Adventist Midwest Health
A Member of Adventist Health System

Community Health Needs Assessment

2013

Chippewa Valley Hospital & Oakview Care Center

Durand, Wisconsin

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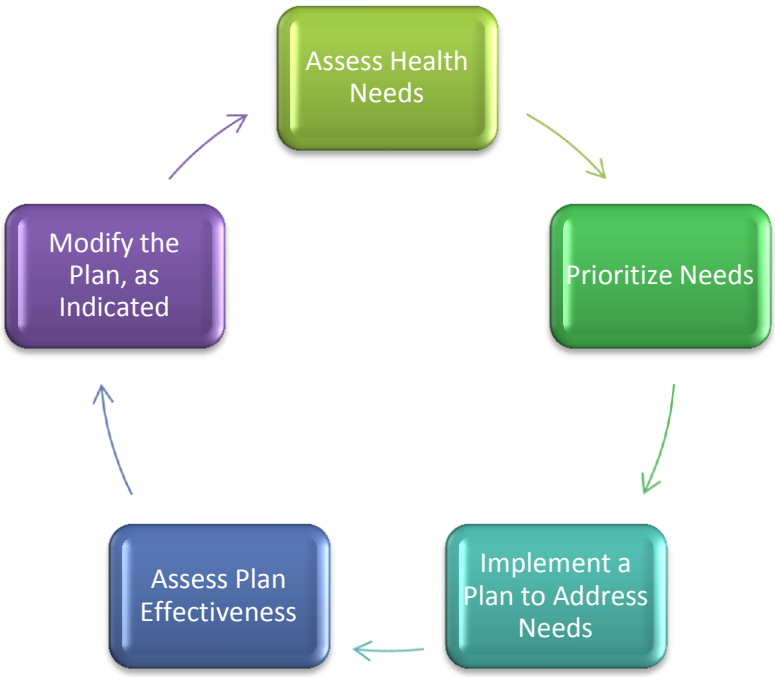
Project Goals

Simply put, a Community Health Needs Assessment is the ongoing process of evaluating the health needs and assets of a community. It is systematic and it is data-driven. Assessment outcomes are analyzed to understand the health status, behaviors and needs of residents in the community. Identified health needs are prioritized so that effective plans may be put in place to address the most critical health needs.

The process is perpetual. Community needs change. Well-implemented plans lead to opportunities to address other, more salient needs. One must assess needs, prioritize needs, implement a plan, assess plan effectiveness, modify the plan if indicated, and again assess the needs. Each cycle of this process, each "turn of the wheel," allows an organization to drill down to a deeper understanding of how it can position itself to be the best community health asset possible.



Expected Outcomes

Community Health Needs Assessments must ultimately result in Community Benefit. It is the expectation of Adventist Midwest Health's Chippewa Valley Hospital that our continued systematic approach to study Community need will continue to result in benefit to the Community.

The Catholic Health Association, in *A Guide for Planning and Reporting Community Benefit* ISBN 0-87125-282-1, defines community benefit as programs or activities that provide treatment or promote health and healing as a response to identified community needs and meet at least one of the four objectives below. Accordingly, and in response to the force of our Mission and our commitment to the needs of our Community, our Community will appreciate direct and meaningful benefit from our hospitals in response to this Community Health Needs Assessment.

Improved Access to Healthcare Services

Enhance population health

Advance increased general knowledge

Reduce the burden of government to improve health

Executive Summary

Adventist Midwest Health is a network of five not-for-profit hospitals in Chicago's western and southwestern suburbs (4) and west-central Wisconsin (1).

As a part of the Adventist Health System, Adventist Midwest Health brings a long tradition of health care to Illinois and Wisconsin. Our national network of 44 campuses in 10 states makes us part of the largest not-for-profit Protestant hospital system in the country. We take a holistic, "whole-person" approach to wellness, providing medical and spiritual support for our patients and their families.

Chippewa Valley Hospital & Oakview Care Center, Inc. ("CVH") in west-central Wisconsin, is the only hospital in Pepin County, providing essential healthcare to county residents; care that would otherwise require many miles and critical moments to obtain. It is a 25-bed Critical Access Hospital with an attached 50-bed long-term care facility. Critical Access Hospitals are a result of legislation enacted as part of the Balanced Budget Act (BBA) of 1997, which authorized States to establish a State Medicare Rural Hospital Flexibility Program under which certain facilities participating in Medicare were able to be defined as "Critical Access Hospitals", with a separate payment system and obligations under the Medicare Conditions of Participation. Of the many requirements for this designation are location in a rural area, provision of 24/7 emergency care, and no more than 25 inpatient/swing beds with at least a 35-mile separation from the nearest hospital. CVH is a not-for-profit health care organization, and embraces a rich tradition of providing benefit to the community, with the ultimate goal of improving community health and increasing access to care. All of the net income (profit margin) generated by the hospital is reinvested back into hospital programs and services. This benefits the patients and communities served rather than individual owners or shareholders.

Under new federal regulations that govern charitable hospital organizations, a Community Health Needs Assessment ("CHNA") was conducted by CVH to assist in identifying the most significant health needs of the community served. The Hospital, as the only hospital in Pepin County, worked directly and collaboratively with Pepin County to assess community need and is now working to implement a plan to effectively meet the needs identified during that assessment. The resulting full Community Health Needs Assessment was approved by the Hospital Board in 2013. This CHNA will serve to guide the next phase of the Community Health Needs Assessment Process: Development of an Implementation Strategy to address these identified needs.

Chippewa Valley Hospital Community - Defined

This CHNA assessed needs specific to Pepin County residents – the community served by CVH. 250 residents participated in the CHNA, representing the demographic makeup of the Community. For the purpose of this Community Health Needs Assessment, the CVH Community is defined by the zip codes that make up Pepin County.

Methodology

Data collection, aggregation and analysis were completed with the goal of identifying the top presenting healthcare needs in the CVH Community. Pepin County, in conjunction with CVH, created a Committee of Community Health Improvement Process Stakeholders ("CHIPS") that represented the broad community as well as low income, minority and underserved populations. Five representatives from CVH served on this Committee, along with representatives from the health clinics located on the hospital campus. CHIPS worked cooperatively to analyze the data and prioritize the issues to be addressed by those in the Community with the appropriate resources and expertise.

1. **Data Collection:** A Community Health Assessment Survey was developed and distributed to Pepin County community members. Care was taken in all data collection to promote participation by a representative sample of the community, including medically underserved, low-income and minority populations. Over 250 responses were received, providing valuable data on self-identified health issues and needs. Secondary quantitative and qualitative data were collated and analyzed from county, state, and national sources (Death Certificate Review Summary, Health Rankings report, Healthiest Wisconsin 2020, Healthy People 2020, etc).

2. **Data Aggregation:** Key health indicators identified through both primary and secondary data collection were collated and categorized so that data comparisons across sources could be made.

3. **Data Analysis:** CHIPS was presented with the key health indicators accounting for primary and secondary data (both qualitative and quantitative) CHIPS (including hospital executives, clinical experts, hospital strategic planning and marketing staff, and community members representing the broader interests of the Community) participated in a data analysis and formal prioritization process using analysis tools to support decision-making. The key health indicators that initially fell out as potentially problematic were compared to additional secondary data sources for additional support.

Input from those Served

The CHNA was conducted under the premise that primary source data was mandatory (collecting first-hand data directly from the individuals living in our Community). Care was taken to assure the individuals sampled for primary source data collection represented the Community demographics.

Prioritization

Top identified needs:

- **Access to Primary and Preventative Care:** Access to care is one of the most pressing

health issues in America today. It has a cumulative effect on the health and wellness of community members in all health need categories. CVH recognizes the important role it plays in Pepin County. Without the existence of this Critical Access Hospital, the health and well-being of community residents would be markedly impacted. Viability of this institution is critical, with need for analytical expertise in navigating the realities of shrinking reimbursement with continued commitment to providing expert healthcare to meet community needs. Access to care is further limited by the lack of insurance for those seeking care. A viable, state-of-the-art facility is of little benefit to the community if those within the community lack the resources to access that healthcare.

- **Chronic Disease Management:** Chronic conditions are defined as conditions that are long-term, do not go away on their own, are rarely healed and can result in disability of some form. Examples are heart disease, chronic kidney disease and diabetes; the leading causes of both death and disability in the United States. Preventive measures to curb chronic disease may be implemented with relative ease, and the impact of implementing preventive measures is of high value both to individuals and to the community at large.

- **Alcohol and Other Substance Abuse:** Wisconsin is above the national average in percentage of alcohol use among adults at roughly 79%, whereas the national average is 55%. According to Healthiest People 2020, alcohol-related deaths are the fourth leading cause of death in Wisconsin. Alcohol or drug abuse may lead to motor vehicle and other injuries; fetal alcohol spectrum disorder and other childhood disorders; alcohol- and drug-dependence; liver, brain, heart and other diseases; infections; family problems; and both nonviolent and violent crimes. Unhealthy alcohol and drug use means any use of a substance that result in negative consequences. These substances include alcohol, prescription drugs and illegal mood altering substances.

- **Healthy Growth and Development (Food, Nutrition and Physical Activity):** The rate of Wisconsin adult obesity increased from 20 percent to 26 percent from 2000 to 2008 (Wisconsin Department of Health Services, Track 2010). **"**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 health care that prevents as well as treats; rewards for healthy behaviors over risky ones—these are goods created through shared decisions and actions, not just individual behaviors. Those who must help make and implement these decisions work in many fields, extending far beyond the health care sector."

  Source: Wisconsin Department of Health Services, Division of Public Health, Office of Policy and Practice Alignment. *Healthiest Wisconsin 2020: Everyone Living Better, Longer.*
  A State Health Plan to Improve Health Across the Life Span, and Eliminate Health Disparities and Achieve Health Equity. P-00187. July 2010.

  Food, nutrition and physical activity were identified by CHIPS as a necessary component

of any improvement plan in light of the impact these factors have on Chronic Disease Management. Specific and purposeful goals and objectives would improve general health, prevent chronic disease, and improve the quality of life for those individuals already living with chronic disease.

Measures and Resources

CVH, in cooperation with Pepin County Health Department and members of CHIPS will develop a Community Health Plan (implementation strategy) based on the health priorities noted above. Measures of success for each identified health need priority will be developed by the CHIPS following a full review and discussion of related implications.

Pepin County is home to many residents with unmet health needs. Healthcare resources, while present, are limited in number due to the rural location of the county. Work under the expert direction of Pepin County Health Department provides both resources and informational guidance to promote benefit to the Community for selected measures.
Key to successfully meeting health needs identified in this CHNA is leveraging the services and resources that are available in a coordinated manner that has the highest impact on community health. To that end, CVH will work collaboratively with Pepin County and CHIPS to implement improvement strategies in a meaningful way. Mechanisms of partnership include active participation in CHIP'S efforts to unite stakeholders across Pepin County with the ultimate goal of aligning benefit activities.

Our Vision

CVH is a critical access hospital and long-term care center of outstanding quality. We work as a partner with patients, families, and healers to achieve optimal health for our patients and the community we serve. We provide unsurpassed value by using practices based on the most up-to-date evidence and by coordinating comprehensive care for every patient in a highly personal environment.

Our Mission

Our Values

Excellence:

For quality care and service with optimal outcomes that seek to exceed patient expectatation

Christian Service Motivation:

Offering compassion, respect, and the belief that every life has value.

Stewardship:

Enhancing staff development, nurturing the environment, conserving resources, and offering value for services

Integrity:

That generates trust, and offers consistency in decision-making.

Our Community; Our Commitment

By David L. Crane, President/Chief Executive Officer, Adventist Midwest Health

"Every live man with a gift must divide it with others, or pay the penalty of having it shrink away and finally shrivel up altogether … it is what we give away that we really keep."

Dr. David Paulson (1904)

Within Adventist Midwest Health hospitals, there is a special effort in place to create memorable experiences for our patients and for our community. We want those we serve to feel God's compassion, grace and truth through our hands, giving them hope and healing.

We call this effort Transforming Care ~ Transforming Lives. But what does this really mean? When Jesus healed, he focused on transforming the lives of those he touched. This is our commitment to our patients and our community. We want to transform lives through the care, compassion and expertise provided by our employees, nurses and physicians. Each day, these care providers apply the gifts they bring to make a positive change in peoples' lives.

This is such an important assignment. It's not one I take lightly. In order to fulfill our mission of extending the healing ministry of Christ, we work as partners to achieve optimal health for our patients and the community we serve. We do this in the midst of a changing healthcare environment. Reimbursement changes and reform are creating a highly competitive healthcare market demanding that hospitals reduce costs and improve quality and safety. Hospitals that don't change to meet new industry demands will not survive. We have a once in a lifetime chance to re-create our organization so we can survive in this radically new healthcare environment and continue our commitment to our patients and to community.

About our Hospital:

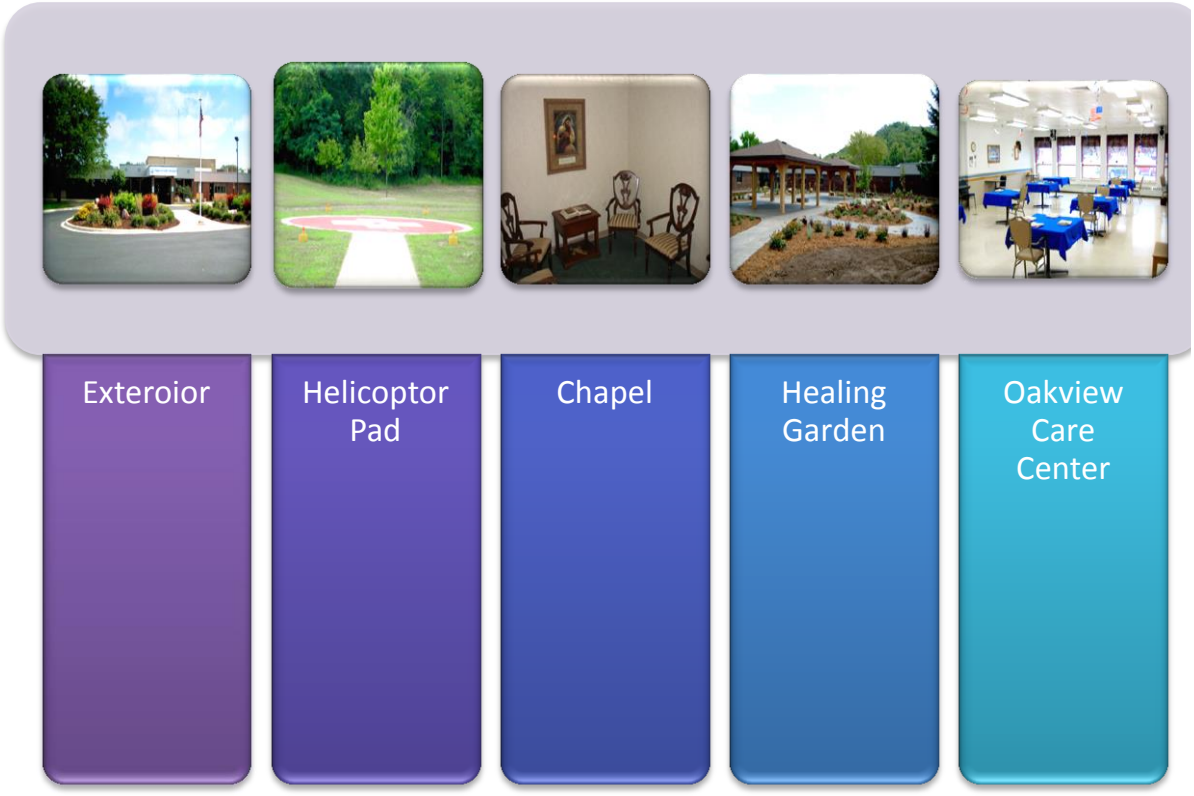
Chippewa Valley Hospital & Oakview Care Center

Durand, WI

Doug Peterson, CEO

CVH brings a community feel with top quality health care professionals and technology. Comprehensive and critical medical services are available to the Pepin County community, including 24/7 Emergency Services that are provided to all individuals, regardless of ability to pay.

Our Facilities:



Our Services:

Gastroenterology

Imaging

Laboratory

24/7 Emergency

Cardiac Rehab

Clinics

Long-term Care

Rehabilitation Services

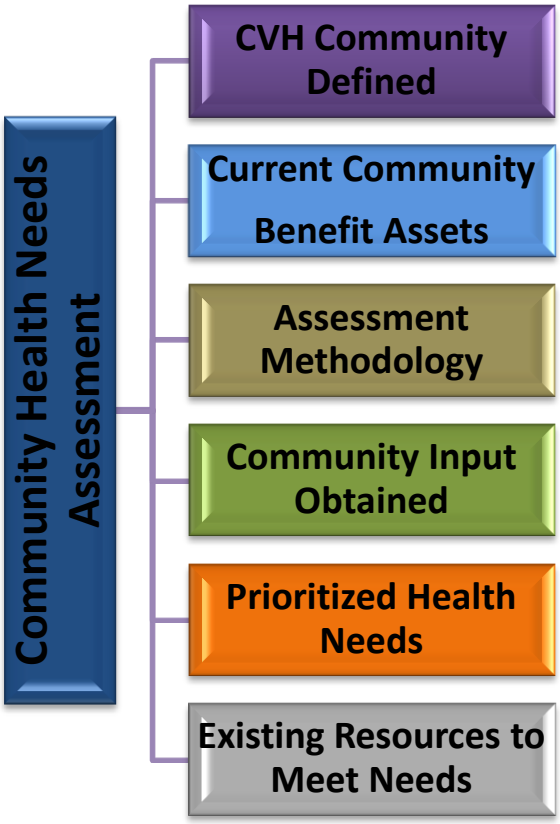
Sleep Disorders

Surgical Services

Assessment Report Components

This Community Health Needs Assessment Report documents steps taken by CVH, in cooperation with Pepin County Health Department and other stakeholders, to capture representative, reliable, and comprehensive information on the health needs and assets of the Community.

The Report, in total, provides readers with a comprehensive view of presenting health needs and CVH's identified priorities for taking action. It also serves as an organizational tool for developing a plan to address identified needs and ultimately effectively guiding benefit to most appropriately impact our Community's health. Report components are below.



The CVH Community

Our Community - Defined

"Bear one another's burdens, and so fulfill the law of Christ."
Galatians 6:2

For the purpose of this Community Health Needs Assessment, CVH Community is defined by the zip codes within Pepin County. Community members receive "safety net" and general inpatient/outpatient services at CVH. Safety net services are those services which generate a low or negative margin and would not be provided if the decision was based purely on financial indicators. Safety net services include emergency care. As a not-for-profit health care provider, our commitment is to provide necessary healthcare services to the Community we serve, even when revenue for necessary service is not appreciated.

Pepin County Zip Codes:

Zip Code	City
54721	Arkansaw
54736	Durand
54759	Pepin
54769	Stockholm

Pepin County Statistics

Source: USA.com http://www.usa.com/pepin-county-wi-population-and-races.htm#PopulationbyRaces

General County Data

Pepin County is located in west Wisconsin. Pepin County has 231.98 square miles of land area and 16.71 square miles of water area. As of 2010, the total Pepin County population is 7,469, which has grown 3.55% since 2000. The population growth rate is lower than the state average rate of 6.03% and is much lower than the national average rate of 9.71%. Pepin county median household income is $48,446 in 2006-2010 and has grown by 28.81% since 2000. The income growth rate is much higher than the state average rate of 11.90% and is much higher than the national average rate of 19.17%. Pepin county median house value is $138,500 in 2006-2010 and has grown by 74.87% since 2000. The house value growth rate is higher than the state average rate of 50.98% and is higher than the national average rate of 50.42%. As a reference, the national Consumer Price Index (CPI) inflation rate for the same period is 26.63%. On average, the public school district that covers Pepin County is close to the state average in quality.

Data Point	Statistic
Population	7,469 (2010), rank #69
Population Growth	3.55% since 2000, rank #37
Population Density:	30.03/sq mi, rank #48
Median Household Income:	$48,446 at 2006-2010—28.81% increase since 2000, rank #30
Median House Price:	$138,500 at 2006-2010—74.87% increase since 2000, rank #40
Time Zone:	Central GMT -6:00 with Daylight Saving in the Summer
Land Area:	231.98 sq mi, rank #72
Water Area:	16.71 sq mi (6.72%), rank #51
State:	Wisconsin
School District:	
Area Code:	715

Race

Pepin County is racially homogenous community, with residents primarily white (98%), born within the United States (99%), and speaking English as a primary language at home (95%).

White:	7,337 (98.23%)
Black:	21 (0.28%,)
Hispanic:	72 (0.96%,)
Asian:	13 (0.17%,)
Native (American Indian, Alaska Native, Hawaiian Native, etc.):	20 (0.27%,)
One Race, Other:	35 (0.47%,
Two or More Races:	43 (0.58%,

Place of Birth and Citizenship

	Pepin County	%	Wisconsin	U.S.
Native	7,456	99.19%	95.42%	87.28%
Born in the State of Residence	4,915	65.39%	71.70%	58.66%
Born in Different State	2,490	33.12%	23.04%	27.28%
Born in Puerto Rico, U.S. Island Areas, or Born Abroad to American Parent(s)	51	0.68%	0.68%	1.33%

Foreign Born	61	0.81%	4.58%	12.72%
Foreign Born with U.S. Citizenship	16	0.21%	1.88%	5.48%
Foreign Born without U.S. Citizenship	45	0.60%	2.70%	7.24%
Born In Europe	27	0.36%	0.92%	1.59%
Born In Asia	6	0.08%	1.42%	3.54%
Born In Africa	0	0.00%	0.15%	0.48%
Born In Oceania	0	0.00%	0.02%	0.07%
Born In Latin America	28	0.37%	1.93%	6.77%
Born In Northern America	0	0.00%	0.13%	0.27%

*Based on 2006-2010 data.

Language Spoken at Home

	Pepin County	%	Wisconsin	U.S.
English	2,928	94.70%	90.64%	79.95%
Spanish	70	2.26%	4.65%	11.42%
Other Indo-European Languages	81	2.62%	3.09%	4.60%
Asian and Pacific Islander Languages	11	0.36%	1.26%	3.14%
Other	2	0.06%	0.36%	0.89%

*Based on 2006-2010 data. View historical language spoken at home data.

Population by Gender

Male: 3,780 (50.61,)
Females: 3,689 (49.39%)

Pepin County	**Male: 50.61%**
	Female: 49.39%
Wisconsin	Male: 49.63%
	Female: 50.37%
U.S.	Male: 49.16%
	Female: 50.84%

Population by Age

Pepin County Residents have a median age that is older than both the State and the United States. The highest concentration of residents falls within the range of 45-54 years of age. This is consistent with both State and United States statistics.

Median Age

Pepin County	44.10 years old
Wisconsin	38.50 years old
U.S.	37.20 years old

Median Age, Male

Pepin County	43.30 years old
Wisconsin	37.30 years old
U.S.	35.80 years old

Median Age, Female

Pepin County	44.80 years old
Wisconsin	39.60 years old
U.S.	38.50 years old

Age Range Concentration

	Pepin County	% of the Total Population	Wisconsin	U.S.
Under 5 years	468	6.27	6.30%	6.54%
5 to 9 years	438	5.86%	6.48%	6.59%
10 to 14 years	481	6.44%	6.61%	6.70%
15 to 19 years	488	6.53%	7.02%	7.14%
20 to 24 years	317	4.24%	6.80%	6.99%
25 to 34 years	746	9.99%	12.69%	13.30%
35 to 44 years	893	11.96%	12.76%	13.30%
45 to 54 years	1,199	16.05%	15.36%	14.58%
55 to 64 years	1,102	14.75%	12.31%	11.82%
65 to 74 years	673	9.01%	7.04%	7.03%
75 to 84	457	6.12%	4.54%	4.23%
85 years and over	207	2.77%	2.08%	1.78%

Education for those 25 Years and Over

	Pepin County	%	Wisconsin	U.S.
Total 25 Years and Over Population	5,214	100%	3,739,243	199,726,659
Less Than High School	598	11.47%,	10.57%	14.97%
High School Graduate	2,168	41.58%,	34.03%	28.99%
Some College or Associate Degree	1,551	29.75%,	29.61%	28.14%
Bachelor Degree	652	12.50%,	17.15%	17.60%
Master, Doctorate, or Professional Degree	245	4.70%,	8.65%	10.30%
USA.com Education Index[#]	12.97	-	13.46	13.39

*Based on 2006-2010 data.

Community Benefit Assets

"Seek the peace and prosperity of the city to which I have carried you … because if it prospers, you too will prosper."

Jeremiah 29:7

Chippewa Valley Hospital Community Health Commitment

CVH has a rich tradition of Community giving. We are committed advocates of our Community's health.

Prioritizing Health Service for those in Poverty

Medically Underserved Area/Population and Critical Access Hospital: The Durand City Service Area was designated by the Federal Government as a "Medically Underserved Area/Population" ("MUA/P") in 1994. Medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial or other barriers. CVH offers a breadth of safety net services that serve a critical role in healthcare delivery to the surrounding community; care that may mean the difference between life and death when life-threatening health issues arise.

Source: http://muafind.hrsa.gov/index.aspx

Criteria:

State: Wisconsin
County: Pepin County
ID #: All

Results: 4 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Pepin County					
Durand City Service Area	03825	MUA	54.33	1994/05/12	
MCD (21225) Durand city					
MCD (61950) Pepin town					
MCD (61925) Pepin village					

Rural Health Clinic: In December of 2013, CVH submitted an enrollment application to the Center for Medicare and Medicaid Services for two health clinics to be designated as Rural health clinics (RHCs). RHC's are clinics that are located in areas that are designated both by the Bureau of the Census as rural and by the Secretary of the Department of Health and Human Services as medically underserved. RHCs have been eligible for participation in the Medicare program since March l, 1978. Services rendered by approved RHCs to Medicare beneficiaries are covered under Medicare effective with the date of the clinic's approval for participation. The clinic care provided by physicians, nurse practitioners and allied health staff augment the emergency, outpatient and acute/inpatient services offered by the Hospital.

Source: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

Charity Care: CVH provides medical care to all individuals seeking emergent, non-elective services without regard to their ability to pay. Patients who qualify for charity care are provided services for which no payment is due for all or a portion of the individual's bill. A patient is established as a charity patient based on established policy.

Community Partnerships

Through participation in the Pepin County Health Department Community Health Needs Assessment and Implementation Plan initiatives, CVH has engaged in meaningful partnerships with Community stakeholders to best meet the needs of those served. Integration of cross-organizational strengths provides a complement of unique services, with depth and breadth to reach specific Community need.

Community Health Needs Assessment Stakeholder Position:

Source: Healthy People Pepin County 2020

A Community-based health improvement process was found to be the necessary backbone to assuring the conditions for populatino health because it:

Assessment of Health Needs	Forms and Strengthens Partnerships
	Increases Community awareness
	Taps into Community's innovative ideas
	Integrates isolated efforts
	Builds on existing services
	Conserves resources/prevents duplication of effort
	Develops comprehensive strategies specific to the Pepin County Community

Public Stakeholders Identified during the Community Health Needs Assessment Process:

Participants in the Community Health Improvement Planning (CHIP) initiatives follow:

- Pepin County Health Department
- Pepin County Board of Health
- Durand Clinic, North (provider-based department of CVH)
- Durand Clinic South (provider-based department of CVH)
- Heike Pharmacy
- Western Wisconsin Cares
- Pepin Manor
- Pepin County Sheriff's Department
- Durand Police Department
- Chippewa Valley Hospital & Oakview Care Center
- Pepin County Human Services
- Pepin County Aging and Disability Resource Center
- Pepin County Counsel of Senior Citizens
- Pepin County Government

- Durand School District
- Pepin County UW Extension
- Assisted Living of Durand
- University of Wisconsin, Eau Claire
- Pepin County Nutrition Coalition
- Durand Fire Department
- Durand Emergency Medical Services

Assessment Methodology

Data Sources

To enrich knowledge of the health status and assets in the CVH Community, an eclectic approach to data gathering was sought. Collaboration through Pepin County Health Department initiatives allowed for the collection of first-hand data that both described Community thoughts about health needs, and quantified those needs using descriptive statistics. It also provided a chance to build on the solid research analysis methodology from our secondary data sources charged with measuring population health. The result is a comprehensive, integrated picture that provides a base from which to build meaningful benefit.

Data Collection and Review:

Primary Data Sources: Quantitative and Qualitative Data

Pepin County Health Department: Through participation in the Pepin County Health Department Community Health Needs Assessment, primary data (both quantitative and qualitative) was collected from Pepin County Residents. The survey instrument ***(Appendix A)*** was distributed to a representative sample of Pepin County residents. Over 250 responses were received (representing over 3% of the total population. The survey instrument did not request information about ethnicity, however over 99% of the population in Pepin County is white and was born within the United States leading to high potential that the responses obtained were representative of this race/ethnic group. Data was aggregated, described statistically and reviewed by CHIP, with representation by CHV, Public Health, and individuals from the Community.

Above data was augmented with "priority-specific" subjective data from responders relative to chronic disease, alcohol/substance abuse, and growth/development ***(Appendix B).***

Secondary Data Sources: Quantitative and Qualitative Data

A variety of secondary data, both qualitative and quantitative was accessed to complement the research generated the Pepin County Health Department collaborative. Data was collected at the the State level, the Federal level (through the Centers for Disease Control, Healthy People 2020, the Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, and US Census Data). Selected trends noted across data sources are outlined below. Information is based on various data sources and guided by the Healthy People Pepin County 2010-2015 publication.

1. **UW-Extension Wisconsin Food Security Project (as presented in Healthy People Pepin County 2010-2015):**

2008 Food Security Profile for Pepin County

Indicator	Pepin County	Wisconsin
%Population receiving food stamps	10.15	12.07
% Population receiving food stamps- Child	15.75	22.72
% Change in food stamp participation 2000-08	235.78	98.52
% Change in food stamp participation 2000-08 Child	220.21	80.3
WIC Participation- Annual	248	203790
WIC Participation- Monthly	156	126042
% of WIC Households with low food security	41	51
Number of congregate meals per 1000 seniors	4828	2809
Number of home delivered meals per 1000 seniors	6060	3119
% Children approved for free or reduced lunch	28.17	32.23
% Low income children who have access to breakfast at school	62.24	81.2

2. **Pepin County Human Services Annual Report (as reported in Healthy People Pepin County 2010-2015).** Both annual caseload and funding for the Food Share Program

Food Share Program for Pepin County: Annual Caseload

Year	All	Adults	Children	Groups
1996	425	230	195	161
1998	246	131	115	105
2000	218	124	94	97
2002	316	174	142	129
2004	472	265	207	198
2006	543	324	219	228
2008	738	437	301	309

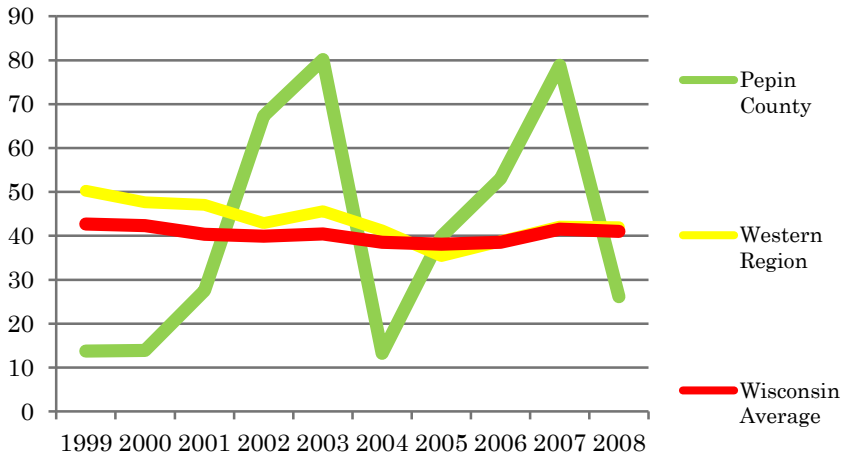
3. Healthiest Wisconsin 2010 Modifiable Risk Factors:

Healthiest Wisconsin 2010 Health Priorities (Modifiable Risk Factors)	Selected Health Conditions															
	Breast Cancer	Diabetes	Food and Water Borne Diseases	Heart Diseases	HIV & Sexually Transmitted Infections	Homicide	Infant Mortality	Influenza and Pneumonia	Low Birthweight Births	Lung Cancer	Motor Vehicle Crashes	Respiratory Diseases	Stroke	Suicide	Teen Pregnancy	Vaccine Preventable Diseases
Access to Primary and Preventative Health Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Adequate and Appropriate Nutrition	X	X	X	X			X		X	X		X	X			
Alcohol and Other Substance Use and Addiction	X			X	X	X	X		X		X		X	X	X	
Environmental and Occupational Health Hazards			X	X	X			X		X	X	X				X
Existing, Emerging, and Re-Emerging Communicable Diseases			X		X		X	X								X
High-Risk Sexual Behavior					X		X								X	X
Intentional and Unintentional Injuries and Violence					X	X					X			X	X	
Mental Health and Mental Disorders						X								X		
Overweight, Obesity, and Lack of Physical Activity	X	X		X									X	X		
Social and Economic Factors that Influence Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tobacco Use and Exposure	X	X		X			X	X	X	X		X	X		X	

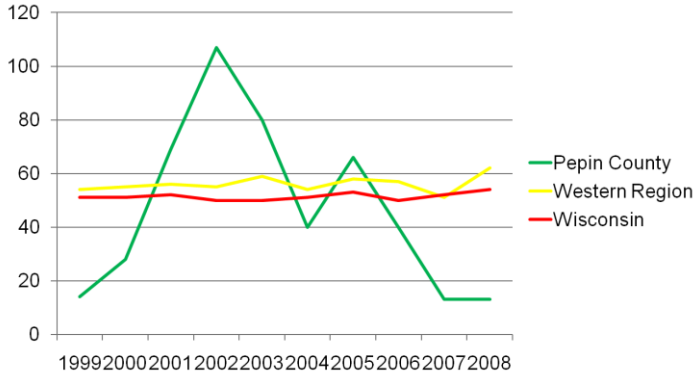
Source: Healthiest Wisconsin 2010, as presented in Healthy People Pepin County 2010-2015.

4. Wisconsin Interactive Statistics on Health:

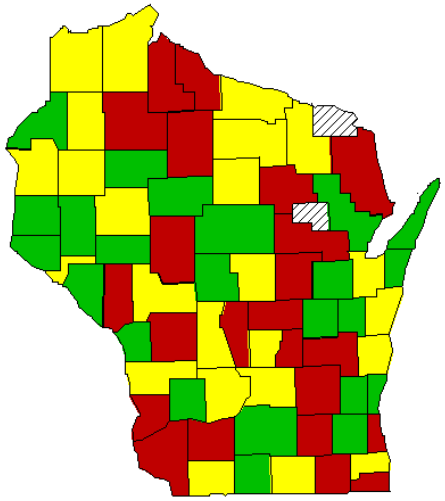
Death rate per 100,000 of Pepin County Residents with Heart Disease Listed as the Primary Cause of Death:



Death rate per 100,000 of Pepin County Residents with Respiratory Disease Listed as the Primary Cause of Death:



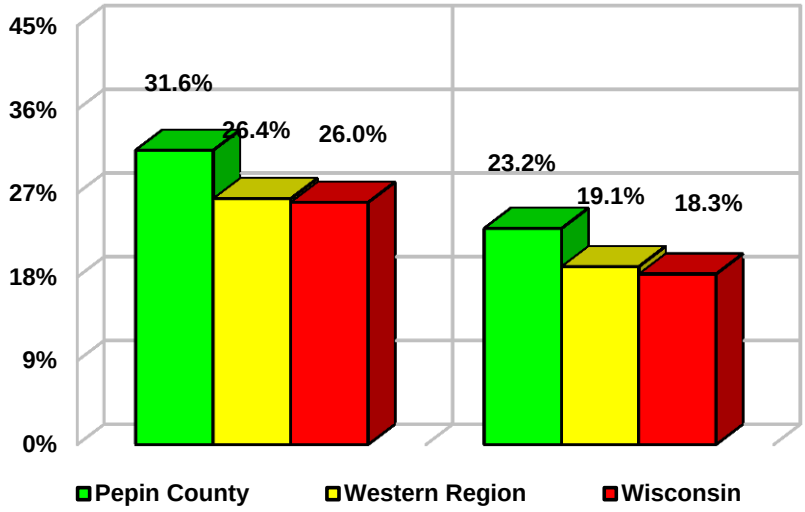
2002-2006 Age Adjusted Mortality Rate with Ischemic/Coronary Heart Disease Listed as Primary Cause of Death – By County of Residence



Age-Adjusted Mortality Rate Per 100,000 Population

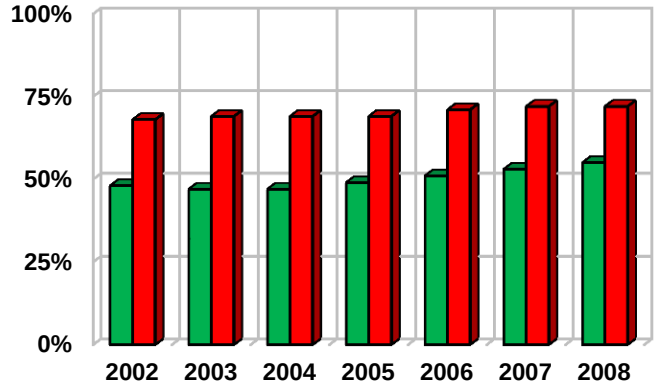
Less than 50 deaths/no rate
0.0-120.6
120.7-137.5 **(includes Pepin County)**
137.6 to 201.4

1997-2001 and 2002-2006 Comparison Age Adjusted Mortality Rate with Influenza/Pneumonia Listed as Primary Cause of Death:

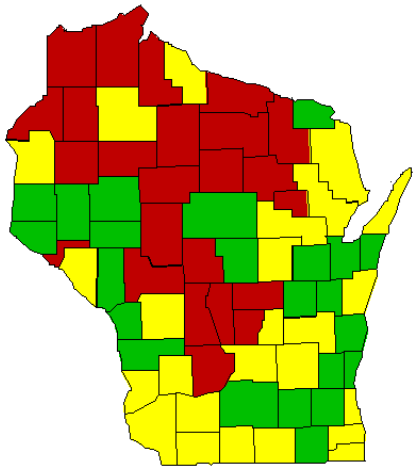


5. **Wisconsin Behavioral Risk Factor Survey:**

Percentage of Wisconsin Adults Reporting they are Overweight (BMI)



6. **The Burden of Diabetes: As reported in Health People Pepin County 2010-2015:**



2006 Diabetes-related Hospitalizations

0.0-13.9
14.0-16.2
16.3-24.1 **(includes Pepin County)**

7. **Wisconsin Department of Health and Family Services:**

The Burden of Diabetes in Pepin County (as reported in Healthy People Pepin County 2010-2015):

Diabetes Prevalence - Pepin County			
Age category	***Estimated Number Diagnosed (%)***	***Estimated Number Undiagnosed (%)***	***Estimated Total Number (%)***
◆ Ages 18-44	**120 (4.9%)**	**50 (2.0%)**	**170 (6.9%)**
◆ Ages 45-64	**120 (6.1%)**	**50 (2.5%)**	**170 (8.7%)**
◆ Ages 65+	**160 (13.1%)**	**70 (5.8%)**	**230 (18.9%)**
◆ All ages adult*	**400 (6.6%)**	**170 (2.8%)**	**570 (9.4%)**

Percent is age-adjusted (direct method) to the US 2000 standard population. Total percent may not be equal sum of diagnosed percent and undiagnosed percent due to rounding.

2006 Hospitalizations - Pepin County				
	Total Number	***Number Diabetes-related (% of total)***	***Total Charges***	***Diabetes-related Charges (% of total charges)***
All ages	**865**	**147 (17.0%)**	**$12,535,500**	**$2,028,100 (16.2%)**

8. **Healthiest Wisconsin 2020 Health Priorities:** Since initial review of the 2010 Healthiest Wisconsin Health Priorities, the Healthiest Wisconsin 2020 plan has been published. This strategic state health plan was prepared by the Wisconsin Department of Health Services, and through the collaborative efforts of public health system partners. It provides objectives for improving health/quality of life in Wisconsin and fulfills the statutory requirement to develop a state public health agenda at least once every 10 years [Wisconsin Statutes, Section 250.07 (1) (a)].

   Priorities for healthcare improvement were selected based on which would offer the most improvements in lifelong health, and which would eliminate disparities in healthcare delivery. Priorities were influenced by more than 1,500 planning participants statewide. The priority objectives are offered to focus the attention and work of policy-makers and organizations (including state, local and tribal government agencies, educational institutions, employers, health care organizations, non-profit and community-based organizations, faith communities, and others)."

   Identified trends that impact health influenced the priorities identified through this initiative, including:

   - Projection of an aging population in Wisconsin
   - Substantive increase in obesity
   - Substantive increase in diabetes
   - Increase disparities in income
   - Health care reform
   - Adoption of electronic health information systems
   - Terrorism and other emergencies
   - Complex food safety issues
   - Global travel/commerce
   - Worsening/stagnant indicators of reproductive/sexual health
   - Widening gap between the demand for and supply of health workers
   - Development of new public health education institutions in Wisconsin.

Health Focus Areas and Objectives Identified through Healthiest Wisconsin 2020

Adequate, appropriate, and safe food and nutrition: The number of households in Wisconsin that are "food insecure" and "food insecure with hunger" rose from 2006-2008 according to the United States Department of Agriculture.

Objective 1
By 2020, people in Wisconsin will eat more nutritious foods and drink more nutritious beverages through increased access to fruits and vegetables, decreased access to sugar-sweetened beverages and other less nutritious foods, and supported, sustained breastfeeding.

Objective 2
By 2020, all people in Wisconsin will have ready access to sufficient nutritious, high-quality, affordable foods and beverages.

Objective 3
By 2020, Wisconsin will reduce disparities in obesity rates for populations of differing races, ethnicities, sexual identities and orientations, gender identities, and educational or economic status.

Alcohol and other drug use

Objective 1
By 2020, reduce unhealthy and risky alcohol and other drug use by changing attitudes, knowledge, and policies, and by supporting services for prevention, screening, intervention, treatment and recovery.

Objective 2
By 2020, assure access to culturally appropriate and comprehensive prevention, intervention, treatment, recovery support and ancillary services for underserved and socially disadvantaged populations who are at higher risk for unhealthy and risky alcohol and other drug use.

Objective 3
By 2020, reduce the disparities in unhealthy and risky alcohol and other drug use among populations of differing races, ethnicities, sexual identities and orientations, gender identities, and educational or economic status.

Chronic disease prevention and management

Objective 1
By 2020, increase sustainable funding and capacity for chronic disease prevention and management programs that reduce morbidity and mortality.
Objective 2
By 2020, increase access to high-quality, culturally competent, individualized chronic disease management among disparately affected populations of differing races, ethnicities, sexual identities and orientations, gender identities, and educational or economic status.

Objective 3
By 2020, reduce the disparities in chronic disease experienced among populations of differing races, ethnicities, sexual identities and orientations, gender identities, and educational or economic status.

Communicable disease prevention and control

Objective 1

By 2020, protect Wisconsin residents across the life span from vaccine-preventable diseases through vaccinations recommended by the U.S. Advisory Committee on Immunization Practices (ACIP).

Objective 2
By 2020, implement strategies focused to prevent and control reportable communicable diseases and reduce disparities among populations with higher rates.

Environmental and occupational health

Objective 1
By 2020, improve the overall quality and safety of the food supply and the natural, built and work environments.

Objective 2
By 2020, increase the percentage of homes with healthy, safe environments in all communities. (Safe environments are free from lead paint hazards, mold or moisture damage, environmental tobacco smoke and safety hazards, and include carbon monoxide and smoke detectors, and radon testing and mitigation.)

Healthy growth and development

Objective 1
By 2020, increase the proportion of children who receive periodic developmental screening and individualized intervention.

Objective 2
By 2020, provide pre-conception and inter-conception care to Wisconsin women in population groups disproportionately affected by poor birth outcomes.

Objective 3
By 2020, reduce the racial and ethnic disparities in poor birth outcomes, including infant mortality.

Injury and violence
Objective 1
By 2020, reduce the leading causes of injury (falls, motor vehicle crashes, suicide/self-harm, poisoning and homicide/assault) and violence though policies and programs that create safe environments and practices.

Objective 2
By 2020, increase access to primary, secondary and tertiary prevention initiatives and services that address mental and physical injury and violence.

Objective 3
By 2020, reduce disparities in injury and violence among populations of differing races, ethnicities, sexual identities and orientations, gender identities, and educational or economic status.

Mental health

Objective 1
By 2020, reduce smoking and obesity (which lead to chronic disease and premature death) among people with mental health disorders.

Objective 2

By 2020, reduce disparities in suicide and mental health disorders for disproportionately affected populations, including those of differing races, ethnicities, sexual identities and orientations, gender identities, educational or economic status.

Objective 3
By 2020, reduce the rate of depression, anxiety and emotional problems among children with special health care needs.

Oral health

Objective 1
By 2020, assure access to ongoing oral health education and comprehensive prevention, screening and early intervention, and treatment of dental disease in order to promote healthy behaviors and improve and maintain oral health.

Objective 2
By 2020, assure appropriate access to effective and adequate oral health delivery systems, utilizing a diverse and adequate workforce, for populations of differing races, ethnicities, sexual identities and orientations, gender identities, and educational or economic status and those with disabilities.

Physical activity

Objective 1
By 2020, increase physical activity for all through changes in facilities, community design, and policies.

Objective 2
By 2020, every Wisconsin community will provide safe, affordable and culturally appropriate environments to promote increased physical activity.

Objective 3
By 2020, every Wisconsin community will provide safe, affordable and culturally appropriate environments to promote increased physical activity for individuals among populations of differing races, ethnicities, sexual identities and orientations, gender identities, and educational or economic status.

Reproductive and sexual health

Objective 1
By 2020, establish a norm of sexual health and reproductive justice across the life span as fundamental to the health of the public.

Objective 2
By 2020, establish social, economic and health policies that improve equity in sexual health and reproductive justice.

Objective 3
By 2020, reduce the disparities in reproductive and sexual health experienced among populations of differing races, ethnicities, sexual identities and orientations, gender identities, and educational or economic status.

Tobacco use and exposure

Objective 1
By 2020, reduce tobacco use and exposure among youth and young adults by 50 percent.

Objective 2
By 2020, reduce tobacco use and exposure among the adult population by 25 percent.

Objective 3
By 2020, decrease the disparity ratio by 50 percent in tobacco use and exposure among populations of differing races, ethnicities, sexual identities and orientations, gender identities, educational or economic status, etc.

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Policy and Practice Alignment. *Healthiest Wisconsin 2020: Everyone Living Better, Longer. A State Health Plan to Improve Health Across the Life Span, and Eliminate Health Disparities and Achieve Health Equity.* P-00187. July 2010.

9. **Healthy People 2020:** Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:
    A. Encourage collaborations across communities and sectors.
    B. Empower individuals toward making informed health decisions.
    C. Measure the impact of prevention activities

    Measurable objectives and goals are developed through Healthy People 2020, providing a benchmark for comparing CVH Community Health Needs Assessment outcomes and guiding selection of health need priorities and outcome expectations.

10. **Behavioral Risk Factor Surveillance System:** In 1984, the Centers for Disease Control and Prevention (CDC) initiated the state-based Behavioral Risk Factor Surveillance System (BRFSS)--a cross-sectional telephone survey that state health departments conduct monthly via phone with a standardized questionnaire and technical assistance from CDC. BRFSS is used to collect prevalence data among adult U.S. residents regarding their risk behaviors and preventive health practices that can affect their health status. Respondent data are forwarded to CDC to be aggregated for each state, returned with standard tabulations, and published at year's end by each state. Over 350,000 adults are interviewed each year.

11. **National Health and Nutrition Examination Survey:** This survey is designed to assess the health and nutritional status of adults and children in the United States. The survey combines interviews and physical exams, providing information on undiagnosed diabetes, caloric intake, elevated blood levels, etc.

12. **US Census Bureau:** US Census online tool was used to access quantitative data defining the counties in which Adventist Midwest Health hospitals reside.

13. **Death Certificate Review**

Community and Public Health Input

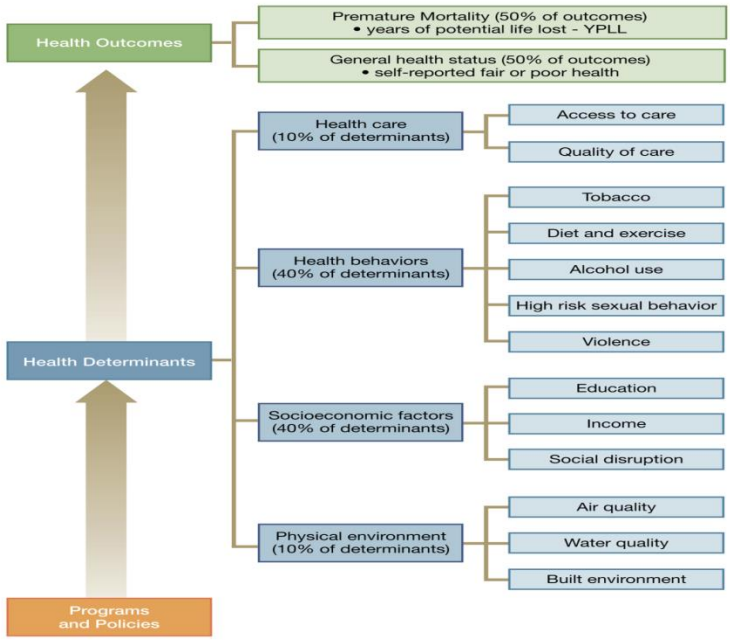
Community and Public Health input is imperative in any Community Health Needs Assessment process. Perceived and demonstrated needs necessarily guide more focused assessments, prioritization of needs, and implementation plans. Input should be representative, assuring the broad interests of the community are addressed.

Persons with Special Knowledge of or Expertise in Public Health:

Public Health input was obtained through direct and collaborative participation with the Pepin County Health Department in the Needs Assessment and Implementation Strategy Plan development. Executive and clinical staff from CVH actively participates on CHIP, resulting in joint action-planning with the Pepin County Health Department.

As such, full access to and integration of Public Health surveillance and assessment findings was completed to guide development of this CHNA, provide comparative data, and assist in prioritization of health needs.

Pepin County Survey results are classified in Healthy People Pepin County 2010-2015, as pictured below. Health determinants are classified as care provision (access to care/quality of care); health behaviors (e.g. smoking, diet/exercise); socioeconomic factors (e.g. education, income); and physical environment (air quality, water quality, etc.). Of interest is that it is the health behaviors that are most determinant of overall health outcomes; the behaviors that individuals arguably have more ability to independently control.



Leaders, Representatives, or Members of Medically Underserved, Low-income, and Minority Populations, and Populations with Chronic Disease Needs in the Community Served by the Hospital

As noted earlier, Pepin County is a racially homogenous community, with 99% of community members being white and born in the United States. One percent of the population is comprised of all other races (with .46% being Hispanic). All efforts are made to assure appropriate assessment of and inclusion of the needs of minorities in the Community.

1. Individuals and entities serving on CHIP serve the needs of individuals with low income and/or disabilities (e.g. Wisconsin Cares; Pepin County Human Services; Pepin County Aging and Disability Resource Center).

2. Representative Community Members serve on CHIP.

3. The Pepin County Health Department and Pepin County Board of Health, with expertise in Pepin County chronic disease issues and management served on CHIP.

4. Providers who manage individuals in the Community who are low-income, minority and who have chronic disease serve on CHIP (e.g. EMS, Durand Medical Clinics, CVH, Pepin Manor, etc.)..

Prioritized Health Needs

Data Analysis

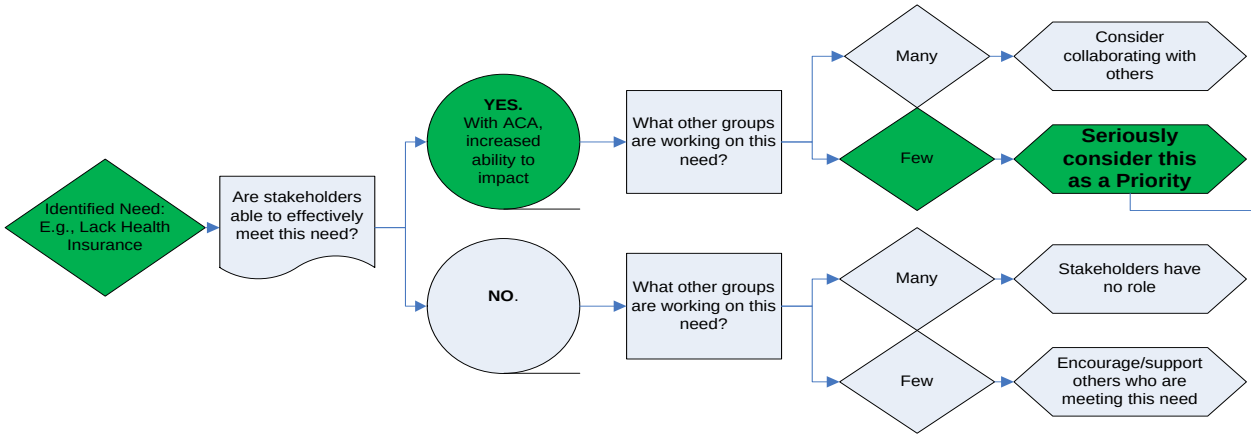
Assessment findings compiled from primary and secondary data sources were analyzed both in isolation and through comparison of like measures. Summary information was created isolating each key health indicator from across the reported health surveys. The information was presented to CHIP for review and discussion. Trends were identified and comparative analysis was initiated, with keen focus on key indicators that fell substantively short of Healthiest Wisconsin 2020 goals, as well as those that demonstrate specific downward trend specific to Pepin County. The data analysis was augmented with integration of internal hospital data supporting the hospital's key strategic initiatives, and how these initiatives may tie to opportunities to benefit the Community.

Priority Selection

CHIP identified and narrowed Health Priorities from identified Community Health Needs Assessment outcomes based on the following:

1. The size/scope of the issue
2. The seriousness of the health issues
3. The consequences of the health issues
4. The current strategies that have been implemented to address the problem
5. The feasibility of implementing interventions to address the problem
6. The local capacity to designate resources

Process Depiction:



Impact analysis additionally assists in identification of potential priorities: Priorities that had lower overall impact on the Community, particularly if the related resource needs were high, were not prioritized.

Top identified needs follow:

- Chronic Disease Management and Prevention
- Alcohol and Other Substance abuse
- Healthy Growth and Development: Appropriate nutrition, physical activity
- Obesity
- Communicable Diseases
- Environmental and Occupational Health
- Mental Health
- Oral Health

1. **Final Priority Selection**

    - **Chronic Disease Management:** Chronic conditions are defined as conditions that are long-term, do not go away on their own, are rarely healed and can result in disability of some form. Examples are heart disease, chronic kidney disease and diabetes; the leading causes of both death and disability in the United States. Preventive measures to curb chronic disease may be implemented with relative ease, and the impact of implementing preventive measures is of high value both to individuals and to the

community at large.

- **Alcohol and Other Substance Abuse:** Wisconsin is above the national average in percentage of alcohol use among adults at roughly 79%, whereas the national average is 55%. According to Wisconsin Healthiest People 2020, alcohol-related deaths are the fourth leading cause of death in Wisconsin. Alcohol or drug abuse may lead to motor vehicle and other injuries; fetal alcohol spectrum disorder and other childhood disorders; alcohol- and drug-dependence; liver, brain, heart and other diseases; infections; family problems; and both nonviolent and violent crimes. Unhealthy alcohol and drug use means any use of a substance that result in negative consequences. These substances include alcohol, prescription drugs and illegal mood altering substances.

- **Healthy Growth and Development (Food, Nutrition and Physical Activity):** The rate of Wisconsin adult obesity increased from 20 percent to 26 percent from 2000 to 2008 (Wisconsin Department of Health Services, Track 2010). **"**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 health care that prevents as well as treats; rewards for healthy behaviors over risky ones—these are goods created through shared decisions and actions, not just individual behaviors. Those who must help make and implement these decisions work in many fields, extending far beyond the health care sector."

  Source: Wisconsin Department of Health Services, Division of Public Health, Office of Policy and Practice Alignment. *Healthiest Wisconsin 2020: Everyone Living Better, Longer. A State Health Plan to Improve Health Across the Life Span, and Eliminate Health Disparities and Achieve Health Equity.* P-00187. July 2010.

  Food, nutrition and physical activity were identified by CHIPS as a necessary component of any improvement plan in light of the impact these factors have on Chronic Disease Management. Specific and purposeful goals and objectives would improve general health, prevent chronic disease, and improve the quality of life for those individuals already living with chronic disease.

- **Communicable Diseases:** While this indicator was not selected by CHIP for prioritization, it was later selected independently by CVH for inclusion. While some sub-indicators are low (he number of selected communicable diseases infecting Pepin County and food-borne and waterborne disease, age-adjusted mortality rate for influenza/pneumonia is higher than for the Western Region of Wisconsin and for the state of Wisconsin. As a provider of outpatient, inpatient and clinic care, CVH feels that work on this indicator will have a high impact, and is also relatively easy to implement.

2. **Measures Not Finally Selected for Priority:** The following measures were not finally selected for priority based on the following:

   - Obesity
     Rationale: Addressing Healthy Growth and Development will have a direct impact on obesity in the County. Therefore, this measure will not be formally and separately addressed.

   - Environmental and Occupational Health
     Rationale: Pepin County outcomes are superior to State outcomes in all but one category of exposure (housing with increased lead risk based on % of houses built before 1950)

   - Mental Health
     Rationale: Many of the mental health outcome measures for Wisconsin have positive trends (% of kids grades 9-12 feeling so sad or hopeless that they have stopped doing some usual activities; % of Wisconsin students in grades 9-12 seriously considering attempting suicide). The number of Pepin County residents with suicide listed as the primary cause of death is decreasing.

   - Oral Health
     Rationale: Not believed to have high impact on overall population health for Pepin County.

Measures and Resources for Implementation

Measures

Measures of success for each identified health need priority will be developed by CHIP and by CVH Executives, clinical experts and Community stakeholders following a full review and discussion of related implications. The Implementation Strategy (Community Health Plan) developed based on the outcomes of this Community Health Needs Assessment will contain goals, objectives and indicators:

1. Goals: Goals are broad statements describing your anticipated accomplishments (e.g. decrease incidence of influenza among people 65 years of age and over).

2. Objectives: The objective describes what specific change is expected following implementation of a strategy. According to the Centers for Disease Control, objectives should be SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime specific).

3. Indicator: The measurement used to determine success in meeting the objective.

Resources

As stated above, CHIP provides a rich resource for multi-dimensional approaches to assuring community health. Key to successfully meeting health needs identified in this Community Health Needs Assessment is leveraging the expertise, services and resources available through CHIP in a manner that has the highest impact on community health with appropriate preservation of resources.

This may be accomplished through:

1. The benefit of full organizational support through Mission and through Executive Leader active participation in the Community Health Needs Assessment Process.

2. Careful review of existing Community Partners to identify potential for shared resources to meet prioritized health needs.

3. Aligning the opportunities and challenges across Pepin County stakeholders to best target healthcare needs of the most medically fragile: those in financial need, and those who lack access to service. This may result in pooling of resources to provide care in areas of the County with the highest indigent population.

4. Redistribution of CVH community benefit spending: Based on the identified health needs in this assessment, recommendations from Hospital leaders will likely lead to changes in how community benefit dollars are directed at CVH.

CHNA Contacts

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