local data resources available for Otter Tail County such as the US Census data, Minnesota Student Survey and the Minnesota Health Access Survey. Data for the entire state of Minnesota was also provided for comparison and context. The data included approximately 75 indicators relating to demographics, social and economic factors, health behaviors, physical environment, the prevalence of health conditions, and health care access. Data from Perham Health’s internal sources was also captured to help tell the story of the Perham Health patient population.

## COMMUNITY STAKEHOLDER MEETING

Community stakeholders were invited to attend a presentation of the findings of the CHNA research. The meeting served to inform the group of the findings, but also catalyze collaboration. Approximately 30 stakeholders attended the meeting.

Agencies represented at the meeting included:

- Boys & Girls Club of Perham
- City of Ottertail
- City of Perham
- Dancing Sky Area Agency on Aging
- KLN Family Brands
- Lund Boat Company
- Mahube-Otwa
- Otter Tail County
- Otter Tail County Human Services
- Otter Tail County Public Health
- Otter Tail County Social Services
- PartnerSHIP 4 Health
- Perham Area Community Center
- Perham Area EMS
- Perham Health
- Perham-Dent ISD 549
- Richville Community Mission - United Methodist Church
- Someplace Safe
- The Connection

Every attendee of the meeting received a packet summarizing the data from both the community surveys and the secondary data sources. Facilitated discussion commenced using a World Café methodology to discuss the findings in the focus areas of children and youth, aging population, substance abuse and safety, mental health, and healthcare access and wellness. Participants had a chance to engage in 20-minute discussions in groups of eight. Participants were asked to share their vision for health in the community, clarify aspects of the priority health areas that are most important to address, and discuss opportunities for Perham Health to support community health by answering these three questions:

- What impression does the data make on you and what do you feel are the biggest needs?
- What resources do we have that already address these issues?
- How, as a community, can we improve these issues?

## FOCUS AREA DIALOGUES

### Aging Services

#### NEEDS

Amidst the many needs identified among the aging population and services that support them, three needs rose to the top after dialogue with the stakeholders.

- The lack of knowledge about aging and aging services, and failure of pre-planning for the aging process on all fronts (e.g., financial, legal, health, etc.).
- Transportation to help get seniors where they need to go to support healthy lifestyles for seniors in rural areas.
- A lack of caregivers. Whether the caregiver is a paid employee or a volunteer/family member/neighbor, there is not enough help to care for this large population.

## SOLUTIONS

The three solutions identified as the most achievable to help address these needs are:

- Legislative awareness and advocacy for senior care and the funds that are needed to support this growing population in rural areas.
- Support for the local program, The Connection. The Connection is a program that connects seniors and their families to the resources seniors need to support healthy aging.
- Involving and exposing youth to senior care. Whether it be programming, scholarships, or the requirement of service, our community needs to do more to encourage young adults to pursue careers in caregiving.

## Children & Youth

### NEEDS

The discussion regarding needs among children and youth of the community brought multiple responses. However, three needs were identified as being areas of focus.

- Childcare availability
- The high rate of vaping among teens.
- Lack of resources to help students with extreme behaviors.

### SOLUTIONS

The three solutions identified as the most achievable to help address these needs are:

- Explore opportunities for subsidizing startup costs for people looking to open a daycare.
- County-wide education to the public on the risk, exposure, and detection of vaping.
- Advocate for more special education funding to help provide proactive early intervention to children in need.

## Healthcare Access & Wellness

### NEEDS

There are many challenges that make healthcare access difficult in a rural area. Participants identified three needs that must be a top priority.

- Access to healthcare, both general and specialized care.
- Community members to lead a healthy lifestyle to reduce the risk of needing high-level healthcare.
- Awareness of all resources that exist in the community to help live a healthy lifestyle.

### SOLUTIONS

The three solutions identified as the most achievable to help address these needs are:

- Increase access to healthcare by utilizing technology to conduct e-visits and telehealth opportunities and invest in support services such as the community paramedic and "Ask a Nurse" programs.
- Develop a community steering committee to work on transforming the overall health and quality of life for the community.
- Expand the model of The Connection to help connect people to resources that are available to them to live a healthy life.

## Mental Health

### NEEDS

Mental Health is a new frontier for many communities, and the participants in this community conversation identified three top needs in this area. These needs are:

- Awareness and education about mental health.

- Availability of placement for those that are struggling with a mental illness to reduce congestion in the emergency department.
- Access to child-specific services for children struggling with mental illness.

#### SOLUTIONS

The three solutions identified as the most achievable to help address these needs are:

- Bring Mental Health First Aid training to the community to train people on how to identify and handle both adults and children dealing with a mental health crisis.
- Increase awareness of adverse childhood experiences (ACEs) and trauma-informed care.
- Develop a care team approach to care for patients that access the clinic for psychiatric care.

### Substance Abuse & Safety

#### NEEDS

Substance abuse and safety concerns within the community had a lot of overlap in need. After much conversation, the top three needs that rose up include:

- Access to alternative practices to address chronic pain to reduce prescriptions for opioids.
- Availability of credible youth education about substance abuse and safety concerns.
- Frequency of distracted driving.

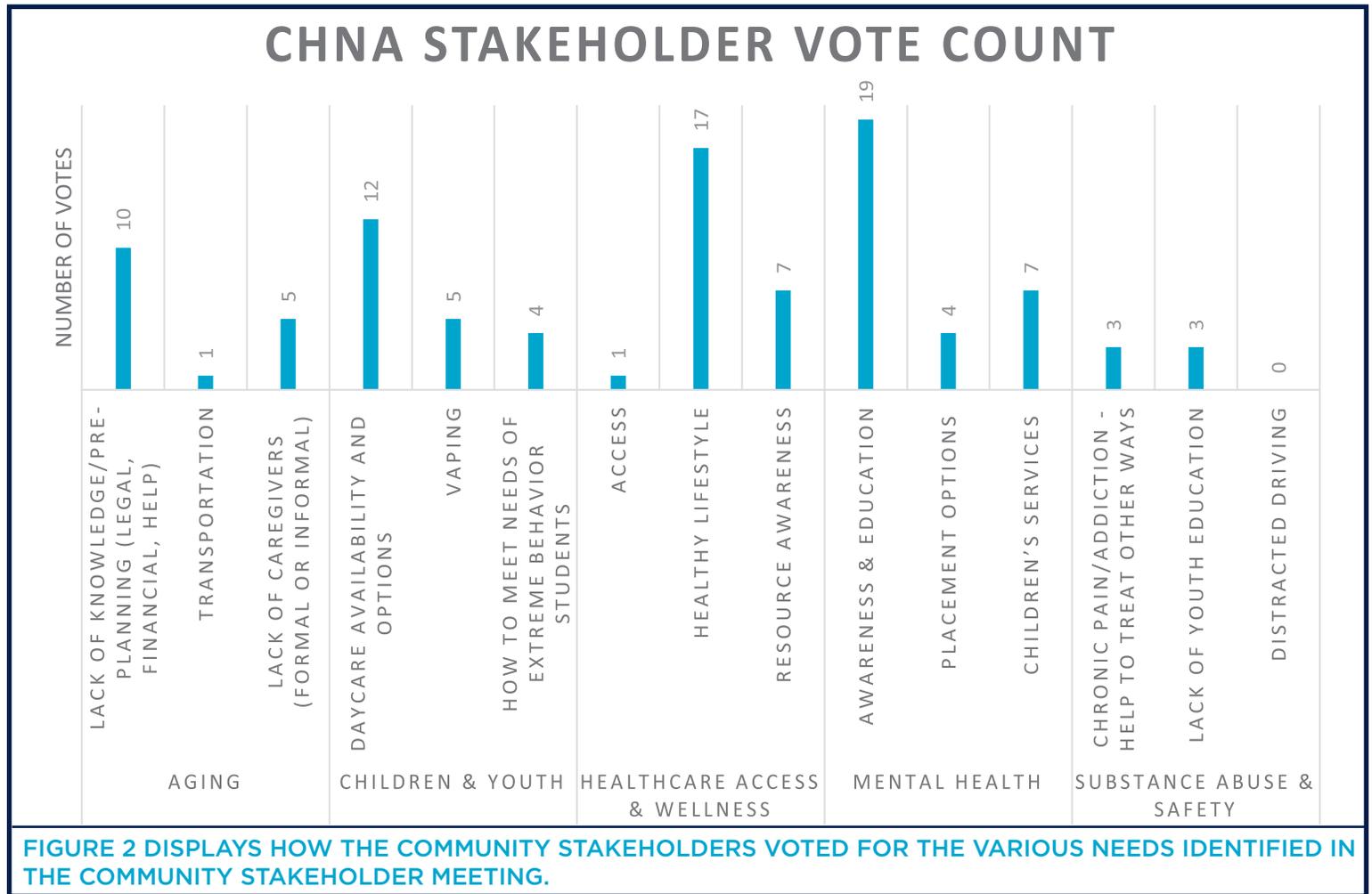
#### SOLUTIONS

The three solutions identified as the most achievable to help address these needs are:

- Increase access to chronic pain treatment options and help people to have healthier lifestyles.
- Work to bring in more reputable youth education programs that teach the youth about substance abuse and safety topics.
- Implement a program targeting adults to prevent distracted driving and help new drivers understand the risks involved.

## RANKING OF NEEDS

Upon all attendees having a chance to discuss the various areas, facilitators reported out the top three needs and solutions of each area that were common among all groups. After recording all themes, attendees were provided three stickers to use as votes to indicate their preferred areas of need they think should be focused on over the next three years. Results are displayed in Figure 2.



## PRIORITIZATION OF NEED

There are many areas of need within the community. However, to be most effective, only two to three areas of need can be focused on over the next three years. Using the data that was collected and the summary of the community stakeholder meeting, Perham Health leadership was tasked with identifying the needs Perham Health will focus on over the next three years.

The leadership team includes:

- Chuck Hofius, CEO
- Justine Anderson, CFO
- Sonda Tolle, Vice President of Patient Services
- Pat Sjolie, Vice President of Ancillary Services
- Tracy Hendrickx, Vice President of Long Term Care
- Pat Ferguson, Human Resources Director
- Beth Ulschmid, Clinic Director
- Amanda Reynolds, Executive Assistant

## FINAL PRIORITIES

Through this process, two priorities were identified for action in 2019-2022:

- Mental Health
- Healthy Lifestyles

# ACTION PLAN

## **OVERVIEW OF PROCESS**

With the adoption of the CHNA, Perham Health will incorporate each priority area into the organization's strategic plan. As a part of the strategic plan, each year Perham Health leadership will assign staff to a team to work on each priority area. These strategic teams will be responsible for carrying out the objectives of each priority over the next three years.

### **PRIORITY 1: MENTAL HEALTH**

#### Goal

Provide education on the importance of individual mental health to help reduce stigma, and increase awareness of the prevalence of mental health issues and the resources available.

#### Objectives

1. Invest in training facilitators of Mental Health First Aid (MHFA) to help with training more community members in MHFA. The purpose of this objective would be to reduce the stigma of mental health and help those who may be experiencing a mental health crisis to access the resources they need, rather than sending them to the emergency department.
2. Develop a team and collaborate with area mental health services to create a comprehensive continuum of care that will help prevent those who experience mental health issues from falling through the gaps of the health care system.
3. Work with community partners to increase awareness of the importance of mental health through programming and campaigns.

### **PRIORITY 2: HEALTHY LIFESTYLES**

#### Goal

To promote healthy lifestyles within the community by developing a community health coalition to spearhead community health initiatives.

#### Objectives

1. Explore funding and opportunities of developing a major health community initiative to steer projects that help promote healthy lifestyles for those who live in the community.
2. Host an annual community wellness fair to help educate community members on how to live a healthy lifestyle and the resources that are available to them within the community.

## **EVALUATION OF OBJECTIVES**

Throughout the implementation of this action plan, specific metrics will be measured to track progress toward meeting the goals. The strategic teams assigned to each goal will have the responsibility of identifying these metrics and reporting them to the Perham Hospital District Board of Trustees every quarter.

# ACKNOWLEDGMENTS

Perham Health would like to thank the many partners who made this assessment and plan possible:

- Community members who offered their time and valuable insights;
- Otter Tail County Public Health, Sanford Health and the Center for Social Research at North Dakota State University for their assistance in gathering community data;
- Partner organizations that met to review and prioritize data and develop implementation plans;
- Perham Health staff who provided knowledge, skills, and leadership to bring the assessment and plan to fruition; and
- Maggie Fresonke, who supported the process throughout.

# CONCLUSION

Perham Health will work diligently to address the identified need prioritized in this process by taking action on the goals and objectives outlined in this plan.

For questions about this plan or the implementation progress, please contact:

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Copies of this plan can be downloaded at <https://www.perhamhealth.org/community-health-needs-assessment/>



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