Northwood Deaconess Health Center
Final CHNA Strategic Implementation Report

Facilitated and Written by the Center for Rural Health

Brad Gibbens, Deputy Director and Assistant Professor

Kylie Nissen, Senior Program Coordinator

Julie Reiten, Program Assistant

May 13, 2017

Funded by:

US Department of Health and Human Services, Health Resources and Services Administration

Rural Hospital Flexibility Program, Grant Number: H54RH00036

Northwood Deaconess Health Center 2017 CHNA Strategic Implementation Plan

This document serves as the Implementation Plan derived from the 2016 Community Health Needs Assessment (CHNA) process for Northwood Deaconess Health Center. It meets ACA requirements.

The report reflects the discussion (including goals and objectives) generated during the Strategic Implementation Planning meeting held March 27, 2017 in Northwood. Approximately 27 people attended. The local health/medical providers, hospital department directors/key staff, and hospital board members comprised the participants. In addition, the hospital CEO and the Clinic manager participated.

From the Center for Rural Health were Brad Gibbens, Deputy Director; Kylie Nissen, Senior Program Coordinator; and Julie Reiten, Program Assistant. Additionally, a CRH student, Jordan Jaeger, working on his masters in Sociology accompanied the staff as a learning experience. Mr. Gibbens facilitated the meeting.

Introduction

The Center for Rural Health had facilitated strategic planning for the Northwood Clinic in January 2016. That session focused primarily on physician recruitment and retention. Since "ability to recruit and retain primary care providers (MD, NP, PA)" emerged as the number one ranked need during the 2016 Northwood CHNA process, the implementation planning session began with a brief update from Mr. Antonson, CEO, Northwood Deaconess Health Center on the health workforce subject.

- Vetting of some candidates.
- Recruitment is ongoing – it is a continuous need, likely always a goal.
- NDHC is in discussions with some providers.
- Process is internal to the hospital and clinic – no community involvement at this time.

The facilitator reiterated that an approach used by a few hospitals has been to have a Community Recruitment and Retention Committee led by the hospital and/or clinic but also includes community members. This opens the process up to be inclusive of various key stakeholders, offers transparency to the community, and provides a sense of community ownership by being actively involved. By having community members engaged there is also a natural communication process as "people talk" within the community and are more aware. Thus, it also shows to skeptics that something "is being done" and it is open to the public. Criticism is sometimes levied at hospitals for being too insulated and "stand offish" so this model is also a form of marketing for the hospital. Additionally, the hospital/clinic gains by having key sectors involved, in the beginning, that would likely be tapped into during a site visit – school, business, realtor, churches, park board, and others.

The CRH provided the group with a recap of the CHNA process and the key findings. The *top ranked concerns from the Northwood CHNA* were as follows:

- Ability to recruit and retain primary care providers (MD, NP, PA)
- Youth drug use and abuse
- Attracting and retaining young families

- Obesity/overweight

Originally, CRH staff anticipated facilitating a planning discussion around the top four needs with corresponding goals and action steps. The CRH facilitator discussed the top statewide needs identified from analyzing the 41 CHNAs. The Northwood community needs aligned well with statewide needs. The "youth drug use and abuse" need is a form of behavioral health, which as a category, was identified in 23 of the 41 CHNAs as a top need. Statewide, the three most prevalent needs were 1) behavioral health (23 CHNAs), 2) mental health (20 CHNAs), and 3) health workforce (17 CHNAs). While behavioral and mental health are related ideas, CRH tends to code them as distinct subjects. The facilitator asked the participants if it was an accepted approach to focus the planning session on their top four CHNA needs. Some participants pointed out that there were other issues important to the hospital/clinic, in addition to the community identified needs. A number of additional fundamental needs were identified and incorporated into the planning process. The discussion was primarily unstructured with the facilitator sometimes asking for more explanation or detail. This facilitated discussion lasted for about 1.5-2 hours. Below is an outline of the issues discussed with some key discussion points. This was an important step as the discussion eventually led to work groups to address the planning steps of determining goals, objectives, and action steps.

General Discussion and Generation of Issues

Below is a bulleted recap of the general discussion. This process produced a number of issues that were important to the hospital. These are hospital issues, but overall they are still community issues. Each area has an impact on the broader community and was framed in a manner where it was clear the benefit of any action was for the improvement of Northwood and the surrounding area. The CHNA produced a number of issues and themes. The implementation planning phase builds on that process. The discussion was passionate at times as the participants felt strongly that there were significant issues, and opportunities for overall health improvement. Here is a summary:

- Mental health
    - In primary care people are not trained a great deal on mental health and psychology and providers commonly feel underqualified to deal with these subjects.
    - No detox services available in the area.
    - To address drug and alcohol use and abuse there needs to be some form of mental health available.
- Cost of healthcare and insurance
    - Increases to the consumer in premiums, co-payments, and deductibles are problems.
    - If people can't afford the copay or to fill a prescription they may not want to come in because they do not have the money.
    - The financial counselor has been very busy.
    - NDHC has a person who helps people enroll in insurance programs.
    - More education to the community about when they need to come in and how hospital staff can help find financial solutions.
- Recruitment of potential medical providers
    - What needs to happen to make the practice and the community attractive?

- Some MDs and other providers do not want to come unless NDHC has Epic as an EMR (one physician and one mid-level candidates have indicated this). The younger medical professionals receive training via Epic in school and expect it in a practice site. They need to feel they can communicate with other facilities and providers be it specialists in Grand Forks or Fargo, or providers in another state (issue of "snow birds" in AZ and their AZ providers cannot communicate with ND providers because of lack of compatibility). While it costs a lot of money to switch systems, it is costing money, time, and lack of recruitment interest to stay committed to the current system, and this would facilitate recruitment and retention. There is a loss of efficiency for the providers, and patients can be frustrated as patients hear how this works in other towns and realize they do not have the same access here. What to do to adopt Epic?
- Need to identify what we do well and focus on and expand on those things – opportunities and challenges – recruitment and retention process is long and complicated and need an inventory of positive features of the practice but also honestly address problems.
- Childcare is a problem for the community including the health facility and would likely be a community problem for provider recruitment. Hospitals in Cando and Rugby own their own daycares.
- New providers fresh out of school do not want to be on call. They want to work 8-5. McVille has one person who just takes calls. Newer providers are "scared" to be the only person available to take a call. Currently, in Northwood, providers take call, work in the clinic, go to the nursing home, and more. To counter this work style there are things in the Northwood system that afford greater flexibility that may not be found in larger facilities such as in scheduling, prescribing, and other areas.
- Lack of access to food and coffee on site – this is desired by current staff – there is no on-site source for food – if NDHC wants to be an employer of choice a little thing like not having access to food is an issue and concern – want to provide a new, exciting, and fresh environment for the staff.

- Building/physical plant issues and offering additional elder care needs
  - What is to be done with the building or should be done with the building? NDHC needs to evaluate building services and physical layout. What do we offer within the four walls and outside the four walls that is attractive (don't need to think strictly on campus)? How do we offer services that will be utilized?
  - Skilled care/LTC/off-site housing. NDHC facility is not set up for the skilled care required in the future, what can we do to stay viable? How do we offer services that people will need in the future, how to prepare for changes in lifestyle and expectations?
    - Skilled dementia care. Should a basic memory care unit be added? – What will skilled care look like in the next ten years? The current building isn't configured for treatment and care needs of the future.

- Non-institutionalized elder needs
  - Six elderly couples who are trying to make decisions on living arrangements. We hear that their adult children want them to move away from Northwood and move closer to them but the parents want to stay here because this is home. They like Northwood and the services from NDHC; however, the big question is where can they live? There are no town homes, and people need settings that are easy to care for and maintain as options if they move into town. They do not need additional medical or nursing home care yet, but see the need to be in town and closer, but there really are no viable housing options available.
  - Need to build duplexes, townhouses for the elders to move into town.
  - A number of services, currently not available, need to be examined to help the elders.
    - ✓ No services to stay independent and in their homes like personal care aides (bath, getting groceries, transportation, medication assistance and set up) – need for CNAs – pool of CNAs now when the census is low, could explore this as a business opportunity and provide in-home CNA services – can help with employment.
    - ✓ Offer respite care for family members.
    - ✓ Offer adult day care.

- Other service ideas
  - Fitness – hospital owns the fitness center; however, many in the community are unaware – more marketing to community, see it as a community benefit – use it more to improve health (offer spin class, dance classes, health education like nutrition, and more).
  - Youth activities – help kids have healthy/safer choices.
  - Daycare – for hospital/clinic/nursing home staff but all of the community – lack of this limits employment options, limits appeal of the facility and the community – important to recruiting families.
  - Study some level of dialysis service – feasibility (need and ICU, MD, and a specialist) – came up in the CHNA

Small Group Breakout Reports

Following the evening dinner, CRH staff briefly discussed grant opportunities to consider as part of an implementation plan. CRH can provide connections to resources such as conducting grant searches through our national informational portal, the Rural Health Information Hub (RHIhub); review federal initiatives such as the Rural Health Outreach grant, Rural Health Network Development grant, and Rural Network Planning grant; information searches, provide letters of support; proposal critiques; and other technical assistance.

It was determined there were some natural themes from the pre-dinner discussion. Some of the discussion points were re-categorized and the group agreed that their small discussion groups would be as follows:

- Provider Recruitment and Retention
- Continuum of Care
- Community Needs Impact – Tri-generational
- Service Development
- Mental Health

Each of the small discussion groups had 5-7 people. They broke into work groups and used a matrix provided by the CRH to capture their thoughts and plans. The matrix had the following categories: goal, action step, objectives, outputs, outcomes, resources, and timeframe, and champion (key person to represent the group).

What follows are the discussion group reports. The first part is a summary of oral reports to the full group. The second is the detailed matrix that was completed.

- **Provider retention and recruitment** (MD) – Main focus was Epic
    - Implement Epic.
        - Determine the cost of the conversion.
        - Get the board involved – gain their approval and support.
    - If MD comes from Sanford, can they stay with Sanford if they want or do they need to become an NDHC employee?
    - Get the community involved in recruitment and retention.
        - Rolling the red carpet out for a provider – create welcome packet with community information from the school, daycare, list of churches, events, etc.
        - Make it a big deal – friendly, really want them here, good place to live.
        - Make it a community effort – have a meeting with key community members – school superintendent, daycare owner, etc.
        - Help candidate and family determine where they will live.
        - Show them what the school is like and its location relative to the hospital.
        - Show them what this community offers – attractive qualities.
    - Having meals available for providers and staff onsite (vending machines, lunches).
    - Update doctors lounge – more welcoming and usable.
    - Consider offering down payment for housing for new MD.
    - National Health Services Corp - HRSA loan repayment is available for recent graduates willing to practice in a federally designated Health Professional Shortage Area (HPSA). Stacy Kusler, workforce specialist at the CRH, is the contact (stacy.kusler@med.und.edu (701)777-3300.
    - Stipend for MD students/Residents.
        - Can we give resident call hours and pay them for that? They could cover the ER. Second and third year medical students can come out and work in the ER.
        - RuralMed Program at UND SMHS (supported by state dollars where medical students have their tuition and some other expenses covered by this program if they commit to practice in a rural area for five years)- contact is Stacy Kusler.

- Flexibility in benefits – raises vs 4-day work week – negotiation with the providers on what they would like and what works for them.
- Extra payment for extra events they serve at and cover.
- Expand to additional places that do not have clinics – Hatton (already have clinics in Larimore and Binford).
- Separate out duties.
  - Some focus on the clinic, ER, nursing home – so can we set up practice where providers concentrate in the area they prefer so long as it can work out for all?
- How to make the job more individually attractive?

Goal – Provider Retention						
Action Step	**Objectives: to meet the action step**	**Activities: specific steps to meet the objectives (step-by-step)**	**Outputs: measurement – once accomplished the following would be evidence**	**Outcomes: What is the impact? What changes? What is improved?**	**Resources to meet goal: Internal and/or external**	**Champion and Time Frame: IMPORTANT – do not let it always be the CEO**
1.	Improve recruitment and retention of MD	a. Get Epic b. Interview candidates c. Community involvement d. Recruiting packet e. Make meals available f. Separate out duties g. Vending machines for sandwiches h. Update doctors lounge i. NDHC can make payment on home for provider j. HERSA loan repayment k. Stipend medical students l. Paid on call hours during residency m. ER time n. Flexibility in benefits o. Pay for additional requirements	a. Have 1 provider as a hospitalist and one in LTC b. Hot meals, punch card, or meal ticket for staff (salad bar) c. Extra day off vs. raises for benefit flexibility d. Pay for ER work and meetings they have to attend		a. Board involvement b. Have as many community members attend meet and greet. c. Develop welcome packet with info on community	a. Pete, Tina b. 3-6 months (needs board approval) c. Jenny in dietary set up meals (3-6 months)

- **Continuum of Care**
  - Improve access across the gap.
    - Provide assistance for medication set-up.
      - Define what type of provider is needed – LPN, RN, Community Paramedic – are there requirements for certification?
      - Determine how reimbursement works.
      - Create enrollment plan to enter the program.

        - How to make community aware.
            - Health fairs – Larimore.
            - Put info in the paper.
        - Outcomes:
            - Fewer ER admissions.
            - Fewer clinic visits.
            - Early detection of medical problems.
            - Decreased morality.
            - Overall health improvement and health outcomes.
            - Patients in the outlying area would feel more connected with NDHC.
            - Patients could remain independent longer; they would not feel as isolated.
        - Resources:
            - More staffing.
            - Vehicle to go to people's homes (fund the mileage).
            - Pharmacy connection.
            - Reimbursement process.
            - Would the ambulance be involved, impacted?
    - Get people in all age spectrums in for yearly physical exams
        - If children are healthy, they are not always brought in for an exam – this is an issue for adults too who skip because they feel healthy.
        - Create community awareness – health fairs, message in the Gleaner.
        - Output:
            - Increase in prevention services.
        - Outcomes:
            - Early detection of medical problems.
            - Improved health outcomes.
            - Lower medical costs.
            - Lower mortality.
- Partner with UND (students), School Board (students), Public health, Northland (EGF technical college)

Goal – Continuum of Care Improve Access to health care across the continuum						
Action Step	**Objectives: to meet the action step**	**Activities: specific steps to meet the objectives (step-by-step)**	**Outputs: measurement – once accomplished the following would be evidence**	**Outcomes: What is the impact? What changes? What is improved?**	**Resources to meet goal: Internal and/or external**	**Champion and Time Frame: IMPORTANT – do not let it always be the CEO**
1.	Provide assistance for medication set up Community paramedic Home personal services	a. Define the role b. Fee payment/ reimbursement c. How to enroll	a. Fewer admissions (ER visits, clinic visits) b. Health Improvement	a. Improved health outcomes b. Connect with NDHS longer a. Independence	a. Staffing b. Vehicle c. Pharmacy d. Ambulance services	
2.	Yearly Preventative Physicals for all ages	a. Partner with UND b. Education c. Community Awareness d. Health fairs	a. Increase in preventative services	a. Early detection of medical problems b. Lower medical costs c. Improved outcomes d. Decreased mortality	a. UND/HS students/ Northland	

- **Community Needs Impact (Goal- Influence indirect community infrastructure through tri-generational support)**
    - Have an influence on the indirect infrastructure needs in community.
        - Daycare – Establish daycare in facility.
            - Look at space and review the physical plant.
            - Look at licensure requirements.
            - Hire staff.
            - Outcomes:
                - Operational licensed daycare for the employees and the community.
                - Retention of existing staff.
                - Recruitment of new staff, jobs.
                - Meet a community need.
                - Provide affordable, accessible daycare.
            - Resources:
                - Walking distance and close to school.
                - Use walking path.
                - Intergenerational programs between the elderly and children.

        - Kitchen space.
        - Locations within the facility.
        - Seek funding sources – Use CRH.
    - Time frame and champion:
        - Study and determination completed by September 2017.
        - Pete Antonson and the Hospital Board.
- Affordable housing
    - Study and research:
        - Location.
        - Budget.
        - Needs of the community.
    - Outcomes:
        - Complete development of 2 to 4 homes that are small scale (about 1200 square feet).
        - Modest facilities constructed to benefit elderly.
        - Options to rent or purchase home.
        - Have occupied units.
        - Build near the parking lot – 4 units in the shape of an L by 1st Avenue.
        - Purpose is to provide more housing options for people, not necessarily to make money for the hospital, but meets a community need, and if help to keep people here it indirectly benefits the facility.
        - Local contractor hired to build.
        - Provide opportunity for some UND students (e.g., OT) to help design a housing unit that is best for elders.
        - Handicapped accessible.
        - Close to healthcare access.
    - Time-frame:
        - Completion of June 2018
- Improve fitness center
    - Evaluate equipment, space, and camera.
    - Add services- personal trainer.

Goal – Influence indirect community infrastructure through tri-generational support						
Action Step	**Objectives: to meet the action step**	**Activities: specific steps to meet the objectives (step-by-step)**	**Outputs: measurement – once accomplished the following would be evidence**	**Outcomes: What is the impact? What changes? What is improved?**	**Resources to meet goal: Internal and/or external**	**Champion and Time Frame: IMPORTANT – do not let it always be the CEO**
1.	Establish daycare within the facility	a. Review of physical plant b. Licensure requirements c. Hire staff	a. Operational licensed daycare	a. Allows retention of existing staff b. Allows recruitment of staff c. Meets community need d. Affordable	a. Cando b. Grant funding c. Location d. Kitchen space e. School with walking path f. Library g. Identify models throughout the community	a. Pete b. Board c. Immediate need – Sept 2017
2.	Initiate affordable housing development	a. Study location, budget and need	a. Completed development b. Improved living arrangement for aging population c. Occupied units	a. Better access to affordable housing	a. External investors b. Contractors	a. Pastor Brad b. Brian c. Pete d. Completion date of June, 2018

- **Service Development**
  - Space
    - Consider examining dementia care, basic care, assisted living, and possibly TBI.
      - Redesign and allocation of these care needs - contact Rebecca Quinn @ CRH (directs TBI and has LTC experience).
    - Develop a new line of business – homemaker services like transportation, grocery shopping, cleaning, etc.
  - Workplace enhancement
    - Coffee shop, child care
  - Study feasibility of additional outpatient services – endoscopy and dialysis
  - Provide fitness trainer

Goal – Service Development						
Action Step	**Objectives: to meet the action step**	**Activities: specific steps to meet the objectives (step-by-step)**	**Outputs: measurement – once accomplished the following would be evidence**	**Outcomes: What is the impact? What changes? What is improved?**	**Resources to meet goal: Internal and/or external**	**Champion and Time Frame: IMPORTANT – do not let it always be the CEO**
1.	TBI Unit, Alzheimer's, Dementia Care (basic memory care)	a. Analyze space needs b. Internal team to identify		b. Community care. c. Keeps community intact	a. Space, staffing	
2.	Home Care	a. Housekeeping services b. CNA visits c. Medication setup		a. Population stays local b. Revenue stream stays local	a. Staff b. Revenue reimbursement	
3.	Coffee shop, personal training, obtaining EPIC	a. Sanford employee enhancement Grant, Red River Valley Economic Development, Grafton, Dawn Keely b. EDC	a. Sales & Revenue	a. Revenue Stream b. Employee Satisfaction c. Visitor comfort	a. Space, staff, management	
4.	Dialysis, endoscopy, personal training, daycare	a. Study needs assessment b. Study feasibility c. Study output services for hospital		a. Population health systems b. Recruit & retain staff	a. Staff, maintenance, equipment b. Space, marketing, staffing	

- **Mental Health** (listed many different issues but focused on chemical dependency)
  - Chemical dependency issues.
    - Resources exist, however we can do a better job to make sure our employees make the community aware. Give information to patients for easy access to contact information.
    - Make tab on website with comprehensive information.
    - Keep pamphlets in patient exam rooms to hand out with important information.
    - Work with other entities in the area to be sure the information is out in the community.
    - Gather data from around the area that can help us determine the areas we need to address – data on occurrence, age/gender, location, etc.

- Be aware of the resources that are available to us – CRH, Grand Forks County, School system, role of churches, VCHC has a strong focus on mental health and NDHC can look to collaborate.

- Counseling/Psychologist –depression/anxiety/family.
- Psychiatry- personality disorders.
- Dementia.
- Abuse and neglect-children and elderly.

Goal – Mental Health						
Action Step	**Objectives: to meet the action step**	**Activities: specific steps to meet the objectives (step-by-step)**	**Outputs: measurement – once accomplished the following would be evidence**	**Outcomes: What is the impact? What changes? What is improved?**	**Resources to meet goal: Internal and/or external**	**Champion and Time Frame: IMPORTANT – do not let it always be the CEO**
1.	Reduce abuse of drugs & alcohol in the community	a. Find out what measures are currently in place b. Talk and join with school c. Talk and join with law enforcement d. Church activities e. AA groups f. VCHC	a. School surveys b. Other data c. Survey of community education	a. Depends on data available b. Consider grant to fund data collection	a. CRH b. Altru hospital c. UND d. State of ND e. Grand Forks County f. State and local government	a. To be determined

Recommendations

1. **Eyes not being bigger than your stomach**. Northwood did a great deal of work in generating some very good and practical ideas; however, it is ambitious. Each of these is likely achievable over time. That is what we recommend; spread it out over the three years, maybe even longer. There are a couple of ways to do this. One, pick a priority goal and put energy behind achieving it. Two, take elements from a number of goals and work on them if they seem achievable in a year or so. The first option has the benefit of checking off an entire goal but the disadvantage of placing all the proverbial eggs in one basket at the expense of addressing some other issues that may be achievable in a reasonable time. The second has the advantage of working on a variety of achievable ideas across a range of goals within a specific and achievable time, but offers the disadvantage of limited cohesion and maybe spreading work responsibility and resources too thin. Still it is up to the board to decide. The board may want to consult with key people from each group to get their thoughts on what they feel can be accomplished in year one or if there is a consensus to address maybe one or two goals in year one, more in year two, and the final

goals in year three. There are advantages either way. The recommendation is channel your resources including time by spreading the work out over three years.

2. **Epic**. It was very clear that the providers see the need to change EMR systems to Epic. Actually, it was rather emphatic. Epic appears to be the dominate player for physicians' EHR (https://ehrintelligence.com/news/epic-systems-tops-cerner-as-top-used-physician-ehr-vendor) being used by 28 percent across the country. Being integrated and compatible are essential to better quality and more efficient health care. It is recommended that the hospital address the EHR issue as soon as it can, even if it decides that it will not tackle all of the elements in the recruitment and retention goal in the outset. The hospital can contact other North Dakota CAHs to lean how they have navigated the change. St. Luke's Hospital in Crosby is also converting to Epic and a conversation is recommended. Additionally, discussions with some of the tertiary facilities (Altru and Sanford) may be in order.

3. **Provider Recruitment and Retention**. There are a number of practical activities outlined in the matrix and during the discussion. We will address a few of these:
    - One of the stated themes was the "need to identify what we do well and focus on and expand on those things." We recommend working with the CRH Workforce Specialist, Stacy Kusler, on an Apgar Project. The Community Apgar Project (CAP) is a research-validated questionnaire used to assist rural North Dakota hospitals identifying strengths and challenges related to recruiting and retaining family medicine physicians. Through a series of interviews with local providers, CRH is able to help the hospital identify strengths and weaknesses associated with a range of community and practice variables that can either facilitate or impede recruitment and ultimately retention of providers.
    - Community involvement. Too often hospitals and/or clinics keep the community distant from efforts to recruit and retain provides. While it is natural to view the recruitment process as both pivotal to the facility and dependent upon facility expertize, rural health organizations lose out on other community-based expertize and most importantly community involvement and energy. A recommendation is to form a Community-based Recruitment and Retention Committee. Such a committee would remain directed by the hospital and clinic and have key personnel involved; however, it could also include key community representatives who would contribute community knowledge and skills to the process. This could include someone from the school, business/banking, faith community, local government, housing, and other areas. The community people will be the new provider's neighbors, community connector, and friend. The other advantage is marketing and public relations for the hospital. Hospitals sometimes allow themselves to be seen as a fortress, removed from the community, and distant. Community people want to support the local health facility but can feel disengaged and unwelcomed. A community-based committee opens up both the recruitment process to new people looking to be involved and supportive, and exposes the hospital to positive impressions. Simply put – it builds good will.
    - Financial incentives. The group discussed a number of financial incentives – federal and/or state loan repayment, medical student stipend, ED work for residents, and even housing assistance such as down payments. These are all feasible. It is recommended to

discuss loan repayment and stipend options with Stacy Kusler. Additionally, explore the option of being a placement site associated with the UNDSMHS Rural Med program. This program, supported by state dollars, pays for medical school tuition if the student agrees to serve for five years post-residency in a rural community. CRH will work to connect Northwood with that program. The housing option should be researched, as it is creative and would require the expenditure of hospital foundation funds.

- Hospitalists. The NDHC should explore this option. Based on 2009 data, about 14 percent of CAHs and 41 percent of other rural hospitals, nationwide, reported using hospitalists in comparison to urban hospitals where about 60 percent employed this specialty. (http://rhrc.umn.edu/wp-content/files_mf/hospitalist_policy_brief.pdf) In the study, a plurality of rural hospitals reported positive financial impacts. This does represent a culture shift for patients who are accustomed to seeing their clinic provider in the hospital. The hospital may provide more community education.
- E-Emergency. This service not only benefits patients, but also can have positive implications for providers. Rural physicians, nurse practitioners, and physician assistants – particularly newly recruited and with limited in the field experience- have been found to appreciate the security found in the expertise of specialists they are connected to through tele-medicine.

4. **Continuum of Care.** The statement implies that the intention of this goal is to address access to care across an age continuum. It covers all age groups but does have a specific focus on elders.
    - Due to the Affordable Care Act (ACA) many preventive health services are now fully covered by insurance. With the focus of the ACA being improved population health, covering the cost of prevention is an economical way to help improve health status. The hospital and clinic should promote not only the benefits of prevention, but also the cost savings to patients. Health fairs, notes in the newspaper, and local speaking engagements can be effective methods of promotion. Additionally, be aware that five North Dakota CAHs (Hazen, Watford City, Rugby, Park River, and Bowman) are all part of a three year federal grant to create an Accountable Care Organization (ACO). ACO are one of the new delivery models with corresponding changes in payment that are part of the ACA. ACO's place a strong focus on population health and prevention with training on care coordination, motivational interviewing, patient data, connections to "call a nurse" programs, and other interventions. It is recommend discussing with the ACO CAHs the benefits of the ACO model and just as importantly how to gain additional population health skill sets for nurses. It is not necessarily the recommendation for Northwood to join the ACO network (although it could explore this) but there are likely transferable skills. One of the North Dakota ACO CAHs may be interested in training Northwood staff. The utilization of staff can vary between facilities within an ACO. For example, Hazen relies on nursing for care coordination, prevention, and other services meant to improve both healthcare and health status. Rugby is incorporating their community paramedics into hospital service delivery. Both hospitals would likely share their approach and processes with Northwood. There is interest in expanding the number of North Dakota hospitals in the ACO so it is a viable option.

- Medication set-up. This appears to be a common-sense approach; nevertheless, it needs to be researched to see what rules and regulations govern the concept. A simple Google search, conducted by CRH, did not generate any reliable information. One question is how does this idea conform or conflict with formal home care and the rules and regulations governing home health agencies? Can medication assistance be administered by a non-home care agency such as the hospital and/or clinic? How does reimbursement work and if not done by a home care agency is it reimbursable? Would it be allowable to have a small personal out-of-pocket fee? Could there be local fundraising to raise money to support the service at least in part? Due primarily to regulatory changes, the number of home care agencies has declined over the years with there being only 16 licensed through the North Dakota Department of Health. The idea is simple – help people stay in their homes by having someone (LPN, CNA, or maybe a community paramedic if that system proves feasible) come to the home and assist the patient to set up the upcoming weeks supply of medications. Medication mistakes are very common – either forgetting to take them, taking too many/too few, having old and/or expired medications in the home, and other common mistakes and problems.

5. **Community Needs Impact (Goal- Influence indirect community infrastructure through tri-generational support).** Three significant ideas emerged from the discussions: daycare, affordable housing, and an improved fitness center.
    - Daycare. NDHC should research the feasibility and sustainability of a daycare at the health center. Essentially a feasibility study should be undertaken. It likely starts by researching the experience of other CAHs (e.g., Towner County Medical Center, Cando, ND and Heart of America Medical Center, Rugby, ND) that have started hospital-based day cares. How did they decide to do this? What are the metrics to consider? What types of data is gathered and analyzed? Was a feasibility study conducted (and who performed it)? What are the positive effects for the hospital and the community? There are a number of questions to consider. It would also involve researching need in the community (number of families both from the community and the facility, population and age trends), along with physical space in the facility, regulations, and staffing needs. There was a strong perception at the planning meeting that there is a need. That is always a good starting place; however, then the facility needs to research overall community need along with costs and other issues. It is possible that that such a facility neither produces a profit or breaks even, and then the facility has to ask: do we subsidize it and at what level? It may be that the hospital decides to proceed as a benefit to the community more so than a benefit for the hospital.
    - Affordable housing. This is similar to the daycare issue in that the hospital needs to research the feasibility and implications of addressing affordable housing, looking at need, costs, and does this too possibly represent an effort to show community leadership to benefit the community more than the hospital. It may not be a money maker; however, it can benefit the community. In the 2016 CHNA, while housing did not emerge as a top issue in Northwood, it was identified as a top issue in four other CHNA's. Housing is a growing concern in rural North Dakota –availability, affordability, and quality. The latter also relates to housing that is handicapped accessible which can

be an issue for older residents. NDHC wanting to explore the issue is constructive. The discussion identified a number of issues including the difficulty for elderly rural residents wanting to move into town but housing options are limited. This becomes an issue for them and their adult children who worry about their elderly parents. Housing, poverty, livable wages, and keeping younger or attracting younger families to a rural community are emerging issues not only for a community, but also they are part of a broader definition of population health issues. There are many contributing factors to health status. Inadequate housing, which includes the inability to move closer to providers for access and safety reasons, is a legitimate concern for the community and the hospital.

- Improve fitness center. This too is part of community life and health. NDHC may want to confer with some CAHs (e.g. Cavalier County Memorial Hospital in Langdon and First Care Health Center in Park River) that have had some experience with the hospital supporting fitness centers and community exercise. Langdon used a federal Rural Health Outreach grant to support fitness operations in a network involving the Cavalier County Jobs Development Corporation, hospital, and public health. They were able to use the grant to purchase exercise equipment for the local fitness center and to conduct community wellness education. Park River used a federal Rural Health Outreach grant to support some exercise and wellness services in Park River. They used much of it to network with about eight smaller, neighboring communities to assist them in gaining exercise equipment and to initiate Bone Builders education for elders (i.e., a very low impact stretching and exercise program) which facilitated both physical movement and increased social engagement. For the Park River CAH this also showed them as a regional leader for health and wellness. With the number of smaller communities Northwood serves through clinic outreach, this may be an additional idea to explore.

6. **Service Development**. This subject covers a wide range of service related ideas such as assisted living, basic care, dementia care, and TBI under the category of space, but then also home care (e.g., medication set-up, CNA visits, and housekeeping), another set of treatment services (dialysis and endoscopy) along with personal training and day care. Additionally, a coffee shop idea is included and a few other ideas previously addressed.
    - The hospital may want to re-evaluate some of the categories generated that evening. During a planning session, ideas flow quickly, along with enthusiasm, and later reflection sometimes adds a new line of thinking. The Service Development goal shows some overlap with other group goals previously discussed along with some wholly new ideas. Regardless, the hospital may want to think along the lines of the following: elder health and health care services (basic memory care services, medication set-up, and more); elder non-health community services (homemaking, housing, and other); new community health services (e.g., dialysis, endoscopy, TBI, and others); and staff services (e.g., provider's lounge, food services for staff, and others). There are likely other approaches (e.g., off-site services vs. on-site services). Do not get hung-up on the name or category, but try to find an easier way to think through your options and steps. Regardless, for most of the ideas there is a need for further assessment/research to include, but not limited to the following: cost considerations, resources (including local and non-local partners), and staffing considerations.

- Overall, the ideas generated are quite good and are well within the norm of what a small community and CAH can accomplish. However, not all at once. No idea should be rejected out-of-hand as too ambitious - it should be reviewed and vetted. This is likely more than a three-year plan and may be closer to five years.
- It is not beyond the realms of possibility for Northwood to think of itself as the "rural retirement center for eastern North Dakota and northwestern Minnesota." Some of the ideas (e.g. independent residential housing for retirement but not necessarily congregate housing) are "big" in nature; they represent visioning for the future. It is easy to imagine a Northwood in 10 years that has an array of attractive services for elders including housing, in home health and non-health services, more targeted elder-focused health services from the hospital and clinic, and a diversified health workforce (a physician, a group of physician assistants and nurse practitioners, community care workers, and even community paramedics). Currently, the hospital and clinic are primarily thinking about local citizens, particularly the elders they know. This is natural and appropriate. However, it is recommended that the health facility think more globally and think of Northwood as a regional magnate for elder or aging services along with being the leader for health and wellness by continuing its clinic services to smaller communities, but also investing in exercise, fitness, and wellness in those communities. Furthermore, NDHC should contact the Red River Regional Council for some additional discussions regarding community development, funding options, forming strategic partnerships, and other assistance. Since some of the ideas go beyond traditional health care services, it may be prudent to get perspective from an organization that focuses on community and business development such as the regional council. The Center for Rural Health would be pleased to be part of the discussions.

7. **Mental Health.** Youth drug use and abuse was one of the community concerns identified in the CHNA. The planning session discussion was more comprehensive than youth drug use; however, a focus on youth may be a sound starting point. The discussion identified a number of steps and partners including the CHC, school, law enforcement, faith community, and even resources in Grand Forks. A number of options for assistance are available:
    - Track through the CRH what other hospitals are doing. The CRH found the number one CHNA identified need to be behavioral health (23 CHNAs) followed closely by mental health (20 CHNAs); thus, Northwood is definitely not alone. By reviewing other CAH CHNA Implementation plans, NDHC can find colleagues and ideas. It would be possible for a number of CAHs with behavioral health/mental health as community needs to come together and share 1) the nature and scope of the problem 2) possible solutions, and 3) avenues of collaboration and cooperation. This could be through phone calls or a special face-to-face. CRH could be available to assist.
    - Behavioral and mental health are a primary policy concerns for state policy makers, both in the legislative branch and in the executive through state agencies. NDHC should monitor and be aware of policy changes that may have a direct impact on local behavioral health such as changes in workforce supply.
    - Grants are another resource. It has been mentioned in this report how CAHs have used federal Rural Health Outreach and/or Network Development grants to address wellness

and exercise. These are broad-based grants covering a wide range of rural health issues. CAHs, Public Health districts, economic development, and other rural community entities should avail themselves to pursuing such grants for behavioral and mental health. Both individual communities and groups of communities have used Outreach and Network Development grants. Valley City had an Outreach grant to address area suicides while four rural hospitals (Bottineau, Harvey, Kenmare, and Rolla) used an Outreach grant to create the Rural Mental Health Consortium (originally funded circa 1994 it is still operating). Thus, there is precedent in using federal grants to address mental and behavioral health. A group of CAHs and/or public health districts with possibly school districts and law enforcement collaborating on the subject is viable.

- NDHC may want to develop a local task force to discuss the behavioral health issues and to form community-wide and even multiple community action steps. The planning discussion identified possible partners in the community health center, law enforcement, school, and others. That is a good starting point. The Center for Rural Health would gladly assist.

8. **Larimore Clinic.** After the strategic implementation planning meeting and while this report was being written a new discussion point emerged and was suggested as part of this plan. While not discussed during the implementation meeting it is germane to the development of the NDHC and is part of this larger planning process; thus, it will be addressed here.
    - NDHC has a clinic in Larimore with a provider who lives there. They are adding an additional provider, who was raised in Larimore; thus, Larimore is a legitimate market for Northwood. The current space has been maximized and NDHC needs to consider options to increase clinic space.
    - One option is to add to the current space, to build-on and extend the lease on the building.
    - A second option is to purchase the building out-right and add onto the space.
    - A third option is to discuss with Valley Community Health Center their interest in selling their clinic to NDHC.
    - The timeframe is to explore this in 2017 and to budget for 2018.
    - The interest in Larimore appears justified as Northwood has a presence there. Investing more is also a sign of commitment on the part of NDHC to addressing health issues in other communities.

Conclusion

Northwood Deaconess Health Center has identified community health issues through the CHNA process and developed an implementation plan. It has met its obligation under the Affordable Care Act. More importantly than simply meeting required policy stipulations, NDHC has shown commitment to its community through community engagement and has an implementation plan to address community concerns. Northwood Deaconess Health Center is a good example of a health center (hospital, clinic, and nursing home) that is not only committed to its patients; it is committed to its community.

Health care is changing rapidly. Health reform is initiating much of the change. Regardless of any new policy changes to the Affordable Care Act, the overall health system is adapting particularly to broad goals such as redesigning the system to be more responsive to population health and modifying the payment system to reflect value over volume. This will continue. At both the 2017 National Rural Health Association (NRHA) Policy Institute and the 2017 NRHA Annual meeting many sessions focused on the continued delivery system redesign, sometimes referred to as "volume to value." At the heart of this is population health as a focal point linking improved quality of care and health system performance. This impacts how care is delivered, paid for, and maybe just as importantly how the delivery system rethinks/restructures itself to provide better health, better care, and to control costs. Many of the ideas generated in the strategic implementation discussion are very forward looking for the community of Northwood and NDHC. They include the following: 1) being more responsive to an aging population both in health services and community-based services; 2) being willing to explore non-traditional health services that could benefit the community overall such as housing for seniors and a community-based day care located at the hospital; and 3) being poised to serve as a regional rural health system via its clinical services to other communities. It is also important to understand that much of this is population health focused and related to the social determinants of health. As one tertiary hospital CEO stated with regard to health reform: "as a hospital we never used to pay much attention to poverty, but now we do. We have to." That is a recognition that the lives of people (where they live, income levels, quality of housing, education, and other factors) contribute to their health status. Health care providers will be reimbursed more and more on quality, value, and performance not merely the number of times a patient is seen or the number of tests ordered. These lifestyle factors play a role; healthcare systems need to be more integrated into the lives of people and the life of their community. For NDHC to look at ideas that are non-traditional (e.g., housing, daycare, community wellness, and more) means that NDHC recognizes the population health focus.