



Sanford Health Network  
Community Health Needs Assessment  
Implementation Strategy  
2017-2019

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HEALTH

Dear Community Members,

Sanford Tracy is pleased to present the 2016 Community Health Needs Assessment (CHNA) and Implementation Strategy. There is great intrinsic value in a community health needs assessment when it serves to validate, justify and defend not-for-profit status and create opportunity to identify and address community health issues.

During 2015 members of the community were asked to complete a non-generalizable survey to help identify unmet health needs. Analysis of the primary research data and secondary research was used to identify health concerns and needs in the community. Community partners and public health leaders assisted with the development of an asset map that lists resources and assets that are available to address each need. A gap analysis and prioritization exercise was also conducted to identify the most significant health needs, and to further address these needs through the implementation strategies that are included in this document.

Sanford Tracy has set strategy to address the following community health needs:

- Physical Health
- Mental health

In this report you will find the implementation strategies for 2017-2019, information about what Sanford is doing to address the needs, assets and resources that are available in the community to address the needs, and a discussion on the impact from the 2013 implementation strategies.

At Sanford Tracy, patient care extends beyond our bricks and mortar. As a not-for-profit organization, ensuring that the benefits of health care reach the broad needs of communities is at the core of who we are. Through our work with communities, we can bring health and healing to the people who live and work across our communities. Together, we can fulfill this mission.

Sincerely,

*Stacy Barstad*

Stacy Barstad  
Chief Executive Officer  
Sanford Tracy Medical Center

## Implementation Strategies

### Priority 1: Mental Health/Behavioral Health

Mental health includes emotional, psychological and social well-being. It affects how people think, feel and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Many factors contribute to mental health problems, including:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Family history of mental health problems

Mental health problems are common but people with mental health problems can get better and many recover completely.

Sanford has prioritized mental/behavioral health as a top priority and has set strategy to help with access and to reduce the time that patients with mental health needs are placed for services. Sanford is working with community partners to create new recovery program options for community members.

Sanford has set strategy to work with the MN Department of Health on a pilot for integrating behavioral health into critical access hospitals.

### Priority 2: Physical Health

Physical health consists of many components, including rest and sleep, nutrition, physical activity, and self-care. Primary prevention is a way to remain physically healthy.

Sanford has set strategy to help the community improve their physical health and chronic health conditions. A goal of this strategy is to increase the awareness of Medical Home and Health Coach.

Additionally, Sanford *fit* is an on-line community health activation initiative created by Sanford Health that provides engaging programs and resources to kids, families, leaders and role models across numerous settings to promote and activate healthy choices. The four key factors of healthy choices, a healthy body and healthy life included in *fit* are, MOOD – Emotions and Attitudes, RECHARGE – Sleep and Relaxation, FOOD – Mindful Nutrition Choices, and MOVE – Physical Activity Levels.

## Community Health Needs Assessment

### Implementation Strategy for Sanford Tracy Medical Center

#### FY 2017-2020 Action Plan

**Priority 1: Mental Health**

**Projected Impact:** To help with access and overall awareness of community of resources for mental health services

**Goal 1:** To show a decrease of time for mental health patients to be in the ER and go to placement

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Continue discussion on holding patients and resources to help with placing patients quickly	Track and evaluate Turnaround time for patients that come into ER and placement availability	State of MN, State Bed Tracker, Providers and Nursing Staff	Barstad/ Schons/ Deadrick- Nelson Wee	Local police and ambulance departments for transportation

**Goal 2:** Awareness of treatment of drug programs to community members

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Work with community partners to create new recovery program options for community members	Alcohol and Drug Treatment program(s) Awareness is marketed to community providers	Public Health, Community and City leaders	Behavioral Health team/ Barstad/ Sammons	City of Tracy leaders/Lyon County Public Health

**Goal 3: Work with MN Dept. of Health on pilot project for integrating behavioral health into critical access hospitals**

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
The National Rural Health Resource Center’s Rural Health Innovations has received a Flex grant from our office to provide technical assistance for improving the health of rural communities by increasing communication, partnership and collaboration among critical access hospitals, behavioral and mental health providers and other community partners	Successfully having more of a presence of behavioral health resources and providers into our critical access hospital at Sanford Tracy	MN Dept of Health, Community Partners	Barstad/ Schons/ Sammons/ Luft	Lyon County Public Health

**Priority 2: Physical Health**

**Projected Impact:** To help community improve their physical health and overall chronic health conditions

**Goal 1: Medical Home and Health Coach utilization**

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Increase awareness and utilization of Medical Home and Health Coach to reach obese patients	Track through running patient registry and follow up on eligible patients	Medical Staff/Health Coach	Sammon/ Kolar/ Morman	N/A

**Goal 2: Sanford Fit Kids Utilization**

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Work with Sanford <i>fit</i> Kids and work with community to bring this service more visibility	Presentations at school and at various community groups	Medical Staff/Schools/ Athletic Trainer/ Marketing	Clouse/ Radke/ Barstad	Tracy Public Schools

**Goal 3: Utilizing Sanford Profile services**

<b>Actions/Tactics</b>	<b>Measureable Outcomes</b>	<b>Resources</b>	<b>Leadership</b>	<b>Note any community partnerships and collaborations - if applicable</b>
Exploring utilization of new Sanford Profile weight management service for the community	Enrollment of at least 3 new patients over the next 1 year	Sanford Profile tools/Provider and community awareness	Radke/ Clouse/ Barstad	N/A

## Community Health Needs Assessment Key Findings

The top assessed needs from the 2016 primary and secondary research include:

- Aging – cost of long term care
- Safety – presence of street drugs and alcohol in the community and the presence of drug dealers in the community
- Health Care Access – the cost of affordable dental insurance and access to affordable health insurance
- Physical Health – chronic disease, inactivity, cancer and obesity
- Mental Health – dementia and Alzheimer’s, underage drinking, underage drug use and abuse, depression, substance use and abuse (drugs, alcohol and tobacco)
- Preventive Health – flu vaccines, immunizations and STDs

### Addressing the Needs

Identified Concerns	How Sanford Tracy Medical Center is Addressing the Needs
<b>Aging</b> <ul style="list-style-type: none"> <li>• Cost of long term care</li> </ul>	<ul style="list-style-type: none"> <li>• Resources to help with patients who leave Sanford Tracy facility to long term care.</li> <li>• Social Worker and discharge planning to help with decisions and resources.</li> </ul>
<b>Safety</b> <ul style="list-style-type: none"> <li>• Presence of drug dealers in the community</li> <li>• Presence of street drugs and alcohol in the community</li> </ul>	Assessment in ER upon admission.
<b>Health Care</b> <ul style="list-style-type: none"> <li>• Cost of affordable dental insurance coverage</li> <li>• Access to affordable health insurance</li> </ul>	Sanford Health Plan advertised and marketed in area.
<b>Physical Health</b> <ul style="list-style-type: none"> <li>• Chronic disease</li> <li>• Inactivity and lack of exercise</li> <li>• Cancer</li> <li>• Obesity                             <ul style="list-style-type: none"> <li>○ County rate is obese 29%</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of Health Coach and Medical Home to monitor and help patients with compliance of their health care. Preventative services, screenings and wellness services are offered.</li> <li>• Promoting Sanford Profile and <i>fit</i> Kids programs through Sanford.</li> <li>• Offering public education on different chronic diseases. Wellness Director has offered exercise “boot camps” for the public.</li> <li>• Oncologist added to outreach providers and expanded chemo therapy program.</li> <li>• Education and screening during <i>Hospital Week</i> and also at community events.</li> </ul>

Identified Concerns	How Sanford Tracy Medical Center is Addressing the Needs
<p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>• Dementia and Alzheimer's</li> <li>• Underage drinking</li> <li>• Underage drug abuse</li> <li>• Depression</li> <li>• Drug use and abuse</li> <li>• Smoking and tobacco use</li> <li>• Alcohol use and abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral health providers embedded in clinic to help with various mental health issues.</li> <li>• Primary care providers working with the mental health providers for referrals and proper placement.</li> <li>• Two MSWs on staff to help with resources and identifying abuse issues.</li> </ul>
<p><b>Preventive Health</b></p> <ul style="list-style-type: none"> <li>• Flu shots</li> <li>• Immunizations</li> <li>• STDs</li> </ul>	<ul style="list-style-type: none"> <li>• Offering flu shot clinics for the public.</li> <li>• Address and encourage keeping updated immunizations with clinic patients.</li> </ul>



## Sanford Tracy 2016 CHNA Asset Map

Identified concern	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
Aging population		Cost of long term care 3.80		X
Safety		Presence of drug dealers in the community 3.60		
		Presence of street drugs, and alcohol in the community 3.60		
Health Care		Cost of affordable dental insurance coverage 3.55		X
		Access to affordable health insurance 3.55		
Physical Health	<p>12% of adults report poor physical health in the last month, compared to 2.5% nationally and 2.8% statewide.</p> <p>6.2% of live births are of low birth weight (less than 2500 grams)</p> <p>29% of adults are obese</p> <p>18% of adults are current smokers</p> <p>19% of adults have no leisure time physical activity</p> <p>Teen births are at 22 per 1000 female population – national rate is 20</p>	<p>Chronic disease 3.58</p> <ul style="list-style-type: none"> <li>• 20.% of respondents reported hypertension</li> <li>• 20% reported high cholesterol</li> <li>• 10.% reported diabetes</li> <li>•</li> </ul> <p>Inactivity and lack of exercise 3.58</p> <p>Cancer 3.53</p> <ul style="list-style-type: none"> <li>• 20% reported cancer</li> </ul> <p>Obesity 3.53</p> <ul style="list-style-type: none"> <li>• BMI – overweight or obese 75%</li> <li>• Only 20% of respondents have 3 or more vegetables/day and 10 % have 3 or more fruits/day</li> <li>• 60% have 3 or more days each week of moderate activity and 20 % report 3 or more days of vigorous activity each week</li> </ul>	<p>Sanford Cancer Biology Research Center</p> <p>Sanford Dietitians</p> <p>MN Extension Service</p> <p>Sanford Medical Home</p> <p>The Sanford Project – to cure Type 1 DB in Denny Sanford’s lifetime</p> <p>Sanford WebMD Fit Kids</p> <p>Sanford’s Better Choices/Better Health Program( chronic illnesses program)</p> <p>Sanford Tracy Medical Center</p>	X

Identified concern	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
Mental Health/Behavioral Health	<p>Number of poor mental health days in the past month is 2.6 compared to 2.3 nationally and 2.6 across the state</p> <p>26% of adults report binge or excessive drinking</p> <p>44% of driving deaths are with alcohol involvement</p> <p>18% of adults smoke</p>	<p>Dementia and Alzheimer's 3.84</p> <p>Underage drinking 3.80</p> <p>Underage drug use and abuse 3.80</p> <p>Depression 3.63</p> <ul style="list-style-type: none"> <li>25% of respondents report that they have been told by a doctor that they have anxiety or stress, and 20% report being told that they have depression</li> </ul> <p>23.6% reported 1 or more days in the last month when their mental health was not good.</p> <p>Drug use and abuse 3.55</p> <p>Smoking and tobacco 3.55</p> <p>Alcohol use and abuse 3.50</p> <ul style="list-style-type: none"> <li>14% of respondents reported 3 or more drinks /d on average</li> <li>42.1% reported 4 or 5 drinks (binge) on the same occasion over the past month</li> <li>17.6% reported having a problem with alcohol use or drug use, however 10.5 % reported that alcohol use had harmful effects on the respondent or a family member</li> </ul>	Sanford One Care	X

Identified concern	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
Preventive Health	<p>77.3% of female Medicare enrollees age 67-69 receive mammography screenings</p> <p>STDs are at 196 compared to 138 nationally and 336 across the state</p>	<p>21.1% did not receive a flu shot in the past year</p> <p>61.1% have not had an immunization in the past year</p> <p>10.6% of respondents report that it has been over a year since they have seen their health care provider and 5.3 % have not seen their dentist over the last year.</p>	<p>Sanford Tracy</p> <p>Public Health Department</p>	X

# Demonstrating Impact

The 2013 Community Health Needs Assessment served as a catalyst to lift up obesity and mental health services as implementation strategies for the 2013-2016 timespan. The following strategies were implemented.

## 2013 Community Health Needs Assessment Sanford Tracy Implementation Strategy

### 1. Implementation Strategy: Urgent Care After Hours

#### Three-Year Plan (January 2012 - January 2015)

- To have full medical staff to be able to coordinate expanded hours
- Nursing staff coordination
- Receptionist staff coordination
- Marketing
- Ancillary staff coordination-Lab/X-Ray, etc.

### 2. Implementation Strategy: Mental Health Services

#### Three-Year Plan (January 2012 - January 2015)

- To increase providers available
- Obtain certification of Medical Home and implement Health Coach to help with resources and guidance for patients
- Continued discussion on holding patients and resources to help with placing patients quickly to an appropriate facility
- Work with community partners to create new recovery program options for community members

The 2013 strategies have served as a base for reaching out and utilizing resources and implementing resources in the Tracy community. The impact has been positive and the work will continue into the future through new or continued programming and services on the strategies.

#### Impact of the Strategy of Urgent Care After Hours

The strategy of adding Urgent Care after hours is a work in process. Provider turnover has been a key in not being able to add this program. Turnover of APPs and MDs over the last three years has been a roadblock in order to have enough providers to sustain after hours services. With the continued recruitment of medical staff, the goal is to implement this program at full staffing levels. Due to the difficulty of recruiting to a rural community, this goal has not been able to be accomplished in the last three to four years.

#### Impact of the Strategy to Address Mental Health

In the spring of 2013, Sanford Tracy was successful in adding a nurse practitioner specializing in behavioral health. In addition, Medical Home certification and the addition of a Health Coach were realized in the fall of 2013. This has helped with patients being able to use specialized services and identifying needs that can be referred to the nurse practitioner by the primary care providers. Due to the shortage of inpatient beds in the state of Minnesota, ongoing communication and working with resources within the state for ER placement of behavioral health patients has been a work in process. The two social workers who have been employed have been able to help Sanford Tracy identify programs for addiction and recovery programs around the community area for access to patients.



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