Table of Contents

Executive Summary

The Patient Protection and Affordable Care Act, enacted March 23, 2010, added new requirements for nonprofit hospitals to maintain their tax-exempt status, including a requirement to conduct a Community Health Needs Assessment (CHNA) once every three years to gauge the health needs of their communities and to develop strategies and implementation plans for addressing them. This CHNA was conducted in compliance with these new federal requirements and as an opportunity for Morton County Health System to fulfill our commitment to our organizational mission to "extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities."

CHNA Methodology and Process

Service Area Definition:

To define our community for the CHNA and to analyze demographic and health indicator data, we used Morton County data.

Qualitative and Quantitative Data Collection:

We began the data collection process by selecting quantitative indicators for analysis. Community Commons, a population health indicator data platform was utilized throughout the quantitative data collection process. This platform compiles data from the US Census, the Behavioral Risk Factor Surveillance System, the CDC, the National Vital Statistics System, and the American Community Survey, among others. Specific health indicator data were selected, including community demographic information, behavior and environmental health drivers and outcomes indicators, as well as coverage, quality, and access data. These indicators were selected because they most accurately describe the community in terms of its demographics, disparities, population, and distinct health needs.

Additionally, we sought to engage our community in the qualitative data collection process. Once health needs were prioritized, we determined groups and individuals appropriate for focus groups, being sure to solicit input from underserved or minority groups within the communities we serve. These focus groups helped identify particularly important needs as seen by our communities, help us identify gaps in knowledge, and understand current external efforts around health needs that could be improved by healthcare participation.

Prioritization Process:

Morton County Health System created a CHNA subcommittee to review the qualitative and quantitative health data, prioritize health needs in our communities, and to develop implementation strategies to address the prioritized needs. This subcommittee was made up of both hospital staff and community stakeholders including representatives from local public health departments. We prioritized health needs in our community using the Centura Health prioritization method, adapted from the *Hanlon Method for Prioritizing Health Problems*. First, members of the hospital subcommittee individually rated

each identified need against the size of the problem, the seriousness of the problem, and how much the need already aligned with Centura Health and the community's existing efforts. Based on the criteria rankings assigned to each health need, we calculated priority scores using the formula: D= C[A + (2B)], where:

D = Priority Score

A = Size of health need ranking

B = Seriousness of health need ranking

C = Alignment ranking

After calculating priority scores for each identified health need, we gave the need with the highest score a rank of 1, with the next highest score receiving a rank of 2, and so forth. This helped us identify the health needs in our community.

Prioritized Need: Obesity and Diabetes Prevention

Obesity and diabetes prevention was a concern of the committee and the community. Obesity is tied to numerous health issues and overall wellness. By June 2019, we plan to increase access to fresh fruits and vegetables in the community. This will be accomplished by supporting and promoting community and home gardens. We will also encourage participation in the community farmers market. Additionally, we will work collaboratively to promote an understanding of the extension offices role in food and wellness programs. We will also increase access to healthy foods and beverages in worksite settings, specifically fresh produce in the hospital cafeteria.

By June 2019, we will be able to offer diabetes programming to the residents of Morton County. There will be a cooperative effort between the local public health department and community groups to identify a champion for diabetes education. As a community, we will seek out and obtain grants to fund diabetes education and prevention programming. We will also continue to explore telehealth options of for counseling and prevention, and continue to provide case management interventions and support through use of a diabetic educator.

Prioritized Need: Behavioral health, Substance abuse, and Suicide prevention

Behavioral health, substance abuse, and suicide prevention were identified as priority areas. By June 2019, we plan to increase access to behavioral health services, create and implement a plan for identifying and obtaining proper treatment for those with substance abuse issues, and reduce suicide and suicide attempts in Morton County.

Implementation Planning Process:

The first step to developing our implementation plans was to present evidence-based practices focused on addressing obesity and behavioral health, substance abuse, and suicide prevention to our hospital subcommittees. Next, we completed an environmental scan to determine which established efforts in Morton County Health System and our community we could leverage or build upon to meet the health needs. We then used the PEARL test to determine if a program or strategy would be effective and appropriate.

The process began by identify community leaders and organizational representatives with diverse background and areas of knowledge to assess gaps and opportunities for improvement in our health system, and as a whole community. We met as a committee on 2/18/16, 3/9/16, 4/19/16, and 5/19/16 as a group.

Implementation Plan Review and Approval:

The final implementation strategies were presented and approved by the Morton County Health System Board on 6/14/2016.

Introduction: Morton County Health System and Our Community

Morton county Health System

We are a small community in the southwest corner of Kansas that borders Oklahoma, Colorado and Texas is just 35 miles away. Our service area covers the communities within Morton County as well as Springfield, CO, Texhoma, Ok and Boise City, Ok. We have worked with the local EMS, Epic Touch (communications company), Ministerial alliance, school system, city administration, law enforcement, Compass (mental health services), local health department and hospital to assess the communities needs and gaps in wellness. Thru a local survey of the community and meetings of the committee, it was determined that mental health/addiction, heart health and obesity were all of concern to the community. The process started with strategic meetings of the committee that lead to a survey of the community to assess the concern and interests of the community.

Background on the Community Health Needs Assessment

The evolving health care landscape has provided health systems throughout the country the opportunity to work with partners in their communities to improve and promote population health. The Patient Protection and Affordable Care Act, enacted March 23, 2010, added new requirements for nonprofit hospitals to maintain their tax-exempt status. One such provision requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) once every three years to gauge the health needs of their communities and to develop strategies and implementation plans for addressing them. This CHNA was conducted in compliance with these new federal requirements.

In addition to Affordable Care Act (ACA) compliance, the implementation of the CHNA furthers Morton County Health System's mission and vision. We honor our commitment to provide outstanding care within our hospital walls and to move upstream to positively impact our patients' lives.

Our Goals for the Community Health Needs Assessment

The CHNA process gave Morton County Health System the opportunity to work closely with our community to identify existing and emerging health needs, understand community assets and gaps, and to implement strategies to improve health. This approach continues to strengthen partnerships between Morton County Health System, our local public health department, community leaders, and stakeholders. Our goal is to build our organizational capacity in population health best practices and to better position Morton County Health System to provide sustainable, whole-person care to our patients

and communities. The CHNA process provided valuable information to guide us in integrating our community health work with our hospital and strategic plans.

With this focus, we bring new dynamism to our historical legacy of addressing community needs. We are moving from the older model of simply caring for the sick to delivering and supporting the full spectrum of health, wellness and prevention resources the community depends upon in a world in which both acute and chronic health needs are prevalent and overwhelming. We specifically looked at factors that we know impact the social determinants of health. We recognize the important role that social factors such as housing, education, and employment play in affecting a wide range of health risks and outcomes. Health can be impacted by where we live, and we know that communities with unstable housing, high rates of poverty and crime, and substandard education have higher rates of morbidity and mortality. We looked at specific indicators representative of the social determinants in our prioritization process. Through the CHNA we sought to bring awareness to the importance of the social determinants of health, and work to promote and create social and physical environments that promote health equity and improve population health.

We seek to create efficiencies in our processes, our partnerships with the community, and in the delivery of care. We have continued to build upon existing relationships between Morton County Health System and the Morton County Public Health Department. Though our work together, we have taken great strides to create a model which hospitals and health care systems around the nation can look to in addressing their own community's needs. By following the model of activating primary care networks, advancing evidence-based practices, providing training for care teams and community providers, Morton County Health System is continuing to strengthen opportunities for good health and addressing the determinants of poor health in the communities we serve.

To more fully integrate a population health mindset throughout Morton County Health System, we leveraged existing data resources, internal expertise, and the strength of our network. This helped assure increased public health knowledge of key stakeholders and engaged internal systems in population health data that helps explain the drivers of emergency room and inpatient visits. The knowledge we gained from the CHNA process helped our hospital more effectively lay out our strategic plan for addressing the needs in our community. Over the course of the year, this CHNA process facilitated collaboration within our community, helping us build a stronger system in which we all benefit from powerful learning networks and relationships, rather than functioning as separate entities.

Morton County Health System: Our Services and History

Since its foundation in 1913, Morton County Health System has provided people throughout southwest Kansas and the Oklahoma Texas Panhandle and the surrounding communities compassionate, personalized, whole-person care. Morton County Health System is a forty-eight bed hospital specializing in primary care with specialty days in cardiology, urology, chiropractic and orthopedic care.

Morton County Health System was founded by Dr. William Tucker in 1913. William V. Tucker, Elkhart's first pioneer doctor came in 1913. In the 20's, Elkhart was a thriving metropolis of 3,900 citizens. Dr. Tucker's practice grew until his small house, which he used as a clinic, was filled to capacity. At this time, Dr. Tucker hired Dr. Hansen and began building the Tucker-Hansen Hospital.

During the Depression the Dust Bowl blew in, and the people of the Southwest flew out. In 1930, there were 4,900 residents living in Morton County. By 1933, only 1,800 people remained. Dr. Tucker became concerned. Patients became fewer and collections fewer still. Because of the severity of the economy, the hospital was purchased by Morton County.

After almost 40 years of service to Elkhart and the surrounding community, the old hospital building on Kansas Avenue became obsolete. Plans were made for new facilities. On Sunday, September 15, 1957, a dedication program and open house were set for the new hospital which had been constructed at 445 Hilltop.

Remodeling programs have taken place at the hospital from 1975 to 2000. Beds have been added to the original fifteen-bed hospital along with some of the most technologically advanced equipment imaginable for a hospital of its size. Currently we have 24 med surgery beds and 4 Intensive Care Unit beds.

Distinctive Services

Morton County Health System offers a broad array of specialties and services. Our distinctive services include:

- Full service laboratory
- Cardiac Rehabilitation and Physical Therapy
- Pulmonary Function Lab/Stress testing
- CT scan, Ultrasound and X-ray capabilities
- Outpatient Surgery

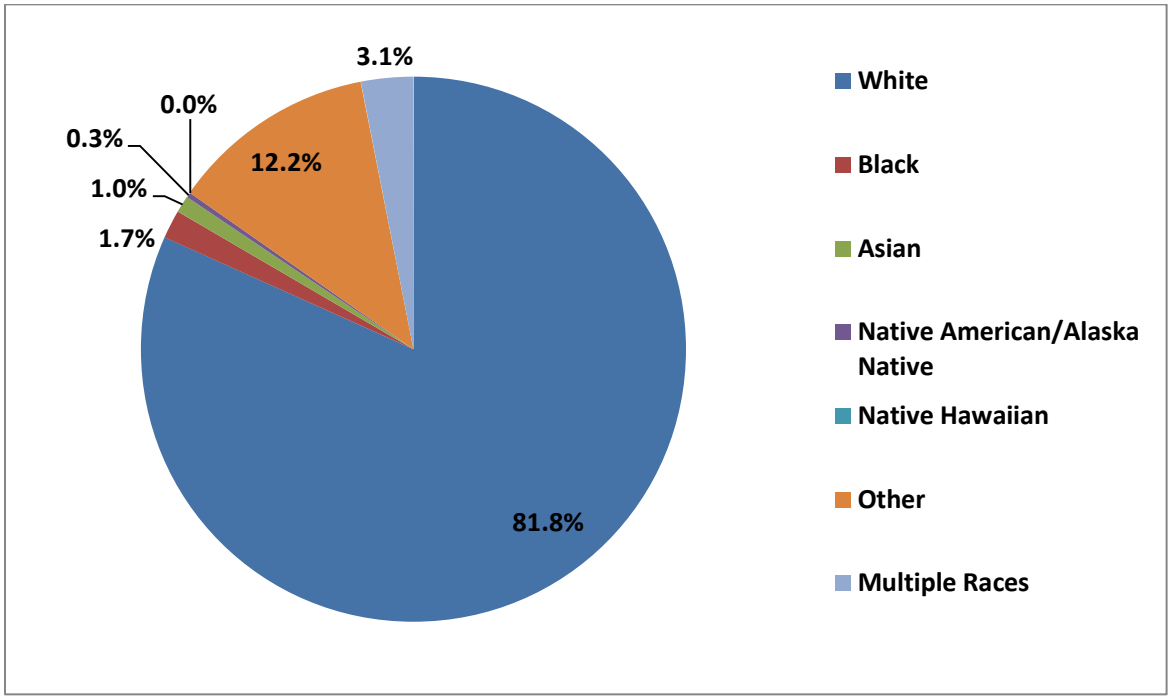
Our expertise in these areas has earned us a number of awards and honors throughout the years. Morton County Health System is proud to have received the following awards:

- 50 years participation in the AHA 2010
- KHEN Partnership Recognition 2011-2016

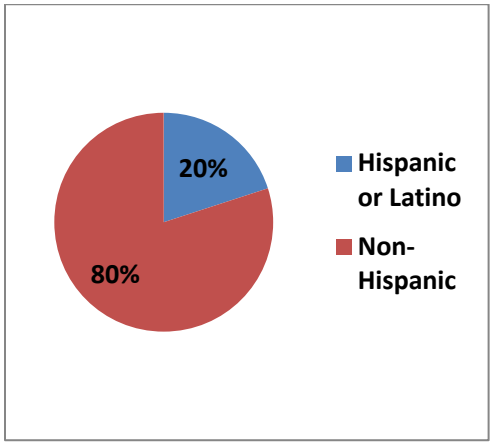
Our Community

To define our community for the CHNA and to analyze demographic and health indicator data, we used Morton County data. Morton County has a population of 3,159. The demographic makeup of our community is as follows:

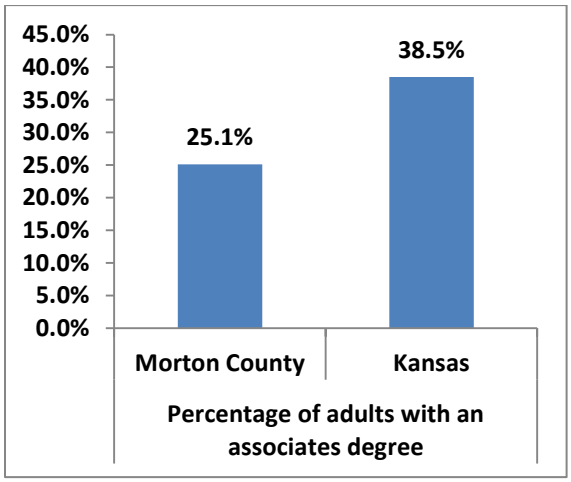
Race and Ethnicity: 81.8% White, 1.7% Black, 1.0% Asian, 0.3% Native American/Alaska Native, 0% Native Hawaiian, 12.2% Other, 3.1% Multiple Races

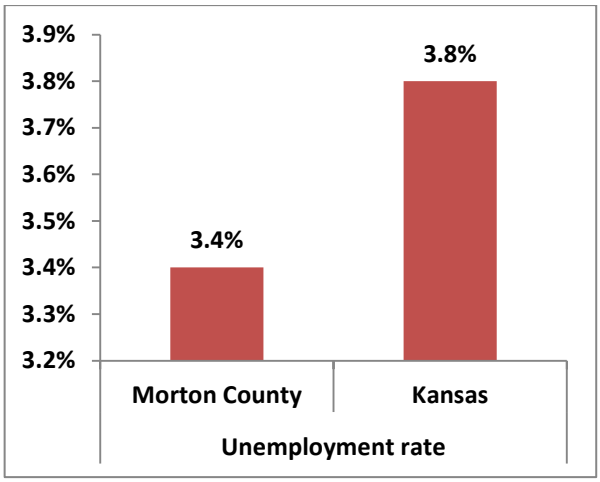


Ethnicity: Hispanic or Latino 20.0%, Non-Hispanic 80%



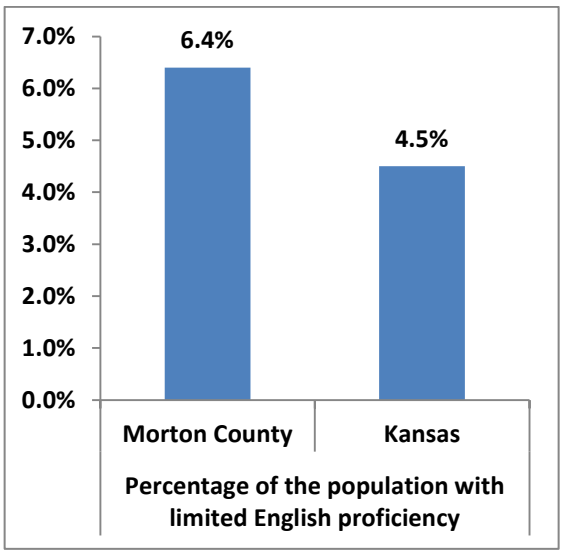
Education Level: 25.1% have an Associate's degree or higher, compared to 38.5% in Kansas.

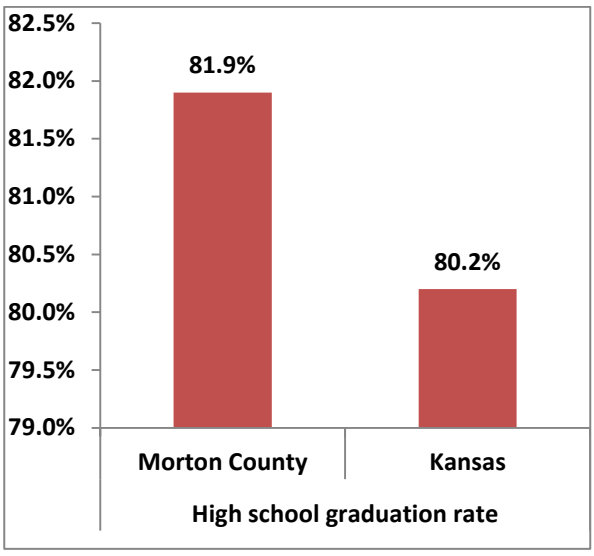




Unemployment Rate: 3.4% in our community, compared to 3.8% in Kansas

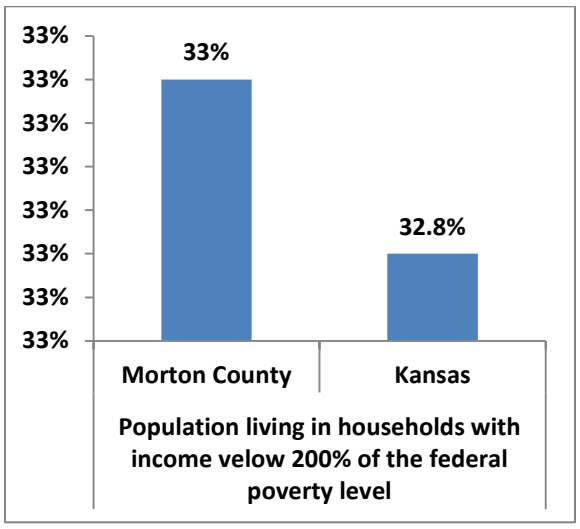
Population with Limited English Proficiency: 6.4% in our community, compared to 4.5% in Kansas





High School Graduation Rate: 81.9% High School Graduation Rate, compared to 80.2% in Kansas

Population Living in Households with Income Below 200% of Federal Poverty level: 33% in our community, compared to 32.8% in Kansas



Our Approach to the Community Health Needs Assessment

In order to assess the needs of our community, we created a hospital subcommittee to solicit and take into account input from individuals representing the broad interest of our community. Our hospital subcommittee was made up of stakeholders from across the community. Our subcommittee:

- Reviewed the quantitative data and provided insight;
- Prioritized health needs using the Morton County Health System Prioritization Method;
- Identified implementation strategies to maximize impact on a specific health need; and
- Coordinated and collaborated implementation strategies across prioritized needs.

Each subcommittee member was provided with a written description of his/her role. We met as a committee on 2/18/16, 3/9/16, 4/19/16 and 5/19/16 as a group. Each meeting was two hours in length. Our first meeting was to utilize quantitative data to determine what issues each of the members saw as a need for the community. The second refined the areas of concern and started looking at resolutions and opportunities. The third meeting was to narrow down realistic options with the geographic location and resources available. The fourth meeting was to finalize actions and talk about the future and how to measure progress and continue the work of the committee for the next three years.

Morton County Health System's Partnerships with Public Health

Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases. Furthermore, our health and well-being are products of not only the health care we receive and the choices we make, but also the places where we live, learn, work, and play. Therefore, the public health department also plays a big role in Morton County community health. We are pleased to say we have a great working relationship with our local health department, and one of our physicians is contracted as their health officer. Therefore, we work closely on a regular basis.

The Morton County Public Health Department administrator was a key member of our subcommittee working closely to help us compile a wide variety of published data to show the current situation and trends affecting public health. Further, various data was compiled which reflected conditions related to demographic, economic, social behavioral, and public health trends. This data further represented objective health indicators that were also identified through the community health survey to be of community concern.

With the Public Health departments' assistance, we can focus on community health improvement by identifying and addressing the health needs of Morton County. After all, working together has a greater impact on health and economic vitality than working alone. Community Health Improvement (CHI) goals bring together health care, public health, and other stakeholders to consider high-priority actions to improve community health.

Stage 1: Scanning the Data Landscape

The CHNA was conducted through a collaborative partnership between Morton County Health System, Morton County Public Health Department, and community stakeholders. Quantitative and qualitative data were collected to gain a full understanding of our community and specific health needs. We began the data collection process by selecting quantitative indicators for analysis. Community Commons, a website and data platform that houses population health indicator data, was utilized throughout the process.

In this process, certain health indicator data were selected, including community and population demographic information, behavior and environmental health drivers and health outcomes indicators, as well as coverage, quality, and access data. These indicators were selected because they most accurately describe the community in terms of its demographics, disparities, population, and distinct health needs. These areas address the social determinants of health, quality of life, and healthy behaviors, all things that we know impact community health. The health needs in the table below (Table 1) were analyzed during the prioritization process. See Appendix B for the full dataset.

Indicator	Community Value	Kansas Value	Healthy People 2020 Value
Percentage of adults 18 and older who self-report that they have ever been told by a health professional that they had asthma	Not Available	12.4%	N/A
Death rate due to cancer per 100,000 population	166.2	168.8	160.6
Percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes	8.8%	9.0%	N/A
Death rate due to coronary heart disease per 100,000 population	154.4	160	N/A
Rate per 100,000 population			5.5
Chlamydia rate per 100,000 population	218.9	387.8	N/A
HIV Rate per 100,000 population	Not Available	115.7	N/A
Death rate due to chronic lower respiratory disease per 100,000 population	0	50.8	N/A
Infant mortality rate per 1,000 births	4.1	7.1	6
Teen birth rate per 1,000 female teens	61.4	39.9	N/A
Percentage of low birth weight births	9.3%	7.2%	7.80%
Depression in Medicare Population	17.0%	16.2%	N/A
Mental Health Care Providers per 100,000	61.5	119.6	N/A
Percentage of adults 18 and older who self-report a Body Mass Index (BMI) greater than 30.0	33.0%	30.1%	N/A
Percentage of adults who did not receive a dental exam in the past year	0.0%	28.3%	N/A
Percentage of adults with poor dental health	0.0%	14.4%	N/A
Adults reporting heavy alcohol consumption	Not Available	15.9%	N/A
Rate per 100,000 population	4 in 2014	14.7	10.2
Death rate due to unintentional injury (accident) per 100,000 population	5 in 2014	43.7	36

Table 1. Health Indicators

Stage 2: Delving into the Data to Identify Priorities

Our Morton County Health System CHNA subcommittee was provided a health indicator data presentation compiled by the CHNA Steering Committee. The subcommittee identified and prioritized community health needs using the Morton County Health System prioritization method as detailed below. They identified the most pressing needs based on health indicators, health drivers, and health outcomes.

Our subcommittee defined a health need as a poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome has not yet arisen as a need. To fit the definition of a health need, the need must be confirmed by more than one indicator and/or data source, and must be analyzed according to its performance against the state benchmark of Healthy People 2020.

Process to Identify Priority and Non-Priority Health Needs:

The Centura Health prioritization method was adapted from the Hanlon Method for Prioritizing Health Problems. First, members of the hospital subcommittee individually rated each identified need against the size of the problem, the seriousness of the problem, and how much the need already aligned with Morton County Health System and the community's existing efforts. The criteria rating rubric for this step is shown below, along with the scores assigned to each need:

Centura Health CHNA Prioritization Method: Sample Criteria Rating

Rating	Size of Health Problem	Seriousness of Health Problem	Alignment
9 or 10	>25% /rate much higher than Colorado benchmark	Very Serious	Alignment with CHNA, CHIP, community groups, hospital and system strengths
7 or 8	10%-24.9%/rate somewhat higher than Colorado benchmark	Relatively Serious	Alignment with 3 of the following: CHNA, CHIP, Community Groups, hospital and system strengths
5 or 6	1%-9.9%/rate slightly higher than Colorado benchmark	Serious	Alignment with 2 of the following: CHNA, CHIP, Community Groups, hospital and system strengths
3 or 4	.1%-.9%/rate same as Colorado benchmark	Moderately Serious	Alignment with 1 of the following: CHNA, CHIP, Community Groups, hospital and system strengths
1 or 2	.01%-.09%/rate slightly lower than Colorado benchmark	Relatively Not Serious	Some alignment with 1 or two of the following: CHNA, CHIP, Community Groups, hospital and system strengths
0	<.01% /rate lower than Colorado benchmark	Not Serious	No Alignment and/or no community gap in need being addressed

Based on the criteria rankings assigned to each health need above, we calculated priority scores using the formula: D= C[A + (2B)], where:

D = Priority Score

A = Size of health need ranking

B = Seriousness of health need ranking

C = Alignment ranking

After calculating priority scores for each identified health need, we gave the need with the highest score a rank of 1, with the next highest score receiving a rank of 2, and so forth. This helped us identify the health needs in our community.

Once our community's health needs were rated by the criteria above, we used the 'PEARL' test to determine the feasibility of addressing those needs. The questions we considered in the PEARL test included:

- **P**ropriety - Is a program for the health problem suitable?
- **E**conomics - Does it make economic sense to address the problem? Are there economic consequences if the problem is not carried out?
- **A**cceptability - Will a community accept the program? Is it wanted?
- **R**esources - Is funding available or potentially available for a program?
- **L**egality - Do current laws allow program activities to be implemented?

Morton County Health System identified two needs as priority areas that we have the ability to effectively impact. These include:

- Obesity and Diabetes Prevention
- Behavioral health, Substance abuse, and Suicide prevention

Stage 3: Working with our Community to Understand and Act

We sought to engage our community in the qualitative data collection process. Once health needs were prioritized, the hospital subcommittee worked with the Morton County Public Health Department to create and distribute the "Morton County Community Health Survey." See Appendix C.

The survey was started by the Morton County Public Health Department and revised to meet the needs of the group. It was attached as an insert in the local paper as well as available at the school, Elkhart Medical Clinic, Morton County Health Department, Tri State News, and Epic Touch. It was available to all of the residents of Morton County which included the communities of Elkhart, Rolla, Richfield and Dermont.

Stage 4: Developing the Implementation Plan

Once our community's health needs were identified and prioritized, we began the process to develop an implementation plan to address obesity and diabetes prevention and behavioral health, substance abuse, and suicide prevention. The first step in developing our implementation plans was to present evidence-based practices focused on addressing obesity and diabetes prevention and behavioral health, substance abuse, and suicide prevention to our hospital subcommittees. Next, we completed an environmental scan to determine which established efforts (in Morton County Health System and our community) we could leverage or build upon to meet the health needs. We then used the PEARL test (mentioned previously) to determine if a program or strategy would be effective and appropriate.

Morton County Health System's (MCHS) Community Health Needs Assessment (CHNA) was a comprehensive process used to assess the various health needs of the populations served by MCHS and to define priorities for our report. The local hospital subcommittee played a crucial role in bringing together all community partners to collaborate on the process. In order to successfully conduct the CHNA, we relied on effective communication within the organization and with collaborating parties. The subcommittee brought valuable knowledge of the communities specific to their expertise, understanding of other community based organizations, and the ability to leverage partnerships for increased impact, alignment, and addressing gaps in services for each identified need.

Health in Morton County Health System's Community

Identified Health Needs

In conducting our Community Health Needs Assessment, we identified the health needs of our community and then narrowed our focus to enable us to have the most impact. A community health need is defined as either:

- A poor health outcome and its associated health drivers
- A health driver associated with a poor health outcome, where the outcome itself has not yet arisen as a need

We used a specific set of criteria to identify the health needs in our communities. Specifically, we sought to ensure that the identified needs fit the above definition, and that the need was confirmed by more than one indicator and/or data source. We looked at demographics to describe our community, health drivers to look at our health behaviors and environmental factors, health outcomes to look at the main causes of illness and death in our community, and access data to analyze the availability of coverage and quality. Finally, we determined that the indicators related to the health need performed poorly against either the Kansas state average or the Healthy People 2020 benchmark. We utilized the Centura Health Prioritization Method to determine our prioritized needs.

The health needs identified in this CHNA included:

- Obesity and Diabetes Prevention
- Behavioral health, Substance abuse, and Suicide prevention

Prioritized Health Needs

Word Limit: 550

Morton County Health System prioritized obesity and diabetes prevention and behavioral health, substance abuse, and suicide prevention.

Obesity and Diabetes Prevention

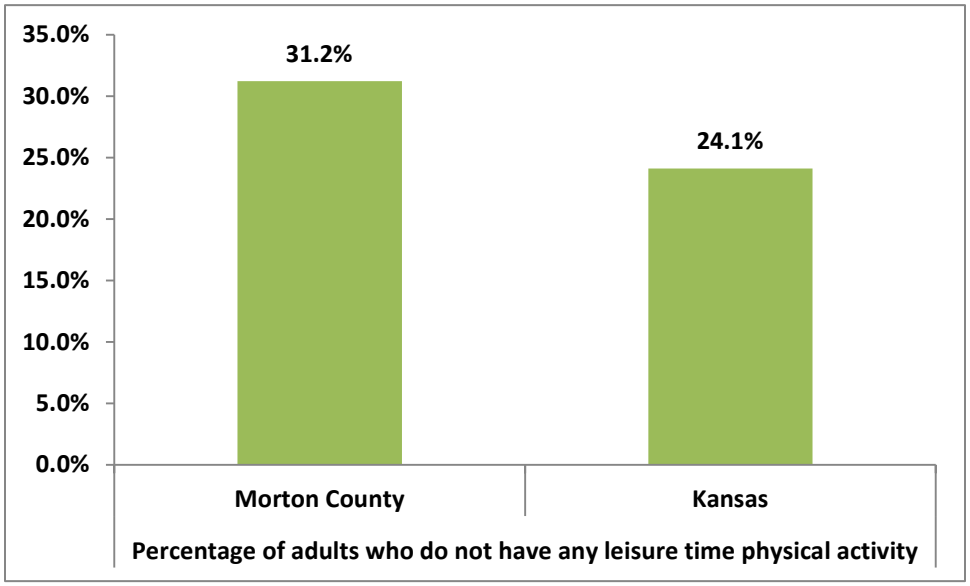
In Morton County, 33% of adults are obese, compared to 30.1% in the state of Kansas. We felt it was important to address this health issue within our community because we know it can lead to other chronic disease such as heart disease and diabetes. In Southwest Kansas, 8.8% of adults have diabetes, compared to 9.0% in the state of Kansas. Although we are not currently higher than the state average, we know that diabetes is a significant problem in our community. Additionally, many adults in our

community are at risk of becoming obese. Roughly 31.2% of adults do not have any leisure time physical activity, compared to 24.1% of adults in Kansas.

There are a few resources available to address obesity and diabetes prevention in the community. We have a cardiac rehab inpatient and outpatient facility. Additionally, there is a farmers market in our community and we participate in the Walk Across Kansas Program. This fall we are opening a community based food bank, which will serve many of our low income community members.

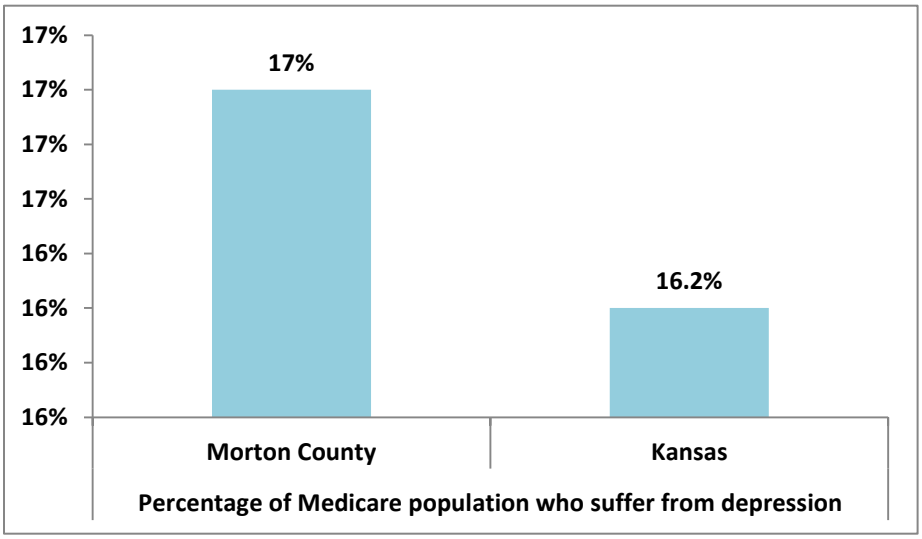
We currently have a diabetes educator in the hospital, but we do not have a diabetes prevention program available.

Behavioral Health, Substance Abuse, and Suicide Prevention



Behavioral health, substance abuse, and suicide prevention are a high priority in our community. In Southwest Kansas 17.6% of adults have fair or poor perceived health status, compared to 12.7% in the state. Roughly 17% of our Medicare population suffers from depression, compared to 16.2% in Kansas. There are only 61.5 mental health care providers per 100,000 individuals in our community, as compared to 119.6 per 100,000 in the state. Many responses to our community survey noted behavioral health as a high need in the community. There are few providers and a high need for services.

The hospital subcommittee felt that suicide was a high priority for the group to focus on. Qualitative data supported a strong need to develop programming aimed at reducing suicide and suicide attempts in our community.



We will continue to partner with Compass to provide care to our behavioral health patients, and work with the school and other community partners to identify individuals who need care.

Implementation Plan

After identifying and prioritizing the health needs in our community, Morton County Health System developed an implementation plan to address the health needs identified in the data collection and prioritization process. We developed an implementation plan to identify goals and activities to address each prioritized health need and leveraged both internal and external resources and partnerships to do so. These implementation plans included SMART goals, a detailed list of activities to meet those goals, including the internal and external resources needed to carry out those activities. For each activity, we specified the metrics we would use to measure our progress and outcomes. These plans are made publicly available at www.mchswecare.com.

Obesity and Diabetes Prevention

As outlined in the above section, Morton County Health System identified obesity and diabetes prevention as an urgent issue in our community. As such, we have prioritized obesity and diabetes prevention and have developed an implementation plan to increase the availability of fresh fruits and vegetables and increase the activity level of the community with the assistance of the health department, Hands for Hope and Morton County Health System.

Goal 1:

By June 2019, increase access to fresh fruits and vegetables in the community.

We can achieve this goal through the following:

- Support and promote community and home gardens. Start or participate in farmers markets.
- Understand the role of the extension office for food and wellness programs and determine if the program needs community support.
- Increase access to healthy foods and beverages in worksite settings, specifically fresh produce in the hospital cafeteria.

To determine our efficacy in the above efforts, we will measure and track:

- The number of plots assigned in the community garden. The number of produce items brought to hospital cafeteria and other worksites from hospital gardens and other worksite gardens and programs

Goal 2:

By June 2019, offer diabetes programming to the residents of Morton County.

We can achieve this goal through the following:

- Partner with local public health and community groups to identify a champion for diabetes education.
- Seek out and obtain grants to fund diabetes education and diabetes prevention and education programming.
- Explore telehealth options for diabetic education and training.

To determine our efficacy in the above efforts, we will measure and track:

- Diabetic educator appointments, amount of grant funding, number of classes held and number of patients that participate.

Goal 3:

Improve opportunities for physical activity and referral and retention in the cardiac rehab program.

We can achieve this goal through the following:

- Continue to participate in the Walk Across Kansas program
- Promote the use of walking path and available gyms in the community.
- Work with providers to ensure referral and retention in the cardiac rehab program.
- Implement worksite programs intended to promote physical activity.

To determine our efficacy in the above efforts, we will measure and track:

- Number of participants in the Walk Across Kansas and number of patients that complete and maintain use of cardiac rehab.

Behavioral Health, Substance Abuse, Suicide Prevention

As outlined in the above section, Morton County Health System identified behavioral health, substance abuse, and suicide prevention as an urgent issue in our community. As such, we have prioritized these needs and have developed an implementation plan.

Goal 1:

By June 2019, increase the number of patients that have access to behavioral health services.

We can achieve this goal through the following:

- Ensure patients are being screened for depression in primary care clinics, and ensure staff is following up to refer to Compass or local provider.
- Continue to partner with the local school to provide behavioral health services.
- Partner with Centura Health/St Catherine Hospital to utilize telemedicine capabilities for behavioral health patients.
- Collaborate with churches, schools, LPH, HHS, to have group therapy or support groups.

To determine our efficacy in the above efforts, we will measure and track

- Number of patients screened for depression. Number of referrals to Compass or local provider. Number of appointments at the school. Number of telehealth consults.

Goal 2:

By June 2019, create and implement a plan for identifying and obtaining proper treatment for those with substance abuse issues.

- At the hospital, identify and screen patients for excessive drinking using SBIRT.
- Provide warm handoff to Compass or other behavioral health provider.
- Refer appropriate candidates to AA and NA meetings.
- Create workgroup to do further community research on viable programs and funding opportunities for substance abuse interventions.

To determine our efficacy in the above efforts, we will measure and track:

- Number of patients screened using SBIRT, number of referrals, number of referrals to AA, formation and plan from workgroup.

Goal 3:

By June 2019, reduce suicide and suicide attempts in Morton County.

- Build protective factors in youth by encouraging positive peer connections through youth mentoring program at high school.
- Promote positive early childhood development including better parenting and violence free homes and facilitate social connectedness, enhancing social, self-esteem and life skills thru ASIST(Applies suicide intervention skills training) or MHFA (Mental health first aid) through grant funding or Centura Health provided support.

To determine our efficacy in the above efforts, we will measure and track:

- Number of participants in youth mentoring program. Number of participants in parenting classes. Number of participants in MHFA or ASIST training program.

Our implementation plans were presented to our hospital Board of Directors and approved on June 14, 2016.

Conclusion

Evaluation

Evaluating our Impact for this CHNA

To understand the impact we are having in our communities, we remain dedicated to consistently evaluating and measuring the effectiveness of our implementation plans and strategies. We will complete bi-annual assessments of core metric progress measures.

Community Feedback

We welcome feedback to our assessment and implementation plan. Any feedback provided on our plan is documented and shared in future reports. For comments or questions, please contact:

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Thank You and Recognition

Our Community Health Needs Assessment is as strong as the partnerships that created it. It is through these partnerships that we were able to ensure we were leveraging the assets in our communities, getting the voices of those who are experiencing challenges with their health and social determinants of health and making a plan to which both the community and hospital are committed. Thank you to the following people who committed their time, talent and testimony to this process.

- Tim Hardy, City of Elkhart Administrator
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- Angela Hattabaugh, Risk Manager/QA Morton County Health System
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- Carla Blackmore, Morton County Hospital Board
- Brian Bache, Centura Health
- Catherine Bader, Centura Health
- Sharmilla Hall, Morton County Health System/Clinic
- Terrell Giddens, Ministerial Alliance

Appendix: A Data Sources

American Community Survey, 2010-14

Bureau of Labor Statistics, 2015

Centers for Medicare and Medicaid Services, 2012

County Health Rankings, 2008-2010

County Business Patterns, 2013

Dartmouth Atlas of Health Care, 2012

Behavioral Risk Factor Surveillance System, 2006-2012

Behavioral Risk Factor Surveillance System, 2005-09

Behavioral Risk Factor Surveillance System, 2006-2010

Behavioral Risk Factor Surveillance System, 2006-2012

Behavioral Risk Factor Surveillance System, 2011-2012

Health Resources and Human Services Administration, Health Professional Shortage Areas, 2015

Federal Bureau of Investigation Uniform Crime Reports, 2010-12

Kansas Department of Public Health and Environment, 2013

Kansas Summary of Vital Statistics, 2014

National Center for Chronic Disease Prevention and Health, 2012

National Center for Education Statistics, 2013-2014

National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, 2012

National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, 2010

National Environmental Public Health Tracking Network, 2008

National Vital Statistics System, 2006-2012

National Vital Statistics System, 2007-2011

National Vital Statistics System, 2009-2012

Small Area Health Insurance Estimates, 2012

State Cancer Profiles, 2007-2011

US Census Bureau, Small Area Health Insurance Estimates, 2013

US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2013

USDA Food Access Research Atlas 2010