2016
Community Health Needs Assessment
St. Catherine Hospital
At a Glance: Community Health Needs Assessment
St. Catherine Hospital

Area Served

Finney County

Priorities

Healthy Eating
Active Living

Behavioral Health

Health Equity/Access to Care

Partners

Finney County Health Department, Finney County Community Health Coalition (LiveWell Finney County), Garden City Public Schools, Kansas State University Research & Extension Center, Genesis Family Health, Western Kansas Statistical Labs, City of Garden City, International Rescue Committee, Dominican Sisters Ministry of Presence/Parents as Teachers, State Farm Insurance
2016

Community Health Needs Assessment
St. Catherine Hospital

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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 St. Catherine Hospital 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 the STARK-Law service areas, defined as the lowest number of contiguous ZIP codes that account for 75% of a hospital’s inpatient admissions. We used the main counties within the STARK-Law service area to analyze our health driver and health outcome data, as health outcome data was generally not available at the ZIP code level.

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:
St. Catherine Hospital 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: Healthy Eating Active Living**

Because we have prioritized healthy eating active living, we support implementation of environmental, health systems and community-clinical linkage strategies to be implemented simultaneously and synergistically to address multiple risk factors and chronic diseases. These community efforts represent a dual approach that improves health for the whole population and for specific, selected population subgroups at high risk for experiencing disproportionate disease burden. In our community, 22.5% of adults don’t get the recommended leisure time activity, 20.4% of adults smoke, and 83.4% of adults eat less than 5 fruits and vegetables per day. These are all risk factors for chronic diseases, such as heart disease and diabetes. In our community, 43.6% of adults are overweight, and 34.5% are obese. These numbers are much higher than state averages, and point to our need to improve healthy eating/active living. Our goal is to promote health, support and reinforce healthful behaviors, and build support for lifestyle improvements.

**Prioritized Need: Behavioral Health**

Behavioral Health is also an issue in our community. Almost 16% of adults report heavy alcohol consumption. Roughly 23.4% of adults report a lack of social or emotional support, compared to 15.7% in Kansas. Additionally, the rate of violent crimes reported by law enforcement is 384.5 per 100,000 residents, higher than the Kansas rate of 363.6 per 100,000.

We will address violence and substance abuse issues issues by promoting education on issues related to family violence by collaborating with community stakeholders to develop education, awareness events and programming in the community. The community plan to reduce and prevent family violence focuses on developing educational programs for the community to increase awareness on the prevention of multiple forms of violence.

**Prioritized Need: Health Equity/Access to Care**

Access to care is a high need in our community. According to Small Area Health Insurance Estimates, in 2012 26.3% of adults were uninsured and 10.2% of children were uninsured. This is higher than the Kansas rates of 17.6% and 7.1% respectively. In our community we understand the importance of a robust Community Health Worker program. By increasing access to healthcare, Community Health Workers seek to both prevent illness as well as reduce costs to the community by preventing more serious complications through consistent care and medical attention.

Our Community Health Workers are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Our Health Workers also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. Their goal is to increase the number of residents who receive necessary health care services by providing community health workers.

**Implementation Planning Process:**

The first step to developing our implementation plans was to present evidence-based practices focused on addressing healthy eating active living, behavioral health, and health equity/access to care to our hospital subcommittees. Next, we completed an environmental scan to determine which established efforts in St.
Catherine Hospital, 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.

To create our implementation plan, we modified the CHAPS Action Plan, provided by CDPHE. For each health priority we created SMART goals, strategies, and metrics.

**Implementation Plan Review and Approval:**

The final implementation plans were presented to and approved by the St. Catherine Hospital Board on June 24th.
Our Mission
We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Our Vision
Centura Health will fulfill a covenant of caring for our communities with excellence and integrity to become their partner for life.

Our Core Values
Compassion
Respect
Integrity
Spirituality
Stewardship
Imagination
Excellence
Introduction

Centura Health, St. Catherine Hospital and Our 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 Centura Health’s and St. Catherine Hospital’s mission and vision. As the region’s largest health care provider, Centura Health fulfills our 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. 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 St. Catherine Hospital 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 St. Catherine Hospital, 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 St. Catherine Hospital 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 and contributing to the disparities we see across race/ethnicity and geography. 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 of health in our prioritization process. Through the CHNA we sought to bring awareness to the importance of the social determinants, 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, community partnerships, and delivery of care. We have continued to build upon existing relationships between St. Catherine Hospital and the Finney County Public Health Department. Together, we have taken great strides to create a model to which hospitals and health care systems around the nation can look to address their own community’s needs. By following the model of activating primary care networks, advancing evidence-based practices, and providing training for care teams and community providers, St. Catherine Hospital 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 the Centura Health system, we leveraged existing data resources, internal expertise, and the strength of our network to design a system-wide CHNA process. This helped to assure key stakeholders’ increased knowledge of public health and to engage internal systems in population health data to help to explain the drivers of emergency room and inpatient visits. The knowledge we gained from the CHNA process helped our hospitals more effectively lay out their strategic plan for addressing the needs in their communities. Over the course of the year, this CHNA process facilitated collaboration within our family of hospitals, helping us build a stronger system in which our hospitals benefit from powerful learning networks and relationships, rather than function as separate entities.
St. Catherine Hospital: Our Services and History

Since its foundation in 1931, St. Catherine Hospital has provided people throughout southwest Kansas and the surrounding communities compassionate, personalized, whole-person care. St. Catherine Hospital is a full-service, award-winning, 102 bed hospital with a full service multi-specialty medical clinic.

St. Catherine Hospital was founded by two pioneering physicians and the Dominican Sisters. They created and maintained the spirit that has enabled St. Catherine Hospital associates to develop a growing health care facility unlike any other in southwest Kansas. As we are move farther into the 21st Century, it is even more important for St. Catherine Hospital to reinforce the legacy that the Sisters began in 1931. Today, St. Catherine Hospital is a Joint Commission accredited regional hospital and is part of Centura Health, the largest, most comprehensive health system in Colorado and western Kansas focused on connecting Kansas and Colorado to world-class care.

Distinctive Services

St. Catherine Hospital offers leading medical experts, cutting-edge technology, and a broad array of specialties and services. Our distinctive services include:

- State-of-the-art Level III emergency department with a critical air transport base
- Seven bed, Level II Newborn Intensive Care Unit
- Ten bed Behavioral Health Centers
- General Surgery Center
- Neurodiagnostic and Sleep Disorders Center
- Multi-specialty physician clinic providing over 20 outreach clinics throughout western Kansas
- Inpatient Dialysis Unit
- 24/7 cardiology, orthopedic and critical care physician coverage
- Nationally accredited Breast Center
- Nationally accredited Stroke Center
- High 5 for Mom and Baby Hospital

Our expertise in these areas has earned us a number of awards and honors throughout the years. St. Catherine Hospital is proud to have received the following awards:

- 2014 AHA Nova Award recipient
- Award of Merit in Healthcare from the ENR Best Projects
- Received the Chamber of Commerce Not for Profit of the Year Award in 2014
- First hospital in Kansas to achieve HIMSS Stage 7
- Only hospital in western Kansas to receive an A for patient safety in Leapfrog’s Fall 2015 hospital safety score
- Top Performer on Key Quality Measures for 2014 by the Joint Commission
- 2016 Gold Level Breastfeeding Employee Support Award
Commitment to Our Community

At St. Catherine Hospital, the work we do outside of medical care is born out of the second part of our mission, “to nurture the health of the people in our communities.” From access for the uninsured, to strengthening community partnerships to build vibrant and healthy neighborhoods, St. Catherine Hospital are partners for life.

As a private, non-profit hospital, our dedication is solely to fulfilling our organizational mission by living out our core values and protecting the health and wellbeing of our communities. Our community benefit activities are integral to our religious mission and are the basis of our tax-exempt status. Throughout Centura Health, these community benefit activities include improving community health by providing services to low-income patients and connecting patients with services after discharge, community building, such as economic development and community health programs, subsidized health services like hospice, home care, research to advance the field, financial and in-kind contributions to the community, and community benefit planning.

In fiscal year 2015, St. Catherine Hospital provided over $7,121,095 in total community benefit. Community services ranged from providing space and over $78,000 in support to the Finney County Community Coalition, to holding open enrollment community events in partnership with United Methodist Mexican American Ministries to enroll uninsured individuals into healthcare coverage plans.
Our Community

To define our community for the CHNA and to analyze demographic and health indicator data, we used the STARK-Law service areas. The STARK-Law service area is defined as the lowest number of contiguous ZIP codes that accounts for 75% of a hospital's inpatient admissions. These ZIP codes have a combined population of 131,964.

The demographic makeup of these communities is as follows:

Race and Ethnicity: The population is 83.95% white, 1.95% black, 1.85% Asian, 0.84% Native American/Alaskan Native, 0.01% native Hawaiian/Pacific Islander, 9.24% some other race, and 2.31% multiple races. Additionally, 44.68% are of Hispanic of Latino descent.

Education Level: In our communities, 31.8% of the population has an Associate's Degree or higher. Kansas average is 37.9%

Unemployment Rate: 2.9%, Kansas average is 5.2%

Population with Limited English Proficiency: 19.5%, Kansas average is 4.5%

High School Graduation Rate: 67.6%, Kansas average is 77.6%

Population Living in Households with Income Below 200% of Federal Poverty level: 40.3%, Kansas average is 32.7%
Population Demographics in St. Catherine Hospital’s Service Area

Race

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>St. Catherine Service Area</th>
<th>State Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic</td>
<td>55.32%</td>
<td>55.32%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>44.68%</td>
<td>44.68%</td>
</tr>
<tr>
<td>White</td>
<td>83.95%</td>
<td>83.95%</td>
</tr>
<tr>
<td>Black</td>
<td>1.95%</td>
<td>1.95%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.85%</td>
<td>1.85%</td>
</tr>
<tr>
<td>Native American/Alaska Native</td>
<td>.84%</td>
<td>.84%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>.01%</td>
<td>.01%</td>
</tr>
<tr>
<td>Other</td>
<td>9.24%</td>
<td>9.24%</td>
</tr>
<tr>
<td>Multiple races</td>
<td>2.31%</td>
<td>2.31%</td>
</tr>
</tbody>
</table>

Ethnicity

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<thead>
<tr>
<th>Population Demographics in St. Catherine Hospital’s Service Area</th>
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<tr>
<td>Black 1.95%</td>
</tr>
<tr>
<td>Asian 1.85%</td>
</tr>
<tr>
<td>Native American/Alaska Native .84%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander .01%</td>
</tr>
<tr>
<td>Other 9.24%</td>
</tr>
<tr>
<td>Multiple races 2.31%</td>
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</table>

Limited English Proficiency

<table>
<thead>
<tr>
<th>Limited English Proficiency</th>
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<tbody>
<tr>
<td>19.5%</td>
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<tr>
<td>St. Catherine Service Area</td>
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<table>
<thead>
<tr>
<th>State Average</th>
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<tbody>
<tr>
<td>4.5%</td>
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Unemployment Rate

<table>
<thead>
<tr>
<th>Unemployment Rate</th>
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<tbody>
<tr>
<td>2.9%</td>
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<tr>
<td>St. Catherine Service Area</td>
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<table>
<thead>
<tr>
<th>State Average</th>
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<tbody>
<tr>
<td>5.2%</td>
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Households Below 200% of Federal Poverty Level

<table>
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<tr>
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<tbody>
<tr>
<td>40.3%</td>
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<td>St. Catherine Service Area</td>
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<table>
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<td>32.7%</td>
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<table>
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<th>State Average</th>
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<tbody>
<tr>
<td>32.7%</td>
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</table>
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 representatives from our hospital and the community. Our subcommittee:

- Reviewed the quantitative data and provided insight;
- Prioritized health needs using the Centura Health 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. Subcommittee members were required to attend up to four meetings, each two to three hours.

St. Catherine Hospital’s Partnerships with Public Health

St. Catherine Hospital has strong partnerships with Finney County Community Health Coalition, Finney County Health Department, Kansas Department of Health and Environment, Kansas Health Foundation and Catholic Health Initiatives. Kansas Department of Health and Environment supports a coordinated approach to prevent and control diabetes, heart disease, obesity and associated risk factors through implementation of the Centers for Disease Control and Prevention’s DP14-1422. Our community is one of seven selected for participation based on the burden of hypertension, risk for type 2 diabetes, potential population reach, social demographic characteristics associated with these conditions or their risk factors. These partners also work to implement the Chronic Disease Risk Reduction initiative, a community program that provides funding and technical assistance to communities to address chronic disease risk reduction through evidence-based strategies that impact tobacco use, physical activity and nutrition.

The Safe Kids Kansas Initiative works to keep all kids safe from preventable injuries. This is done through data collection, advocacy, awareness, education and programs.

The Kansas Health Foundation is committed to improving the health of all Kansans, and one of their key focus areas is to promote healthy behaviors, including ensuring proper nutrition, increasing physical activity and decreasing tobacco use. We partner with them on the Healthy Communities Initiative which supports communities as they create a healthier environment for their citizens.

In partnership with Catholic Health Initiatives and Finney County Community Health Coalition, we are committed to creating and promoting a culture of non-violence as an essential element of healthy communities and a healthier society. Our work includes public policy initiatives, community-based programs, sharing of leading practices and external networking and socially responsible investing.
Stage 1: Scanning the Data Landscape

The CHNA was conducted through a collaborative partnership between St. Catherine Hospital, Finney County Public Health Department, and community stakeholders. We used the main counties within the STARK-Law service area to analyze our health driver and health outcome data. Health outcome data was generally not available at the ZIP code level. St. Catherine Hospital’s main service area encompasses Finney County, which was the data used for this process.

The subcommittee used both quantitative and qualitative data 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. To be sure we were measuring all determinants of health, we conducted a full legal and environmental scan of issues and policies impacting health in our community.
**Table 1. Health Indicator Data:** The health needs in the table below were analyzed during the prioritization process. See Appendix B for the full dataset.

<table>
<thead>
<tr>
<th>Health Need</th>
<th>Indicator</th>
<th>Community Value</th>
<th>Kansas Value</th>
<th>Healthy People 2020 Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Percentage of adults 18 and older who self-report that they have ever been told by a health professional that they had asthma</td>
<td>14.4%</td>
<td>9.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Cases per 100,000 females per year, age adjusted</td>
<td>No Data</td>
<td>122.5</td>
<td>40.9</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>Cases per 100,000 females per year, age adjusted</td>
<td>No Data</td>
<td>7.2</td>
<td>7.1</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>Cases per 100,000 population per year of colon and rectum cancer, age adjusted</td>
<td>No Data</td>
<td>44.9</td>
<td>38.7</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes</td>
<td>9.1%</td>
<td>9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Death rate due to coronary heart disease per 100,000 population</td>
<td>127</td>
<td>164.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Homicide</td>
<td>Rate per 100,000 population</td>
<td>No Data</td>
<td>4.2</td>
<td>5.5</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Chlamydia rate per 100,000 population</td>
<td>482.7</td>
<td>387.81</td>
<td>N/A</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>HIV Rate per 100,000 population</td>
<td>63.4</td>
<td>115.66</td>
<td>N/A</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>Death rate due to chronic lower respiratory disease per 100,000 population</td>
<td>37.3</td>
<td>50.7</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternal, Infant, and Child Health</td>
<td>Infant mortality rate per 1,000 births</td>
<td>5.2</td>
<td>7.1</td>
<td>6</td>
</tr>
<tr>
<td>Maternal, Infant, and Child Health</td>
<td>Teen birth rate per 1,000 female teens</td>
<td>77.9</td>
<td>39.9</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternal, Infant, and Child Health</td>
<td>Percentage of low birth weight births</td>
<td>7.4%</td>
<td>7.2%</td>
<td>7.80%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Percentage of adults who lack social or emotional support</td>
<td>23.4%</td>
<td>15.7%</td>
<td>N/A</td>
</tr>
<tr>
<td>Obesity/Overweight, Physical Activity and Nutrition</td>
<td>Percentage of adults 18 and older who self-report a Body Mass Index (BMI) greater than 30.0</td>
<td>34.5%</td>
<td>30.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Percentage of adults who did not receive a dental exam in the past year</td>
<td>28.1%</td>
<td>28.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Percentage of adults with poor dental health</td>
<td>10.7%</td>
<td>14.4%</td>
<td>N/A</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>Cases per 100,000 males per year, age adjusted</td>
<td>No Data</td>
<td>152.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Adults reporting heavy alcohol consumption</td>
<td>15.9%</td>
<td>15.9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Suicide</td>
<td>Rate per 100,000 population</td>
<td>12.3</td>
<td>13.5</td>
<td>10.2</td>
</tr>
<tr>
<td>Unintentional Injury</td>
<td>Death rate due to unintentional injury (accident) per 100,000 population</td>
<td>56.3</td>
<td>42.5</td>
<td>36</td>
</tr>
</tbody>
</table>
Stage 2: Delving into the Data to Identify Priorities

Our St. Catherine Hospital CHNA Subcommittee received a health indicator data presentation compiled by the CHNA Steering Committee. The Subcommittee identified and prioritized community health needs using the Centura Health prioritization method as detailed below. They identified the most pressing needs in the Finney County community 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 or 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 aligned with Centura Health and the community’s existing efforts. The criteria rating rubric for this step is shown below, along with the scores assigned to each need:

Table 2. Centura Health CHNA Prioritization Method: Sample Criteria Rating

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

Guiding Considerations

Size of Health Problem should be based on baseline data collected from the community

Does it require immediate attention? What is the economic impact? What is the impact on quality of life? Is there a high hospitalization rate? Is there public demand?

Is this health need being addressed by our last CHNA? Is this health need addressed in our last CHIP? Is this health need addressed by a local public health department’s CHIP? Is this health need addressed by a strong local community organization?
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:

- **Propriety** - Is a program for the health problem suitable?
- **Economics** - Does it make economic sense to address the problem? Are there economic consequences if the problem is not carried out?
- **Acceptability** - Will a community accept the program? Is it wanted?
- **Resources** - Is funding available or potentially available for a program?
- **Legality** - Do current laws allow program activities to be implemented?

In addition to the PEARL test questions, we also considered Centura Health’s Mission and Values when considering health needs to prioritize and address. The final question we considered was whether our activities and strategies to address the health need align with 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.

St. Catherine Hospital identified three needs as priority areas that we have the ability to effectively impact. These include:

- Healthy Eating Active Living
- Behavioral Health
- Health Equity/Access to Care
Stage 3: Working with our Community to Understand and Act

We sought to engage our community in qualitative data collection. Once health needs were prioritized, the Subcommittee worked together to determine groups and individuals appropriate for focus groups, being sure to solicit input from those in the communities we serve who know the experiences of the underserved, minority, and aging populations best through personal experience or close work with them. When connecting with partners, we identified those with strong community connections and trust, including within historically underserved communities.

Next, the group identified key questions to better understand healthy eating active living, behavioral health, and health equity/access to care. Specifically, we wanted to identify focus areas, knowledge gaps, unmet needs, or current external efforts that could be improved by health care participation.
Stage 4: Developing the Implementation Plan

Once our community health needs were identified and prioritized, we began to develop an implementation plan for to address healthy eating active living, behavioral health, and health equity/access to care. The first step was to present evidence-based practices focused healthy eating active living, behavioral health, and health equity/access to care to our hospital subcommittees. Next, we completed an environmental scan to identify those established efforts in St. Catherine Hospital 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.

On September 17, 2015, the CHNA hospital leads from each Centura Health hospital attended a panel at Porter Adventist Hospital. The panel featured local experts on mental health, healthy eating, and active living initiatives:

- Shannon Breitzman, Branch Director, Injury, Suicide and Violence Prevention, CDPHE
- Doug Muir, Director of Behavioral Health Service Line, Porter Adventist Hospital
- Sarah Kurz, VP of Policy and Communication, Livewell Colorado
- Kim Patton, HRSA, Acting Deputy Regional Administrator, Mental Health
- Reg Cox, Senior Minister, Lakewood Church of Christ
- Andrea Bon-Wilson, Psychological and Behavioral Counselor, Cardiac Rehabilitation and Health Wellness, HELP for Diabetes Program, St. Anthony Hospital

The panelists spoke about available resources and programs in their communities that are impactful, and gaining traction locally, regionally, and/or statewide that address mental health and/or healthy eating and active living. They also spoke to current programming gaps in programming that health care systems or hospitals can help to address.

To create our implementation plan, we modified the Colorado Health Assessment and Planning System (CHAPS) Action Plan, provided by Colorado Department of Public Health and Environment. CHAPS is a standardized process used by local public health departments to meet the community health needs assessment and planning requirements. For each health priority we created specific, measurable, achievable, realistic, and time bound (SMART) goals, strategies, and metrics.

The Social-Ecological Model

The social-ecological model recognizes the complex interplay between individual, relationship, community, and societal factors. Individuals are responsible for making and maintaining lifestyle choices, such as healthy eating and active living. However, the ability to make these choices is determined largely by the social environment we live in (i.e., community norms, laws, policies). Barriers to healthy eating and active living are shared by the community, and removal of the barriers makes behaviors attainable and sustainable. The overlapping rings in the model illustrate how factors at one level influence factors at another level (see Figure 2). Therefore the most effective approach to impacting health outcomes is a combination of efforts at the individual, interpersonal, organizational, community, and public policy levels.

The following are examples of factors in the social-ecological model for the areas of priority for this Community Health Needs Assessment. To achieve long-term health outcomes among our communities, changes at every level of the model will both support people making the healthy choices and removing the barriers to making the healthy choices. The model makes it such that a person can leave the physician's office and their community – people and environment – will support the person in the changes recommended by the physician. It also makes it
possible for healthy choices to be supported in diverse communities or various income and race/ethnicity.

**Healthy Eating:**

Individual: Eat nine servings of fruits/vegetables daily

Interpersonal: When friends gather, there are fruits/vegetables served

Organizational: At work and in schools, vending machines and cafeterias offer fruits/vegetables

Community: Stores that sell fruits/vegetables are in all communities (e.g., food pantries, convenience stores and grocery stores)

Public policy: Women, Infants and Children Program for lower income moms can be used to purchase all healthy options within a store

1http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html

**Active Living:**

Individual: Exercise for 150 minutes/week

Interpersonal: Friends and neighbors go for walks together as a part of their routines

Organizational: At work and in schools, there are daily opportunities to get up and move for longer periods of time (e.g., breaks and recess)

Community: There are places to walk in communities that support people safely walking where they would typically go (e.g., sidewalks to stores)

Public policy: Complete Streets policies guide cities and states to create sidewalks and bike lanes along with roads

Figure 2. The Social-Ecological Model
Health in St. Catherine Hospitals’ Community

Identified Health Needs

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. Finally, we determined that the indicators related to the health need performed poorly against either the Colorado 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, in order of priority:

• Healthy Eating Active Living

• Behavioral Health

• Health Equity/Access to Care

Prioritized Health Needs

Healthy Eating/Active Living (HEAL) – Diabetes and Heart Disease Prevention

Because we have prioritized healthy eating active living, we support implementation of environmental, health systems and community-clinical linkage strategies to be implemented simultaneously and synergistically to address multiple risk factors and chronic diseases. These community efforts represent a dual approach that improves health for the whole population and for specific, selected population subgroups at high risk for experiencing disproportionate disease burden.

In our community, 22.5% of adults don’t get the recommended leisure time activity, 20.4% of adults smoke, and 83.4% of adults eat less than 5 fruits and vegetables per day. These are all risk factors for chronic diseases, such as heart disease and diabetes. In our community, 43.6% of adults are overweight, and 34.5% are obese. These numbers are much higher...
than state averages, and point to our need to improve healthy eating/active living. Our goal is to promote health, support and reinforce healthful behaviors, and build support for lifestyle improvements. We will accomplish this by:

• Develop and implement transportation and community plans that promote walking
• Strengthen community promotion and physical activity through signage, worksite policies and social support
• Strengthen healthier food access and sales in retail venues and community venues through increased availability, improved pricing and placement and promotion
• Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes
• Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change

Additionally, we will implement health system interventions and community-clinical linkages that more directly focus on populations experiencing higher risk or disproportionate disease burden. We can achieve this goal through the following:

• Increase engagement of non-physician team members (i.e. nurses, pharmacists, nutritionists, physical therapists and patient navigators/community health workers) in hypertension management in community health care systems
• Increase use of self-measured blood pressure monitoring tied with clinical support
• Increase engagement of community health workers to promote linkages between health systems and community resources for adults with high blood pressure and adults with prediabetes or at high risk for type 2 diabetes
• Implement systems to facilitate bi-directional referral between community resources and health systems, including lifestyle change programs

Behavioral Health – Violence and Substance Abuse Prevention

Behavioral Health is also an issue in our community. Almost 16% of adults report heavy alcohol consumption. Roughly 23.4% of adults report a lack of social or emotional support, compared to 15.7% in Kansas. Additionally, the rate of violent crimes reported by law enforcement is 384.5 per 100,000 residents, higher than the Kansas rate of 363.6 per 100,000.

We will address violence and substance abuse issues by promoting education on issues related to family violence by collaborating with community stakeholders to develop education, awareness events and programming in the community. The community plan to reduce and prevent family violence focuses on developing educational programs for the community to increase awareness on the prevention of multiple forms of violence. Additionally, we will:

• Work with community organizations to provide
Adverse Childhood Experiences (ACE) Training on effects of trauma and stress on children and victims of domestic violence

• Establish and sustain neighborhood learning center to increase the number of individuals who participate in family education programs

• Review workplace violence prevention and health/wellness policies for companies in Finney County

• Prevent abusive behaviors by engaging faculty, staff and students in promoting healthy relationships

We will also identify and further develop educational programming for children and parents on alcohol/drug abuse prevention. Objectives include:

• Implement Reality Tour® an evidence-based prevention program for all 10 year olds in Finney County to educate and inform pre-teens and their parents about the consequences of drug and alcohol use

Access to Care

In addition to the above prioritized health needs, Centura Health and St. Catherine Hospital recognize that access to care is a critical factor to assess, screen, and provide treatment that improves and maintains health. We have a primary duty to ensure we address barriers to access, and link our communities to the care they need.

Access to care has been a top priority for Centura Health throughout our history. Our founders recognized a community need for health care services and built the first hospitals to meet that need. More recently, we have proactively redesigned our core services and facilities to create low-cost healthcare options, including urgent care and neighborhood health centers, closer to our patient’s homes.

While not a driver of health outcomes, improving access to care is a critical factor in addressing the mental health, obesity and injury prevention needs identified in the CHNA process. As a nonprofit and faith-based hospital, St. Catherine Hospital has a mission to understand all of the potential factors that prevent members of our community from accessing the care, both mental and physical, that they need. The rising costs of healthcare can prevent members of our communities from seeking care or from continuing with the care they need. Additionally, the recent expansion of Medicaid has greatly increased the number of patients in our communities seeking specialty care. This increased demand has led to access barriers for our Medicaid populations who are typically the most vulnerable and underserved members of our community.

Centura Health continually promotes programs and services to ensure that individuals in our communities can access the care they need. Throughout the organization, we engage Community Health Advocates (CHA’s) who work with uninsured individuals or those without a primary care doctor to enroll them into coverage and link them with providers. Our goals are to increase the number of patients in our communities who have a designated primary care medical home and to decrease the number who are uninsured. We identify uninsured patients in our Emergency Departments, our community-based partner organizations, and at local events to engage them with CHA’s to guide them through the insurance enrollment process and navigation to the appropriate source of care. Once they have received the coverage they need, our Advocates refer the patients to providers so they may begin to receive high quality and consistent medical care.

Access to care is a high need in our community. According to Small Area Health Insurance Estimates, in 2012 26.3% of adults were uninsured and 10.2% of children were uninsured. This is higher than the Kansas rates of 17.6% and 7.1% respectively. In our community we understand the importance of a robust Community Health Worker program. By increasing access to healthcare, Community Health Workers seek to both prevent illness as well as reduce costs to the community by preventing more serious complications through consistent care and medical attention.

Our Community Health Workers are frontline public health workers who are trusted members of and/or have an
Health in St. Catherine Hospitals’ Community

An unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Our Health Workers also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. Their goal is to increase the number of residents who receive necessary health care services by providing community health workers. They seek to:

- Provide Diabetes Prevention Program classes in Spanish, Burmese and Somali
- Provide Hypertension screenings to community
- Provide prenatal and child development training for appropriate families
- Implement neighborhood urgent care clinic with easy access for residents of underserved areas
- Advocate for the basic healthcare needs of the community. Community Health Workers reach disparate populations in the community through the hospital and health clinics, the health department and school system, as well as local physicians and employers. Critical to the success of the intervention is the trust created between the community and the Community Health Workers.

We will also work to improve health insurance literacy and enrollment assistance for the Health Insurance Marketplace. We will:

- Provide Spanish speaking Navigator on hospital campus
- Access to Navigator through community events, flexible office hours to include evenings and weekends

Access to Mental Health Services

Inadequate access to mental health services is also a concern in the communities we serve. Centura Health has recognized this gap and is currently working with mental health partners and providers to better integrate mental health services into our hospitals, clinics, and neighborhood health centers. At St. Catherine Hospital, we are currently working with community partners to provide mental health services to our patients and our communities.

Source: Robert Wood Johnson Foundation
Other Issues Impacting Health across the State and in Our Community

Smoking

Kansas enacted the Kansas Clean Indoor Air Act which bans smoking in many public places such as restaurants, bars, places of employment, and hotels. Garden City has not extended these bans in any substantial way. There are no farmers’ markets in Finney County that accept WIC or SNAP payments.

Medicaid Expansion

Governor Sam Brownback gave the decision of expanding Medicaid to state lawmakers. The state Legislature wrapped up their session for the year on June 2, 2013, without taking action on any expansion proposals. States that are declining to expand Medicaid are passing up billions in federal funding. States would not only get the direct federal money, but would save the money that taxpayers end up spending on so-called uncompensated care. The decision not to expand Medicaid has more than financial effects. It leaves a lot of people without any inexpensive options for health insurance. A report also concluded that, “No state would experience a positive flow of funds by choosing to reject the Medicaid expansion. Because the federal share of the Medicaid expansion is so much greater than the state share, taxpayers in non-participating states will nonetheless bear a significant share of the overall cost of the expansion through federal tax payments—and not enjoy any of the benefits.”

A study by the Urban Institute says that not expanding Medicaid will cost hospitals in Kansas $2.6 billion between 2013 and 2022. Expansion of Medicaid would increase Kansas’ Medicaid costs by $525 million over 10 years but it would generate an additional $5.3 billion in federal funding.

After the rejection by state lawmakers, the Kansas Hospital Association (KHA) crafted an expansion proposal
Health in St. Catherine Hospitals’ Community

for lawmakers to consider in the 2015 session. The proposal was tailored specifically to Kansas. The alternative plans, which require federal approval, expand Medicaid coverage using federal Medicaid dollars to purchase private coverage. The KHA is also considering a number of funding options for expansion, including the possibility of raising a state assessment on hospitals to pay for Medicaid beneficiaries. This, in turn, triggers an increase in federal matching funds to the state.

The Bridge to a Healthy Kansas is the Medicaid expansion to the current KanCare program. The Bridge would extend access to health care to 150,000 Kansans. Currently, 76% of Kansans support expanding KanCare.

**Immigration and Refugees Reform**

The Chamber will provide input for legislators to help businesses hire legal guest workers. Guest workers are in demand by SW Kansas and Finney County businesses. The federal immigration system is in need of reform that allows law-abiding and responsible prospective guest workers an expeditious process for gaining employment in SW Kansas and Finney County.

There is an International Rescue Committee branch in Garden City, KS. The IRC provides opportunities for refugees to thrive in America. As newcomers doubled the population to roughly 30,000 over the last 30 years, Garden City made a collective community decision to welcome them. The town has built a well-organized network of social services offering English classes, food banks, job help, shelters, and a refugee center.

Each year, Kansas resettles approximately 350 refugees. The majority of refugees include people from three main groups: Iraqis, Bhutanese and Burmese. The Kansas Department of Health and Environment has provided cultural and historical information on their website in an effort to better provide services to these refugees.

The Refugee Health Program is one part of a comprehensive Refugee Resettlement Program administered by the Kansas Department of Health and Environment.

**Access to Providers**

Finney County is also facing challenges with access to medical providers, including primary care physicians, dentists and mental health providers. This is largely due to the fact that Garden City is a rural community. Statistics in 2014 reveal that there are more than 3,700 patients for each of the 10 primary care physicians in the county. The DHHS designates areas as having a shortage of physicians when there are at least 3,500 people per full-time doctor. The medical community is addressing these challenges through creative recruitment tools and other healthcare avenues. One way is by working with other local healthcare providers, like Plaza Medical Center in Garden City to offer new graduates assistance with the start-up of their practice, income guarantees, and relocation assistance. Another issue arises with the distribution of doctors in Kansas. It is predicted that the number of physicians in Kansas is probably adequate, and that a problem arises with maldistribution, which hurts the rural areas.

Shortage areas can also receive health personnel recruitment assistance and improved Medicare reimbursement for providers. They can also be eligible for rural health clinics and loan repayment programs for physicians, nurses, assistance and midwives. At St. Catherine, new patients are being referred to Advanced Practice Nursing Practitioners (APRNs) who are advanced practice nurses with their Master’s in differing specialties.

The issue of provider shortages links back to Kansas’ failure to expand Medicaid coverage. According to date released by the KS Dept. of Health and Environment, the 2016 average benefit for each of the 84 Critical Access Hospitals in KS would be $255,469. For each of the 16 rural, non-CAH hospitals, the average benefit would be $913,418 per hospital. For each of the 28 urban hospitals, the average benefit would be $6,255,445 per hospital. This would solve issues of budgeting and recruiting of more primary care physicians to rural areas, as well as maldistribution of physicians across Kansas.
Conclusion

Evaluation

Progress since our last CHNA

In our last assessment we prioritized healthy people/supportive community environment, improving healthy behaviors, and accessible care. We have worked collaboratively with the Finney County Public Health Department, and the Finney County Coalition, to improve health outcomes in these related areas.

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. St. Catherine Hospital will also track progress through annual community health improvement plans and community benefit reports.

Community Health Improvement Plans

The CHNA allows St. Catherine Hospital to measurably identify, target, and improve health needs in our communities. From this assessment, we will generate annual Community Health Improvement Plans to carry out strategies for the advancement of all individuals in our communities. These plans detail the specifics of implementing the strategies from the CHNA, including the prioritized needs, partnerships in the community to address those needs, goals, initiatives, and progress to date.

Community Benefit Reports

As mentioned previously, a vital aspect of our non-profit and religious hospital status is the benefit we provide to the communities. Each fiscal year, we publish our annual community benefit report that details our communities by county, their demographics, the total community benefit that we provided, and the community benefit services and activities in which we engaged. These reports are an important way to visualize the work we do in our communities and to show the programs and services we offer along with the number of people reached through them. We will continue to use these reports to track our progress with the CHNA implementation strategies because they clearly demonstrate the number of people reached through our programs and services and the resources spent to achieve our goals.

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:

Lee Ann Shrader, Executive Director Finney County Health Coalition/LiveWell Finney County,
LeeShrader@Centura.org, 620-765-1185

No written feedback from the community was received on our last Community Health Needs Assessment.
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.

• Lee Ann Shrader, Chief Executive Officer, Finney County Community Health Coalition
• Skylar Swords, Director of Public Health & Safety, Finney County
• Julie Wright, Chief Executive Officer, Genesis Family Health
• Irma Robbins, Community Health Worker, Genesis Family Health
• Sister Janice Thome, Dominican Sister, Ministry of Presence/Parents as Teachers, Garden City Schools
• Troy Unruh, Business Owner, State Farm Insurance
• Shannon Dick, Business Owner, Western Kansas Statistical Labs
• Allie Medina, Human Resources Director, City of Garden City
• Amy Longa, Site Manager, International Rescue Committee
• Debra Bolton, Extension Specialist, Family and Consumer, Kansas State University Research and Extension Center
• Beth Koksal, Wellness Supervisor, St. Catherine Hospital
• Bridget Clarke, Wellness, St. Catherine Hospital
• Janet Colson, Breastfeeding Clinic, St. Catherine Hospital
• Callie Dyer, Assistant Director, Community Health, Finney County Community Health Coalition
• Diane Garvey, Assistant Director, Behavioral Health, Finney County Community Health Coalition
• Karen Canales, Navigator Program Coordinator, Finney County Community Health Coalition
• Khaing Pyi, Community Health Worker, Finney County Community Health Coalition/Genesis Family Health
• Wahe Dar, Community Health Worker, Finney County Community Health Coalition
• Donna Gerstner, Chronic Disease Risk Reduction Coordinator, Finney County Community Health Coalition
• Renee Hulett, Director of Women’s Services, St. Catherine Hospital
Appendix A: Data Sources

American Community Survey, 2008-12
Colorado Health and Hospital Association, 2010-12
County Health Rankings, 2008-2010
County Business Patterns, 2012
Dartmouth Atlas of Health Care, 2012
National Center for Education Statistics, 2012-2013
National Center for Education Statistics, 2008-2009
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
Federal Bureau of Investigation Uniform Crime Reports, 2010-12
Health Resources and Human Services Administration, Health Professional Shortage Areas, 2014
National Center for Chronic Disease Prevention and Health Promotion, 2012
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, 2006-2010
Small Area Health Insurance Estimates, 2012
State Cancer Profiles, 2007-2011
Area Health Resource File, 2012
US Department of Health & Human Services, Health Resources and Services Administration
USDA Food Access Research Atlas, 2010
Appendix B: First Round of Data

Centura Health Data Approach

DEMOGRAPHICS: COMMUNITY & POPULATION
HEALTH DRIVERS: BEHAVIORS & ENVIRONMENT
HEALTH OUTCOMES: MORBIDITY & MORTALITY
ACCESS: COVERAGE & QUALITY CARE

Service Area Definition

- Stark versus County
- The Stark law-defined service area is defined as the lowest number of contiguous zip codes that accounts for 75% of a hospital’s inpatient admissions
  - Demographic data was gathered for Stark service areas
- County level data used for health drivers, outcome, and access data
  - Keep it consistent when we prioritize. Outcome data not available at zip code level
Data Sources

- American Community Survey
- Behavioral Risk Factor Surveillance System
- National Center for Education Statistics
- National Vital Statistics System
- State Cancer Profiles
- Bureau of Labor Statistics

St. Catherine Community

St. Catherine Hospital

DEMOGRAPHICS: COMMUNITY & POPULATION

Centura’s Communities

St. Catherine Stark Service Area

Service Area Population: 131,964

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Population in Age Range</th>
<th>Percent</th>
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<td>0-4</td>
<td>12,464</td>
<td>9.44%</td>
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<tr>
<td>5-17</td>
<td>28,232</td>
<td>21.41%</td>
</tr>
<tr>
<td>18-24</td>
<td>12,916</td>
<td>9.79%</td>
</tr>
<tr>
<td>25-34</td>
<td>17,692</td>
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<td>35-44</td>
<td>16,693</td>
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<td>45-54</td>
<td>17,251</td>
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<td>55-65</td>
<td>12,980</td>
<td>9.84%</td>
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<tr>
<td>65+</td>
<td>13,745</td>
<td>10.42%</td>
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Source: American Community Survey, 2008-12
**Appendix B: First Round of Data**

**HEALTH DRIVERS: BEHAVIORS & ENVIRONMENT**

**Population with Associate Level Degree or Higher**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>31.8%</th>
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<tr>
<td>Kansas</td>
<td>37.9%</td>
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<table>
<thead>
<tr>
<th>High School Graduation Rates</th>
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<tbody>
<tr>
<td>Service Area</td>
</tr>
<tr>
<td>66.5%</td>
</tr>
<tr>
<td>Kansas</td>
</tr>
<tr>
<td>80.2%</td>
</tr>
<tr>
<td>Healthy People 2020</td>
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<td>82.4%</td>
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**Health Behaviors**

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<tr>
<th>Adults reporting heavy alcohol consumption</th>
<th>Adults eating less than 5 fruits and vegetables daily</th>
<th>Current smokers</th>
<th>Adults with no leisure time physical activity</th>
</tr>
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<tbody>
<tr>
<td>Service Area</td>
<td>15.9%</td>
<td>83.4%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Kansas</td>
<td>15.9%</td>
<td>80.9%</td>
<td>17.7%</td>
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</table>

**Environment**

<table>
<thead>
<tr>
<th>Liquor Store Access Per 100,000 Population</th>
<th>Low Income Population with Low Food Access</th>
<th>Recreation and Fitness Facility Access Per 100,000 Population</th>
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<tbody>
<tr>
<td>Service Area</td>
<td>29.9</td>
<td>11.8%</td>
</tr>
<tr>
<td>Kansas</td>
<td>21.4</td>
<td>8.9%</td>
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</table>

**Health Outcomes: Morbidity & Mortality**

<table>
<thead>
<tr>
<th>Air Quality/Ozone Percentage of Days With Ozone Levels Exceeding Standards</th>
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<tbody>
<tr>
<td>Service Area</td>
</tr>
<tr>
<td>0.0%</td>
</tr>
<tr>
<td>Kansas</td>
</tr>
<tr>
<td>0.0%</td>
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</table>

<table>
<thead>
<tr>
<th>Violent Crime Rate of Violent Crime Reported by Law Enforcement per 100,000 Residents</th>
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<tbody>
<tr>
<td>Service Area</td>
</tr>
<tr>
<td>384.5</td>
</tr>
<tr>
<td>Kansas</td>
</tr>
<tr>
<td>363.6</td>
</tr>
</tbody>
</table>

Source:
- American Community Survey, 2008-12
- National Center for Education Statistics, 2006-09
- Behavioral Risk Factor Surveillance System, 2005-09
- Behavioral Risk Factor Surveillance System, 2006-09
- National Center for Chronic Disease Prevention and Health, 2012
- County Business Patterns, 2012
- USDA Food Access Research Atlas, 2010
- Federal Bureau of Investigation Uniform Crime Reports, 2010-12
Appendix B: First Round of Data
**Uninsured Children Under Age 19**

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Population Without Medical Insurance</th>
<th>Percentage Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Area</strong></td>
<td>43,246</td>
<td>4,428</td>
<td>10.2%</td>
</tr>
<tr>
<td><strong>Kansas</strong></td>
<td>746,446</td>
<td>52,764</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Source: Small Area Health Insurance Estimates, 2012

---

**Access: Mental Health**

<table>
<thead>
<tr>
<th></th>
<th>Age-Adjusted Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Area</strong></td>
<td>23.4%</td>
</tr>
<tr>
<td><strong>Kansas</strong></td>
<td>15.7%</td>
</tr>
</tbody>
</table>

Source: Behavioral Risk Factor Surveillance System, 2006-12

---

**Access: Quality Care**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Service Area</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mammogram</strong></td>
<td>58.4%</td>
<td>58.4%</td>
</tr>
<tr>
<td><strong>Pap Test</strong></td>
<td>70.8%</td>
<td>70.8%</td>
</tr>
<tr>
<td><strong>Sigmoidoscopy or Colonoscopy</strong></td>
<td>48.0%</td>
<td>48.0%</td>
</tr>
</tbody>
</table>

Source: Dartmouth Atlas of Health Care, 2012

---

**Access: Oral Health**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Dental Care Utilization</strong></td>
<td>28.1%</td>
</tr>
<tr>
<td><strong>Poor Dental Health</strong></td>
<td>10.7%</td>
</tr>
</tbody>
</table>


---

**Access: Quality Care**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults Without a Regular Doctor</strong></td>
<td>35.0%</td>
</tr>
<tr>
<td><strong>Access to Primary Care</strong></td>
<td>53.8%</td>
</tr>
</tbody>
</table>


---

**Access: Quality Care**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Management</strong></td>
<td>85.5%</td>
</tr>
<tr>
<td><strong>High Blood Pressure Management</strong></td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Source: Dartmouth Atlas of Health Care, 2013

---

Appendix B: First Round of Data
### ACCESS: QUALITY CARE

**Pneumonia Vaccination**
- Percentage of adults 65 and over who have received

| Service Area | Kansas | 68.8% |

*Behavioral Risk Factor Surveillance System, 2006-2012*

**Preventable Hospital Events**
- Discharge rate per 1,000 Medicare enrollees for ambulatory-sensitive events

| Service Area | Kansas | 59.8 |

*Source: Dartmouth Atlas of Health Care, 2012*

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### Centura Health Data Approach

- **Demographics**
  - Community
  - Population
- **Health Drivers**
  - Behaviors
  - Environment
- **Health Outcomes**
  - Morbidity
  - Mortality

- **Access**
- **Coverage**
- **Quality Care**