

# AdventHealth Durand

## 2020-2022

### COMMUNITY HEALTH PLAN



Chippewa Valley Hospital & Oakview Care Center, Inc. d/b/a AdventHealth Durand

**Approved by Hospital Board on:** May 7, 2020

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Extending the Healing  
Ministry of Christ



# 2020-2022 COMMUNITY HEALTH PLAN

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## Acknowledgements

This community health plan was prepared by Tali Schmitz with contributions from members of AdventHealth Durand Community Health Needs Assessment Committee representing health leaders in the community and AdventHealth Durand leaders.

A special thanks to The Pepin County Health Department and Partners for their expertise and support in the collection and analysis of the data.

We are especially grateful for the internal and external partners who helped guide the development of the community health plan, which will enable our teams to continue fulfilling our mission of *Extending the Healing Ministry of Christ*.

# OVERVIEW

Chippewa Valley Hospital & Oakview Care Center, Inc d/b/a AdventHealth Durand will be referred to in this document as AdventHealth Durand or the “Hospital.”

## Community Health Needs Assessment Process

AdventHealth Durand, in Durand, Wisconsin conducted a community health needs assessment in 2019. The assessment identified the health-related needs of the community including low-income, minority and other underserved populations.

In order to ensure broad community input, AdventHealth Durand created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met throughout 2018-2019. The members reviewed the primary and secondary data, helped define the priority issues to be addressed by the Hospital and helped develop the Community Health Plan (CHP) to address the priority issues.

The CHP lists targeted interventions and measurable outcomes for each priority issue noted below. It includes resources the Hospital will commit and notes any planned collaborations between the Hospital and other community organizations and hospitals.

## Priority Issues to be Addressed

The priority issues to be addressed include:

1. Chronic Disease Management
2. Healthy Growth, Development and Obesity (Food, Nutrition, and Physical Activity)

*See Section 3 for goals, objectives and next steps for each priority selected to be addressed.*

## Priority Issues not to be Addressed

The priority issues that will not be addressed include:

1. Substance Use
2. Mental Health

*See Section 4 for an explanation of why the Hospital is not addressing these issues.*

## **Board Approval**

On May 7, 2020, the AdventHealth Durand Board approved the Community Health Plan (CHP) goals, objectives and next steps. A link to the 2020 Community Health Plan was posted on the Hospital's website prior to May 15, 2020. The Community Health Plan can be found at <https://www.adventhealth.com/community-health-needs-assessments>.

## **Ongoing Evaluation**

AdventHealth Durand's fiscal year is January – December. Implementation of the 2020 CHP begins upon its approval by the Board. The first annual evaluation will begin from the date of implementation through the end of the calendar year. Evaluation results will be attached to the Hospital's IRS Form 990, Schedule H. The collective monitoring and reporting will ensure the plan remains relevant and effective.

## **For More Information**

Learn more about the Community Health Needs Assessment and CHP for AdventHealth Durand at <https://www.adventhealth.com/community-health-needs-assessments>.

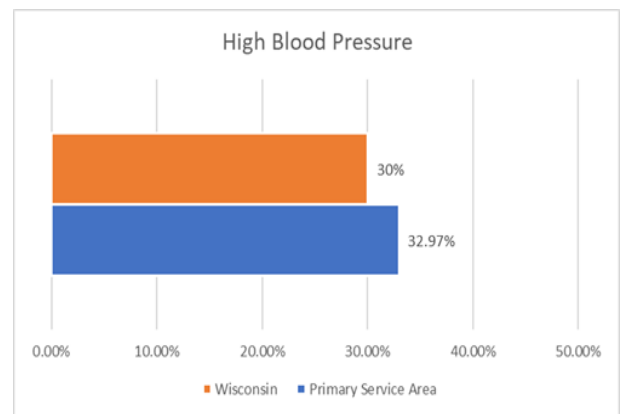
# CHP PRIORITY 1

## Chronic Disease Management

According to the Centers for Disease Control and Prevention (CDC), chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention and/or limit activities of daily living. Nearly half of Americans suffer from at least one form of chronic disease. Six in 10 Americans have a chronic disease such as heart disease, cancer or diabetes, which are the leading causes of death and disability in the United States. In the Hospital’s Primary Service Area (PSA), heart disease and diabetes diagnoses are higher than that of the state. These diseases affect more than one in two adults in the United States. It is estimated that 47% of the United States population will have at least one chronic condition by 2020.

According to secondary data, 35.29% of adults in the Hospital’s PSA have high cholesterol and 32.97% have high blood pressure. When chronic disease goes untreated, it can lead to more serious health issues. For example, untreated diabetes may lead to vision loss, heart disease or nerve and kidney diseases.

The Centers for Disease Control and Prevention notes that more than two-thirds of deaths are due to chronic disease. Most chronic diseases can be prevented by healthy eating, being physically active, getting health screenings and avoiding both excessive drinking and tobacco use. By making chronic disease management a top priority, the impact of implementing preventative measures are of high value both to individuals and to the community at large.



<b>Goal</b>	<b>Improve knowledge around diabetes and the impact of lifestyle choices on diabetic conditions for community members.</b>
<b>Objective</b>	Use curriculum from the Centers for Disease Control and Prevention’s (CDC) National Diabetes Prevention Program to provide 10 classes for the community by the end of year three.
<b>Objective</b>	Engage and educate 60 community members using the CDC curriculum by the end of year three.
<b>Objective</b>	Provide pre and post biometrics screenings for class participants to measure effectiveness of curriculum and lifestyle changes.
<b>Objective</b>	Establish two new community partners by the end of year three to partner with as potential sites for diabetes program.
<b>Objective</b>	Host three health talks focused on diabetes and lifestyle choices for community members by the end of three.

## **Hospital Contributions**

- Sponsor cost for staff dietician to certify in CDC diabetes curriculum.
- Provide dietician to teach CDC curriculum.
- Cover costs for all educational materials for diabetes classes.
- Provide free biometric screenings for program participants.

## **Community Partners**

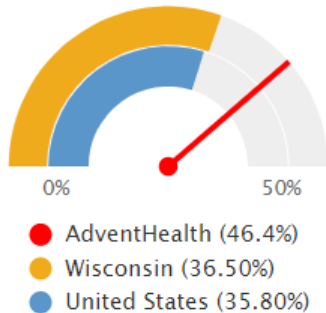
- Identify partners to serve as potential sites for diabetes program.

## CHP PRIORITY 2

# Healthy Growth, Development and Obesity

Also referred to as Food, Nutrition and Physical Activity, the Hospital's CHNAC combined Obesity and Healthy Eating/Access to Health Foods into one category in order to focus efforts on two interconnected issues.

Percent Adults Overweight



The state of Wisconsin has seen an increase in the rate of obesity in adults from 26% to 31% from 2008 to 2018. Additionally, according to secondary data 46.4% of adults in the Primary Service Area (PSA) have self-reported that they have a BMI between 25.0 and 30.0 (the BMI range that is to be considered overweight), which is higher than that of the state at 36.5%. Obesity was ranked as one of the top two risk factors for community members' health by community stakeholders in interviews.

The availability of healthy, affordable foods contributes to a person's diet and risk of related chronic disease. According to the Centers for Disease Control and Prevention (CDC), fewer than one in 10 children and adults eat the recommended daily amount of vegetables.

The American Heart Association recommends 30 minutes of aerobic exercise three to four times a week. Physical inactivity is defined as achieving less than the recommended amount of exercise. Inactivity during childhood and adolescence increases the likelihood of being inactive as an adult. Adults who are less active are at greater risk of dying of heart disease and developing diabetes, colon cancer and high blood pressure. Half of American youth aged 12-21 are not vigorously active on a regular basis, and 14% of young people report no recent physical activity. Participation in all types of physical activity declines with both age and grade in school. Secondary data reported that 20% of adults in the PSA receive no leisure time or physical activity.

Factors that have shown to promote healthy behaviors include: easy access to nutritious food; clean air and water; safe transportation; healthy spaces for walking, playing and socializing; schools that equip youth with important health skills; and health care that prevents as well as treats and rewards for healthy behaviors over risky ones.

The above factors are determined based on shared decisions and actions, not just individual behaviors. Those who must help implement these decisions work in many fields, extending far beyond the health care sector. Through education and increased access to healthy foods, community members are positioned to achieve and maintain a healthy weight and lifestyle, which are critical components to overall health outcomes.

<b>Goal</b>	<b>Sponsor annual events for community members that promote exercise, activity and healthy lifestyle.</b>
<b>Objective</b>	Provide funding and in-kind staff support to host annual “fun runs” for children, teenagers and adults for a total of three by the end of year three.
<b>Objective</b>	Host two health talks a year focused on exercise, nutrition and healthy cooking for the community for a total of six by the end of year three.
<b>Goal</b>	<b>Empower community members to improve health outcomes through education.</b>
<b>Objective</b>	Provide free biometric screenings for up to 100 community members annually.
<b>Objective</b>	Refer community members when appropriate to free hospital sponsored CDC diabetes program.

## Hospital Contributions

- Funding for community events.
- Costs for biometric screenings.
- Staff to provide biometric screenings.
- Educational materials and food for health talks.
- Staff to host community health talks.

## Community Partners

- Local schools to engage youths for fun runs.
- Local businesses to offer biometric screenings.



# PRIORITIES THAT WILL NOT BE ADDRESSED

The Community Health Needs Assessment also identified the following priority health needs that will not be addressed. These specific issues and an explanation of why the Hospital is not addressing them, are listed below.

## **1. Substance Use/Abuse<sup>1</sup>**

The CHNAC agreed that the issues of alcohol abuse, electronic smoking, illegal drugs and tobacco use were all important issues based on both primary and secondary data as well as group discussions. The term Substance Use/Abuse was utilized to encompass various forms of use or misuse. The Community Asset Inventory identified existing community-based efforts already in place to address these issues. These include the Pepin and Buffalo County Justice Services, which helps low-risk crime offenders with alcohol/substance abuse. In addition, the Pepin County Health Department has partnered with the school district to address substance use and misuse. The Hospital will continue to direct community members to available resources in the community.

## **2. Mental Health**

Eau Claire and Chippewa County both provide inpatient and outpatient services through Chippewa County Recovery & Wellness Consortium. The Consortium connects individuals experiencing a mental health emergency, mental illness and or substance use disorder with necessary services such as psychiatry, mental health and substance abuse counseling, supported employment and individual skill development. The Hospital felt that these existing resources and partners were better equipped to address the issue of Mental Health. The Hospital is committed to whole person health and will continue to direct the community to available resources.

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<sup>1</sup> Substance Use/Abuse includes Alcohol Abuse, E-Cigarettes, JUUL, Vaping, Illegal Drugs, and Tobacco.