Palmer Lutheran Health Center
www.PalmerLutheran.org

Community Health Needs Assessment

Palmer Lutheran Health Center
December 2013

Introduction and Purpose

The Patient Protection and Affordable Care Act requires non-profit healthcare organizations to perform a Community Health Needs Assessment (CHNA) every three years and adopt an implementation strategy, known as a Health Improvement Plan (HIP), to meet the outstanding community health needs and to continue to qualify for federal tax exemption.

Palmer Lutheran Health Center (PLHC) began its Community Health Needs Assessment process in August 2012, with a target completion date for the plan of December 31, 2013. The Health Improvement Plan will then be implemented during PLHC's fiscal years 2014-2017 with a yearly reporting update.

The CHNA-HIP process does three things:

- Describes the health state of a local population
- Enables the identification of the major risk factors and causes of ill health, and
- Enables the creation of actions needed to address these factors

Palmer's Community Health Needs Assessment identified numerous areas of concern with three priority categories on which to focus:

- **Resources/Knowledge of Services**: confusion or no knowledge of current services within the community and other providers/organizations; organizations not working in sync to offer the best care to the community; funds between organizations are not being collaborated; no place to find all health-related organizations quickly; confusion over insurance.
- **Youth Health/Wellbeing Concerns:** obesity within the youth population is increasing; healthy eating/nutrition; safe environments; lack of basic life necessities; lack of mentors; sex education; staying fit; social media; lack of places to participate in physical activities; and lack of life skills.
- **Disaster Preparedness**: community as a whole is not prepared for disasters; lack of action plan; need for simulations; unsure where to find resources before/during/after a disaster.

Thirty (30) activities are outlined in the report focused on the three above priorities. These activities will occur over a 3-year period, 2014-2017. The PLHC Board of Trustees approved this Community Health Needs Assessment and Health Improvement Plan September 18, 2013.

Organization Overview

PLHC (PLHC) is a progressive, not-for-profit 25-bed Critical Access Hospital in northeast Iowa. Located in West Union, Iowa, seat of government for Fayette County, the hospital serves a population base in excess of 15,000. The hospital is affiliated with Gundersen Medical Systems, LaCrosse, Wisconsin and is devoted to providing excellence in medical care in a compassionate, caring atmosphere.

The mission of PLHC is to meet the health care needs of our communities, recognizing that people, knowledge and technology are our greatest assets.

As a provider of health care we support our mission through accepting and embracing the following values:

- **INTEGRITY** - we are committed to candor, honesty, and ethical behavior with each other and those that we serve.
- **RESPECT** - we maintain a health care environment based on mutual respect, which reflects an appreciation of the unique qualities of each individual.
- **RESPONSIBILITY** - we will strive to be good stewards of our resources and accountable for our job performance and behaviors.
- **DEDICATION TO SERVE** - we will devote our efforts toward the care of those we serve. We each take personal responsibility to live by these values in all of our interactions, understanding that our pledge may involve difficult choices, hard work, and courage.

According to the Iowa Hospital Association, in fiscal year 2013, Palmer Lutheran had an economic impact of nearly $14.5 million on the local economy in Fayette County, meaning the hospital and associates purchase a large amount of goods and services from local businesses.

Section 1: Past Community Health Needs Assessments

Community Health Needs Assessments have been an on-going process at PLHC. In 2011, a community focus group with 10 individuals was conducted and 40 phone surveys were completed. The same year, a questionnaire was sent to 800 households (see Appendix A) with a return rate of approximately 41% (see Appendix B for results).

Top issues identified/addressed in Fayette County (2011) were:

- Increased knowledge of services offered
- Increased support groups offered to the public
- Urgent Care Clinic availability
- Increase of Community Health Offerings
- OB and prenatal education expansion

In addition, Palmer Lutheran Health Center assisted with Fayette County Public Health Community Health Needs Assessment in 2010. Iowa Public Health agencies are required to conduct a Community Health Needs Assessment and Health Improvement Plan every 5 years. From the Public Health Assessment, the below priorities were established. As Public Health is a department of Palmer Lutheran Health Center, the hospital was greatly involved in the planning and implementation of Public Health's Improvement Plan.

- Decrease the percentage of obese adults in Fayette County from 22.8% to less than 20% and decrease the percent of children over the age of 2 that are overweight and obese children by 3% by 2015.
- Establish a website to list services available for residents of Fayette County by 2013.
- Educate the community on Public Health Emergencies and Preparedness by decreasing the number of respondents from 29% to 20% who report preparedness is available but fails to meet needs adequately by 2015.

Section 2: Community Served

Service Area

PLHC is a primary provider for Fayette County (2010 census 20,880). Another hospital, Mercy Hospital, is located in Oelwein and also serves the population of Fayette County. PLHC also draws patients from neighboring counties within a 30 mile radius of West Union, IA, including small parts of- Winneshiek, Allamakee, Clayton, Buchannan, Bremer and Chickasaw. As shown below from Iowa Hospital Association Dimension Data, the majority of patients come from Fayette County.

Palmer Lutheran Health Center
2012 Discharge/ER Statistics
IHA Dimensions Data

In-Patient Discharges:

Total patients discharged in 2012:	596		
Fayette county residents:	438	or	73.5% of all discharges
Allamakee	97		16.3 %
Winneshiek:	17		2.9 %
Bremer:	15		2.5 %
Clayton:	13		2.2 %
West Union Zip Code:	222	or	37.2 % of all Fayette county discharges

% Discharges of Fayette County residents from surrounding hospitals:

Oelwein:	220	or	85.3 % of hospital's total
Independence	37		10.2 %
Decorah:	81		6.7 %
Waukon:	19		2.1 %

ER:

Total patients seen in 2012:	3,387	
Fayette county residents:	2,604	or 76.9% of all ER patients
West Union Zip 52175:	1,226	or 36.2% of all Fayette county patients

Compared to our surrounding hospitals (above) we had 56.6% Market Share for Fayette county ER patients.

Due to the majority usage of our facility by Fayette County residents, the primary focus for the Community Health Needs Assessment was Fayette County. The area population has a high proportion of seniors, age 65+, who are of white ethnic origin (non-Hispanic or Latin) as shown in the table below. Other key demographics are also shown.

	Fayette Co.	Iowa
Persons 65 years and over, percent, 2012	19.8%	15.3%
White alone, not Hispanic or Latino, percent, 2012	95.0%	88.0%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	16.9%	24.9%
Median household income, 2007-2011	$42,108	$50,451
Persons below poverty level, percent, 2007-2011	11.7%	11.9%

Health Characteristics

According to the County Health Rankings & Roadmaps (www.countyhealthrankings.org) and shown in the summary table below, Fayette ranked #54 in Overall Health Outcomes (mortality and morbidity) of 99 Iowa counties, and #77 in Health Factors.

County Health Rankings 2013	Fayette County (rank of 99 Iowa Counties)
Health Outcomes	54
Mortality	60
Morbidity	46
Health Factors	77
Health Behaviors	87
Clinical Care	56
Social & Economic Factors	65
Physical Environment	46

County Health Rankings & Roadmaps
A Healthier Nation, County by County

Fayette (FA)

	Fayette County	Error Margin	Iowa	National Benchmark*	Rank (of 99)
Health Outcomes					54
Mortality					60
Premature death	6,371	5,094-7,648	5,971	5,317	
Morbidity					46
Poor or fair health	11%	7-16%	11%	10%	
Poor physical health days	3.0	2.1-3.9	2.8	2.6	
Poor mental health days	3.0	2.0-4.0	2.7	2.3	
Low birthweight	6.3%	5.1-7.5%	6.9%	6.0%	
Health Factors					77
Health Behaviors					87
Adult smoking	22%	17-28%	18%	13%	
Adult obesity	33%	28-39%	29%	25%	
Physical inactivity	26%	21-32%	25%	21%	
Excessive drinking	25%	19-32%	20%	7%	
Motor vehicle crash death rate	17	11-25	14	10	
Sexually transmitted infections	216		346	92	
Teen birth rate	28	23-32	32	21	
Clinical Care					56
Uninsured	12%	11-14%	11%	11%	
Primary care physicians**	2,608:1		1,395:1	1,067:1	
Dentists**	2,405:1		1,823:1	1,516:1	
Preventable hospital stays	58	50-66	60	47	
Diabetic screening	90%	80-100%	89%	90%	
Mammography screening	66%	55-76%	69%	73%	
Social & Economic Factors					65
High school graduation**	92%		88%		
Some college	62%	55-68%	68%	70%	
Unemployment	6.6%		5.9%	5.0%	
Children in poverty	19%	13-24%	17%	14%	
Inadequate social support	20%	14-27%	16%	14%	
Children in single-parent households	24%	18-29%	27%	20%	
Violent crime rate	162		280	66	
Physical Environment					46
Daily fine particulate matter	11.2	11.0-11.3	10.3	8.8	
Drinking water safety	0%		5%	0%	
Access to recreational facilities	5		11	16	
Limited access to healthy foods**	2%		6%	1%	
Fast food restaurants	30%		43%	27%	

* 90th percentile, i.e., only 10% are better.
** Data should not be compared with prior years due to changes in definition.
Note: Blank values reflect unreliable or missing data

2013

Due to its geographic location, PLHC addresses the unique health needs of a very rural population, much different than those found in an urban setting. According to the NRHA (National Rural Health Association), economic factors, shortcomings in education, cultural/social differences and isolation of living in rural areas, hinder the rural communities to lead healthy lives.

- Only about ten percent of physicians practice in rural America despite the fact that nearly one-fourth of the population lives in these areas.
- Rural residents are less likely to have employer-provided health care coverage or prescription drug coverage, and the rural poor are less likely to be covered by Medicaid benefits than their urban counterparts.
- Although only one-third of all motor vehicle accidents occur in rural areas, two-thirds of the deaths attributed to these accidents occur on rural roads.
- Rural residents are nearly twice as likely to die from unintentional injuries other than motor vehicle accidents as are urban residents. Rural residents are also at a significantly higher risk of death by gunshot than urban residents.
- Rural residents tend to be poorer. On the average, per capita income is $7,417 lower than in urban areas, and rural Americans are more likely to live below the poverty level. The disparity in incomes is even greater for minorities living in rural areas. Nearly 24% of rural children live in poverty.
- People who live in rural America rely more heavily on the federal Food Stamp Program, according to The Carsey Institute at the University of New Hampshire. The Institute's analysis found that while 22 percent of Americans lived in rural areas in 2001, a full 31 percent of the nation's food stamp beneficiaries lived there. In all, 4.6 million rural residents received food stamp benefits in 2001, the analysis found.
- There are 2,157 Health Professional Shortage Areas (HPSA’s) in rural and frontier areas of all states and US territories compared to 910 in urban areas.
- Abuse of alcohol and use of smokeless tobacco is a significant problem among rural youth. The rate of DUI arrests is significantly greater in non-urban counties. Forty percent of rural 12th graders reported using alcohol while driving compared to 25% of their urban counterparts. Rural eighth graders are twice as likely to smoke cigarettes (26.1% versus 12.7% in large metro areas.)
- Anywhere from 57 to 90 percent of first responders in rural areas are volunteers.
- There are 60 dentists per 100,000 population in urban areas versus 40 per 100,000 in rural areas
- Cerebrovascular disease was reportedly 1.45 higher in non-Metropolitan Statistical Areas (MSAs) than in MSAs.
- Hypertension was also higher in rural than urban areas (101.3 per 1,000 individuals in MSAs and 128.8 per 1,000 individuals in non-MSAs.)
- Twenty percent of nonmetropolitan counties lack mental health services versus five percent of metropolitan counties. In 1999, 87 percent of the 1,669 Mental Health Professional Shortage Areas in the United States were in non-metropolitan counties and home to over 30 million people
- The suicide rate among rural men is significantly higher than in urban areas, particularly among adult men and children. The suicide rate among rural women is escalating rapidly and is approaching that of men.

- Medicare payments to rural hospitals and physicians are dramatically less than those to their urban counterparts for equivalent services. This correlates closely with the fact that more than 470 rural hospitals have closed in the past 25 years.
- Medicare patients with acute myocardial infarction (AMI) who were treated in rural hospitals were less likely than those treated in urban hospitals to receive recommended treatments and had significantly higher adjusted 30-day post AMI death rates from all causes than those in urban hospitals.
- Rural residents have greater transportation difficulties reaching health care providers, often travelling great distances to reach a doctor or hospital.
- Death and serious injury accidents account for 60 percent of total rural accidents versus only 48 percent of urban. One reason for this increased rate of morbidity and mortality is that in rural areas, prolonged delays can occur between a crash, the call for EMS, and the arrival of an EMS provider. Many of these delays are related to increased travel distances in rural areas and personnel distribution across the response area. A national average response time from motor vehicle accident to EMS arrival in rural areas was 18 minutes, or eight minutes greater than in urban areas.

Community Health Status Indicators (www.cdc.gov/CommunityHealth) provides 2009 rural Access to Care obstacles Fayette County faces.

Uninsured individuals (age under 65)[1]		1,728
Medicare beneficiaries[2]		
	Elderly (Age 65+)	4,008
	Disabled	495
Medicaid beneficiaries[2]		3,567
Primary care physicians per 100,000 pop[2]		19.7
Dentists per 100,000 pop[2]		39.5
Community/Migrant Health Centers[3]		No
Health Professional Shortage Area[3]		No

[1] The Census Bureau. Small Area Health Insurance Estimates Program, 2006.

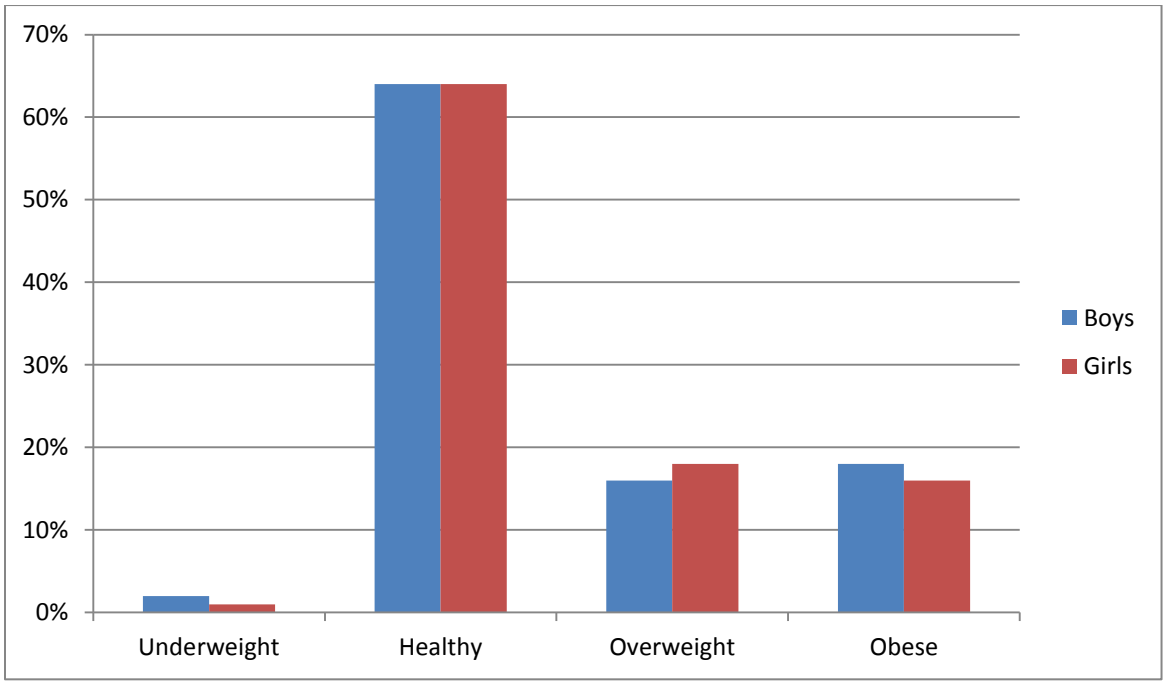
[2] HRSA. Area Resource File, 2008.

[3] HRSA. Geospatial Data Warehouse, 2009.

In addition to adult healthy behaviors, Fayette County also deals with obesity in children as a key component in healthcare. Women, Infant and Children (WIC) data indicates the percentage of overweight and obese 2 year-old and older children in Fayette County is more than the Iowa average.

> 2 y/o overweight 85-95 % (Overweight)		
	Fayette County	Iowa
2006-2008	20.3%	17.5%
2007-2009	18.7%	17.5%
2009-2011	17.7%	17.20%
> 2 y/o overweight >95 % (Obese)		
	Fayette County	Iowa
2006-2008	15.9%	15.1%
2007-2009	15.2%	15.0%
2009-2011	15.2%	14.5%

1-8th Grade BMI Results – North Fayette, West Union/Hawkeye/Fayette (School Nurse Data)



205 Boys Total-5 Underweight (2%), 131 Healthy (64%), 33 Overweight (16%), 36 Obese (18%)

221 Girls Total-3 Underweight (1%), 142 Healthy (64%), 40 Overweight (18%), 36 Obese (16%)

BMI percentages: Underweight=less then 5th pecentile; Healthy=5th percentile to less then 85th percentile; Overweight=85th percentile to less then 95th percentile; Obese=equal to or greater then 95th percentile

Section 3: Assessing the Community's Health Needs

Approach, Process and Methods

Following a review of the community served, past community health assessments and health characteristics provided from reputable organizations, PLHC coordinated with Fayette County Public Health to identify significant health needs.

In May 2013, in response to the CHNA requirement, a community-wide focus group with over 30 participants was conducted. PLHC invited public participants to the event via website and local newspapers. In addition, various organizations, health-related stakeholders and community-minded individuals were personally invited to give input to the discussion. The process included separate groups each with a facilitator and open discussion about community health care needs. Five groups were given direction to discuss what they believed to be community health needs in the area. Facilitators were given national, state and local data for informational purposes for each group; however, they were to facilitate the discussion and not offer ideas or opinions. Each facilitator was provided with a list of topic starters if needed to keep conversation and brainstorming continuing. This list contained specific data in the areas of: Youth/Young Adult Health, Adults/General Public Health, Adequacy and Affordability of Health Care Services, Public Health and Environmental Hazards, Preventing Injuries, and the community's satisfaction in certain health-related areas.

This stakeholders' session was held in West Union on May 13, 2013, with public health, school, business, government, organizational, community leaders and community-minded individuals, to prioritize each section's top five community health needs creating a database of over 30 areas to improve. From these priorities, using public outcomes as stated above, health professionals determined the most significant health needs for the local communities.

Results were reviewed with PLHC administrative staff, Fayette County Public Health, hospital marketing/community relations and a Community Health Needs committee who then developed the set of improvement recommendations, prior to submission to the Board of Trustees.

Broad Interests of the Community

Participants in the discussion meetings represented a broad spectrum of the community. A number of planning meetings and follow-up communications were held with Public Health representatives from Fayette County, hospital CEO and administrative staff and the Community Health Needs hospital committee. General public, hospital/clinic staff, other primary care providers, dentists, optometrists, chiropractors, public health professionals, mental health professionals, healthcare workers, schools, government and business leaders were invited to partake in the public meeting. In addition, uninsured, low-income and minority populations were represented as community members in these groups and were invited to participate in the meeting in addition to numerous entities that deal directly with this category of the populations were invited and/or in attendance (i.e. DHS, school officials, etc.).

Communication of the meeting was reported at the Board meeting and various other interdisciplinary meetings and covered by area newspapers. Information and event details were placed on the www.palmerlutheran.org website inviting community members to partake in the meeting.

Section 4: Community Health Needs Prioritization

During the community meeting, needs were discuss and each section determined its top five community health care need priorities, which were then combined into one larger database.

Community priorities included:

- dental needs
- mental health (children and adult)
- childhood obesity
- health transportation
- trails and recreational needs
- medical specialist
- health fairs
- mentoring programs
- elderly services
- life skills
- alcohol misuse
- nutritional education
- health education (services available, insurance, programs)
- autism
- workplace wellness
- driving/biking/walking safety
- violence in relationships
- disaster plans
- community health initiatives

Top Priorities

The three categories reflecting the top items of concern are as follows:

- **Resources/Knowledge of Services**: confusion or no knowledge of current services within the community and other providers/organizations; organizations not working in sync to offer the best care to the community; funds between organizations are not being collaborated; no place to find all health-related organizations quickly; confusion over insurance.

- **Youth Health/Wellbeing Concerns:** obesity within the youth population is increasing; healthy eating/nutrition; safe environments; lack of basic life necessities; lack of mentors; sex education; staying fit; social media; lack of places to participate in physical activities; and lack of life skills.
- **Disaster Preparedness**: community as a whole is not prepared for disasters; lack of action plan; need for simulations; unsure where to find resources before/during/after a disaster.

Even though numerous issues were addressed, these three categories were the top priorities from all five groups. Once presented to stakeholders, hospital staff and various interdisciplinary meetings, these priorities were identified as issues that affect the community as a whole.

Resources/Knowledge of Services- stakeholders, staff, the community and various organizations noticed a lack of communication and knowledge of different services and determined no one knew where to go for information on needs (such as, transportation, community action, healthcare concerns, etc.). Therefore, a resource database was chosen as a priority.

Youth Health/Wellness Concerns- based on the overwhelming data that was collected about youth health in the county and the community priorities, stakeholders chose Youth Health/Wellbeing;

Disaster Preparedness- lack of structured drills and collaboration with Emergency Medical Services and other organizations as noted by the hospital Command Center Team (no multi-disciplinary meetings, poor attendance at drills) combined with the public's concern of recent disasters led the stakeholders to choose Disaster Preparedness as a priority as well.

With the other priorities not chosen by Palmer Lutheran Health Center as a focused top concern, communication regarding these concerns and priorities was shared with appropriate entities (i.e. concerns on park and recreational offerings was shared with the West Union Park & Rec director and board; or senior healthcare concerns was shared with a local homecare agency). In addition, Palmer Lutheran offered these organizations assistance should they plan to implement any activities or events that are geared toward these community health needs.

Section 5: Implementation Strategy – Health Improvement Plan

Please refer to Palmer Lutheran Health Center's Health Improvement Plan for the Implementation Strategy of the three goals listed above- Resources/Knowledge of Services; Youth Health/Wellness Concerns; and Disaster Preparedness.

On an annual basis, through the course of the 3-year period, Palmer Lutheran Health Center plans to assess the impact by re-measuring perceptions of the problems identified in the 2013 community meeting.

Section 6: Adopting the Community Health Needs Assessment

Board of Trustees

The Palmer Lutheran Health Center Board of Trustees (7 volunteer board members) approved this plan September 18, 2013. The Board was also represented during the community health needs assessment meeting and provided input. We appreciate their guidance and input in the Community Health Needs Assessment process, as well as their dedication to both the hospital and the community.

Section 7: Community Partners

Fayette County Public Health has been Palmer Lutheran Health Center's primary partner. In addition, we have collaborated with and received support and participation in this process from ABBE Center Mental Health, Full Circle Services, Helping Services, Prairieview, Allen Knox Associates, West Union Park & Recreation, Maple Crest Manor, Northeast Iowa Community Action, City of West Union, Food & Fitness, Fayette County Wellness Coalition, North Fayette School District, Valley Community School District, Upper Explorerland, Upper Iowa University, SODA (Students Okay Without Drugs & Alcohol), Valley Community Coalition, WIC, Gundersen Medical System, Fayette County Union, Northland Area on Aging, Fayette County Supervisors, Tri-State Ambulance, Stoneybrook, area business owners, churches, other nonprofit organizations, Palmer Lutheran Health Center patients and staff, and concerned citizens. In addition, PLHC has shared ideas and priorities collected by/with neighboring hospitals.

Our partners have advised us and provided great insights to the healthcare needs of our community. They have been generous with their time and ideas. We appreciate the input from those that attended the community health needs meeting. Those in attendance represented viewpoints from West Union, Elgin, Clermont, Hawkeye, Fayette, Wadena, Postville and other surrounding areas. We express our appreciation to all participants from Fayette County.

Section 8: Dissemination of the CHNA Results

Availability of the CHNA

Palmer Lutheran Health Center will make its Community Health Needs Assessment and Health Implementation Plan available by request without charge at Palmer Lutheran Health Center by making arrangements through the Marketing Department.