

2012

HealthEast Community Health Improvement Plan



Community Health Needs Assessment
Leadership Team and Wilder Research
for HealthEast Care System
8/31/2012

HealthEast Care System is a community-focused, non-profit health care organization that provides innovative technology, compassionate care and a full spectrum of family health services. HealthEast includes Bethesda Hospital, St. John's Hospital, St. Joseph's Hospital and Woodwinds Health Campus as well as outpatient services, clinics, home care, and medical transportation services. Furthermore, we are the largest, locally-owned health care organization in the Twin Cities' East Metro with 7,300 employees, 1,200 volunteers and 1,500 physicians on staff.

HealthEast has a long tradition of meeting the needs of the community and the mission speaks of our commitment to the community:

*Rooted in Judeo-Christian values, our mission is
Compassionate, high quality, cost effective health care
For the communities we serve.*

This commitment is further articulated in our Values:

- **Life:** Life is a gift to be valued highly.
- **Compassion:** Caring attends to physical, emotional and spiritual dimensions of persons.
- **Respect:** Each person is unique and deserving of respect.
- **Community:** We exist to serve our community.

Background of Community Benefit

Serving the community has been a part of the HealthEast culture since the founding of our anchor hospitals. Therefore, when in 1969, federal legislation passed which mandated that non-profit hospitals must report community benefit activities on their IRS Form 990 to demonstrate how they are giving back to the community, the organization was able to respond. Since then, much work has been done across the nation to articulate community benefit from a definition and accounting perspective. In the past decade, this work has taken on a more scientific approach and today's hospitals have evidenced-based models and metrics that have improved the health of many communities.

In March 2010, the U.S. Congress passed the Patient Protection Affordable Care Act that included new reporting requirements for private non-profit hospitals to maintain 503(c)3 tax-exempt status. For tax years beginning after March 2012, each hospital must:

- Conduct a Community Health Needs Assessment at least once every three years and must include public health and community voice.
- Develop action plans to address unmet community needs and obtain Board of Director approval of the plan.
- Report the process and plan to the community and on IRS Form 990.

As health care has evolved and with the current state of health care reform, we now need a more systematic approach to understanding the health needs of the community. We will partner with other community resources to plan programs and services to meet those needs. HealthEast is renewing its commitment to improving the health of the community.

We are pleased to present the following implementation strategy. This is in response to the community health needs assessment that was conducted between September 2011 and June 2012. On August 9, 2012, the HealthEast Board of Directors approved the implementation plan based on the needs assessment. Both the assessment and implementation plan approval took place during the HealthEast fiscal year ending August 31, 2012.

As the organization moves forward, it will be important to adopt a common vocabulary to define this work. The Catholic Health Association for decades has championed community health improvement efforts and has developed a process and definitions to standardize community benefit efforts undertaken by non-profit hospitals across the nation. HealthEast will adopt the following terms as defined by the Catholic Health Association:

A community health needs assessment is a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon unmet community health needs.

An implementation strategy is the hospital's plan for addressing community health needs, including health needs identified in the community health needs assessment. The implementation strategy is also known as the hospital's overall community benefit plan.

Community Benefit is a legal term first used in IRS in 1969. It encompasses a full range of services and activities provided by nonprofit hospitals to address the symptoms and causes of health-related concerns that should produce a measurable impact in the community through evidenced-based, population health approach.

Community Health Needs Assessment Process

HealthEast senior leaders identified a core community health needs assessment (CHNA) leadership team and approved the process that would be used to conduct the assessment. This team developed the following process steps to conduct the needs assessment:

1. Establish the infrastructure
 - a. Steering Committee (senior leadership), Internal Advisory Committee (operations and support leaders), Data Collection Team, Communications Team, and the External Advisory Team (local and state public health).
 - b. Wilder Research was contracted to assist with primary data collection and analysis.
2. Define the Purpose and Scope (advised by Senior Leadership)
 - a. The purpose of the CHNA is to:
 - i. Identify community health needs
 - ii. Inform HealthEast strategy
 - iii. Focus and prioritize program planning
 - b. The scope of the assessment is the primary service areas (80 percent patients reside) for the hospitals.
 - i. Ramsey, Dakota, and Washington Counties for St. Joseph's, St. John's and Woodwinds
 - ii. State of Minnesota for Bethesda
3. Collect and Analyze Data
 - a. Secondary data was collected and summarized by the Data Collection team from local and state public health data, as well as HealthEast patient data.
 - i. Interviews were conducted with key internal stakeholders within HealthEast operations regarding the results of the secondary data to obtain their reaction and feedback for further study.
 - ii. The results of the interviews informed the team as the focus of the primary data sources.

- b. Primary data collection was conducted by Wilder Research in order to obtain unbiased information. The following groups were targeted:
 - i. Passport Town Hall Meetings (representing the aging population) – four meetings were conducted with a total of 140 people attending.
 - ii. Patient interviews were conducted with short-term acute care patients who were “30-day readmits” or observation patients for a total of 135 interviews.
 - iii. Mental Health Patient Truth Point interviews were conducted by staff.
 - iv. Surveys were conducted with care givers of Bethesda.
 - v. Key cultural broker interviews were conducted, including foreign-born Somali, American Indian, African American, Hispanic, Hmong, Karen, and homeless.

Our Community

In order to determine the scope of this assessment, the population to be studied was defined as the area in which 80 percent of the HealthEast patients live. Therefore, the “service area populations” refer to the populations of Dakota, Ramsey and Washington counties for our acute care hospitals (St. Joseph’s, St. John’s and Woodwinds) and the State of Minnesota for our long-term acute care hospital, Bethesda. The public health data was also compared with our inpatient and clinic patient data and, therefore, “patient population” refers to consumers of health care at HealthEast facilities.

Summary of the Assessment Methodology (Prepared by: Wilder Research)

HealthEast Care System began the assessment process by completing an in-depth review of its own patient data and state and local public health data, and then contracted with Wilder Research, a nonprofit research and evaluation firm in St. Paul, Minnesota, to assist with the primary data collection and preparation of reports for the community health needs assessment. Using data gathered through the assessment process, HealthEast Care System developed implementation strategies for its four hospitals: Bethesda Hospital, St. John’s Hospital, St. Joseph’s Hospital, and Woodwinds Health Campus.

A mixed method approach, incorporating both reviews of existing data sources and new data collection activities with specific patient populations and community stakeholders, was developed collaboratively by HealthEast and Wilder Research. Information gathered in this stage of the assessment process was intended to describe the health and wellness needs of East Metro residents, with particular attention to the needs of aging residents, those with chronic conditions, and medically underserved populations, including communities of color and uninsured/underinsured populations.

This summary describes the characteristics of residents who live in the East Metro area and anticipated demographic changes expected to occur in the region. This summary also provides a high-level overview of factors contributing to health disparities in the East Metro region before highlighting common health and wellness priorities identified across patient population and community stakeholder groups. Finally, included is a framework for HealthEast to consider using to guide ongoing assessment and implementation activities.

Characteristics of east metro residents

HealthEast serves a culturally and economically diverse region

The primary service area for three of the four HealthEast hospitals includes the three East Metro counties of Dakota County, Ramsey County, and Washington County. Combined, the service area includes over 1 million residents. During the past decade, the East Metro region has become increasingly culturally-diverse and home to a growing aging population. In addition, as a result of the recent economic recession, a growing number of East Metro residents live in poverty. These recent and anticipated changes in the region's population may influence the types of services provided by HealthEast and the ways in which services are delivered.

Increased cultural diversity

Since 2000, the population across all three counties has become increasing culturally diverse, with nearly one-quarter (24 percent) of residents identified as persons of color in 2010. HealthEast currently serves a diverse patient population and is seeing growth in the number of hospital visits by patients of color, particularly new patients of new immigrant and refugee communities. Although most patient hospital visits are with patients who speak English as their primary language, more than 8,000 hospital visits in 2010 were with patients who spoke languages other than English. The demand for culturally- and linguistically-appropriate care is likely to increase. Over the next 30 years, the number of residents of color in the Twin Cities region is expected to double, while at the same time, the White, non-Hispanic population is expected to slightly decline.

A growing aging population

In 2010, 11 percent of East Metro residents were age 65 or older. Not surprisingly, many of the patients who receive services at HealthEast hospitals also fall into this age group. In the three hospitals that serve the East Metro region, as few as one in five patient visits and up to one in three patient visits were with patients age 65 or older in 2010. A dramatic increase in the number of seniors is expected over the next 30 years; by 2040, more than 20 percent of Twin Cities residents are expected to fall into this age category.

Increased economic disadvantage

The recent economic recession has also had an impact on East Metro residents. The percentage of residents living in poverty has roughly doubled in each of the East Metro counties. Poverty rates are higher overall in Ramsey County, where there has also been a sharp increase in the percentage of residents living in poverty, from 9 percent in 2000 to 17 percent in 2010. A substantial number of East Metro residents may also have difficulty accessing health care services due to lack of insurance, limited money to afford services, or a lack of medical service providers. Although a growing number of residents will have health insurance as a result of federal health care reform, the percentage of uninsured residents varies from 7 percent in Washington County to 12 percent in Ramsey County. In addition, American Indians are considered a medically-underserved community in the East Metro and there are five federally-designated medically underserved neighborhoods in Ramsey County.

There are significant racial and economic health disparities in the East Metro region

Chronic diseases are illnesses and conditions that often persist for years, resulting in long-term disability, reductions in the quality of life, and premature death. Risk for many chronic diseases can be reduced significantly by maintaining a healthy lifestyle: following a balanced, nutritious diet; avoiding tobacco use; maintaining a healthy weight; and getting physical activity. Although mortality rates for both cancer and heart disease have declined in Minnesota over the past two decades, more than 16,000 Minnesotans died as a result of these largely-preventable conditions in 2010.

Perhaps more important to consider in this assessment process, however, is the persistent evidence of racial and economic disparities across a variety of chronic disease conditions and health problems. The full assessment report provides current data and recent trends describing how the rates of cancer, heart disease, stroke, Alzheimer's disease, and diabetes vary by race/ethnicity and gender. Mortality rates overall, and for many specific disease conditions, tend to be higher among American Indian and African American populations. However, while racial disparities are often evident, the American Cancer Society reports that poverty is a more significant risk factor for cancer than race. In addition, lower rates of screening and use of preventive services may also lead to higher rates of deaths due to chronic disease in some instances.

Differences in health behavior and risk factors that contribute to disease are also likely contribute to disparities in health outcomes. The full report describes differences in obesity, consumption of healthy foods, physical activity, and tobacco use among East Metro residents by gender, age, educational status, and poverty status. Again, in most of these areas, the prevalence of risk factors that contribute to higher rates chronic disease is often higher among lower-income residents.

A holistic approach is needed to address the health and wellness needs of East Metro residents

Using a variety of data collection strategies, feedback was gathered from HealthEast patients and community stakeholders to better understand how East Metro residents define health and wellness, the strategies they currently use to maintain their health, their experience accessing health care services and barriers to care, and their perceptions of gaps in care and community resources. Despite differences in the characteristics of the individuals who provided feedback, a number of common themes emerged that are important for HealthEast to consider as they consider ways to meet the needs and address the priorities of community residents.

Three of the themes that emerged around health and wellness are described briefly below:

- **Health is considered to be more than simply the absence of illness.** Residents focused primarily on concepts of wellness and quality of life, ensuring they do not become a burden to their family, and finding balance in one's physical, spiritual, and emotional life.
- **Physical activity, healthy eating, and social connectedness were all seen as important strategies to maintaining health.** However, some residents face significant barriers in accessing available resources due to a lack of neighborhood services, limited transportation, poverty, or physical limitations.
- **Larger system-level factors often contribute to challenges in accessing care.** Some of the challenges residents faced in accessing health care services were a result of limited experience with the health care system, as well as limited knowledge of their health insurance benefits and resulting fears in the cost of services. Many representatives of cultural communities saw gaps in the number of bi-lingual/bi-cultural providers and challenges in accessing health information for residents who speak languages other than English as significant barriers to care. In addition, prior experience with medical providers can have either a positive or negative impact on residents' decisions to seek future medical services.

A framework to guide the next steps of the community health needs assessment and implementation process

While this data gathering process provides HealthEast staff with important information about the health and wellness needs of community residents, in many ways, it is only an initial step in the full assessment process. Using the information gathered throughout the assessment process, Wilder Research developed a set of guidelines for HealthEast to consider as we work to develop future community benefit strategies. These suggestions are intended to offer guidance to HealthEast in identifying appropriate activities that align with the interests and priorities of community residents, and to inform the process HealthEast staff can use to further engage East Metro community residents in identifying and prioritizing culturally-specific health and wellness needs and developing strategies to address these community concerns.

Framework to Address the Health and Wellness Needs of East Metro Residents

1. Adopt a comprehensive view of health and wellness.
 - a. Identify opportunities to develop resources, services, and support that enhance the quality of life for residents.
 - b. Work in partnership with community residents to increase access to existing health and wellness activities and identify culturally-specific resource/service needs.
 - c. Consider opportunities to provide education and learning opportunities around various health and wellness topics, including nutrition.
 - d. Use group activities to provide residents with key health information and foster social connectedness among residents.
2. Expand patient and community knowledge of services.
 - a. Encourage and expand the use of health navigators or community health workers.
 - b. Improve knowledge of and access to mental health services and supports.
 - c. Identify or develop additional resources for emotional support for patients and support people.
 - d. Be an active community partner in communicating information.
3. Improve coordination of care.
 - a. Improve coordination of care, including facilitating access to non-medical supports.
 - b. Improve communication between providers.
4. Work in partnership with culturally-specific organizations and nonprofits.
 - a. Partner with organizations already embedded within the community.
 - b. Ensure small, community-based organizations can participate in meaningful ways.
 - c. Assess needs of cultural groups directly.
5. Expand culturally competent services
 - a. Expand the workforce, at all levels, to be more culturally-representative.
 - b. Initiate additional training for providers, staff, and interpreters to provide more culturally responsive services.
 - c. Assess needs of cultural groups directly.

Implementation Strategy Process: How Priorities Were Determined

The community health needs assessment data was analyzed by both the HealthEast Data Collection Team as well as Wilder Research. Wilder presented the final synthesis report of both primary and secondary data. In addition to summarizing the data, Wilder also made key recommendations from the findings. To begin the process of determining priority health needs to address, the team started by meeting with local public health leaders from Ramsey, Dakota, and Washington Counties, to get input and discuss alignment with their priority goals and initiatives. They identified gaps and partnership opportunities.

Next, the Assessment leadership team along with Wilder Research met with the HealthEast Internal Advisory Committee and Steering Committee to review the needs identified through the assessment. We used the following process to focus the health priorities:

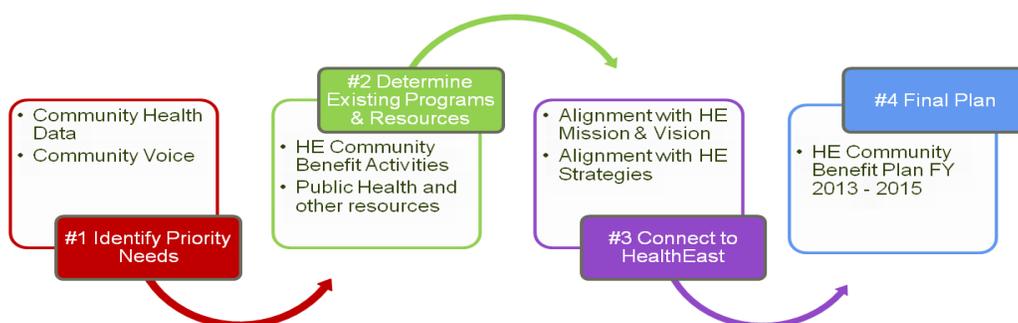
Screen #1: Determine community health priorities for HealthEast using the following criteria:

- a. Impact: Does this affect or exacerbate quality of life, health-related issues, or cost of care?
- b. Magnitude: How many people are affected, what is the variance from benchmark data and targets, and what is the affect on cost of care?
- c. Seriousness: Does the problem lead to death, disability or impairment, or quality of life?
- d. Feasibility: Can we make a difference? What is the ability of HealthEast to impact the issue, given the available resources?
- e. Consequences of inaction: What if we don't act? What is the risk of exacerbating the problem if we don't act?

Screen #2: Compare prioritized needs with existing programs and resources.

- a. Review health needs/gaps with local and state public health representatives to determine where there are overlaps, potential partnerships and gaps.
- b. Review existing community benefit activities conducted by HealthEast that align with prioritized needs.

Screen #3: Review health needs/gaps with HealthEast strategic planning process and operations annual planning.



Community Health Implementation Strategy

The information gathered throughout the assessment process was reviewed to develop a set of factors and trends for HealthEast to consider in developing community benefit strategies. Using this framework, the organization will adopt a multi-pronged approach that will bring HealthEast Care System and community benefit activities together with the goal to improve community health and wellness. The initial HealthEast Community Benefit Implementation Strategy for FY 2013 is detailed below.

Step # 1: Develop Community Health Infrastructure

As HealthEast renews its commitment to community health improvement, we will first establish a sustainable community benefit infrastructure to carry out the development of the strategy and oversee its implementation. The Catholic Hospital Association's *A Guide to Planning and Reporting Community Benefit* recommendations will be the foundation of the infrastructure plan.

- A vision promise that is clearly articulated to guide the community benefit program.
- Leadership commitment to improving access and community health.
- Adequate resources (staffing and budget).
- Policies supporting the community benefit program to increase organizational and leadership accountability, increase the quality of program planning, implementation and evaluation; and enhance the sustainability of organizational and programmatic commitment.

HealthEast will do the following:

1. Build the infrastructure for Community Benefits operations (see below) to include:
 - a. Clear leadership roles, responsibilities, and accountabilities
 - b. Dedicated resources
 - c. System policies governing activities
 - d. Metrics for value and impact of Community Benefit activities
2. Develop a funding model with HealthEast Foundation to support health improvement activities including:
 - i. Criteria for how to use charitable resources
 - ii. Priorities for funding
3. Conduct a comprehensive review of all existing community benefit activities in order to:
 - a. Determine those that meet or could be enhanced to align with the core principles and priority needs.
 - b. Determine those community benefit activities that could/should be sunset in order to free up staff and financial resources for other community activities.
 - c. Standardize the content categories and accounting methods for community benefit activities for reporting.
4. Identify partnerships within and outside of HealthEast in order to expand and maximize the capacity of the organization and extend our reach of community benefit activities.
 - a. Implement asset mapping of all community relations activities in order to coordinate efforts and determine if/where gaps exist.
 - b. Develop or strengthen partnerships with local public health, Minnesota Department of Health, community organizations, health plans, and other health care providers.
5. Develop standardized performance measurements, including programmatic metrics and outcomes metrics.

Step # 2: Plan to Address Community Health Needs: Pre-Diabetes Prevention

While many opportunities for community health improvement initiatives were identified, HealthEast leadership determined that in order to make an impact and sustain this work, a focused approach was more prudent. Therefore, HealthEast will initially focus on a medical minority that stood out in the needs assessment, keeping in mind one of the guiding principles discussed earlier:

“Assessment results and the implementation strategy must be put into action and these actions should be evaluated and refined, as needed, to ensure that the community and community partners are achieving their ultimate goal – improved community health.” [Catholic Health Association]

Therefore, in order to make an impact, it was decided that the focus be on a high-risk, high-utilizer population with an ambulatory sensitive condition. The initial community health initiative will center on pre-diabetes prevention.

Using the implementation prioritization criteria outlined above, the team answered the question: Why pre-diabetes?

- Impact: Quality of life compromised; 375,000 Minnesotans diagnosed with diabetes (2010)*.
- Magnitude: 7 to 8 percent of East Metro residents have diabetes*.
- Seriousness: Diabetes ranks 7th for leading cause of death in Minnesota**; cost is almost \$12,000 per Minnesotan with diabetes.
- Feasibility: HealthEast Diabetes Care has expertise and experience in community-based diabetes prevention.
- Consequences of inaction: Heart disease and stroke is higher in those with diabetes.

*Source: Metro Health Survey, 2010

**Source: MDH, Center for Health Statistics (2010)

This chronic disease is an important health issue from the national perspective to our local community. Pre-diabetes is a serious health condition that increases the risk of developing type 2 diabetes, heart disease, and stroke. What is startling is that only 7 percent of people with pre-diabetes are aware of their condition. According to the Center for Disease Control, 35 percent of adults ages 20 years and older have this condition and half of all Americans aged 65 years and older have pre-diabetes.

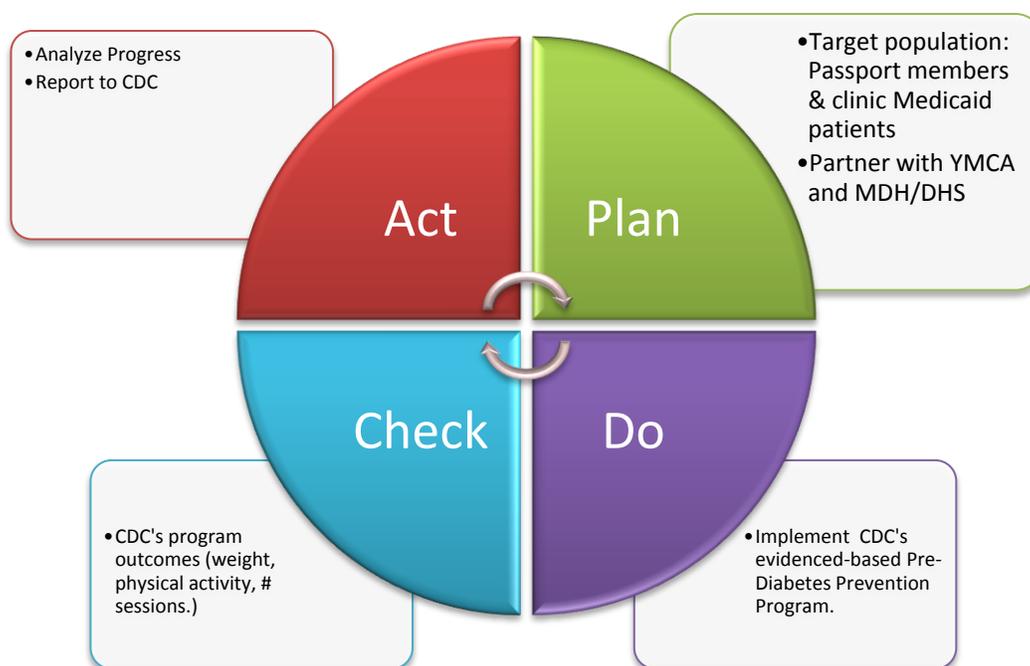
Finally, diabetes prevention efforts are proven and effective in reducing the burden of the disease and offers interventions with the biggest impact.

- **National Level:** The Centers for Disease Control (CDC) has identified pre-diabetes as an area of national concern. Not only have they identified it as a priority, in September 2011, the CDC launched a Diabetes Prevention Recognition Program. This lifestyle change program has demonstrated effectiveness in decreasing an individuals' risk for developing type 2 diabetes.
- **State Level:** Minnesota has been awarded a five-year, \$10 million grant to develop effective clinic methods to decrease an individuals' risk of developing type 2 diabetes. “We Can Prevent Diabetes Minnesota” initiative is starting in 2012.
- **Local Level:** HealthEast has existing HealthEast Diabetes Care capabilities:
 - Tools and resources to identify individuals at risk for diabetes; blood sugar screening
 - Skilled diabetes educators who are members of state and national diabetes committees
 - Established community partners (YMCA, Lion's Clubs, Hmong day care centers)
 - Established diabetes education program that has met national standards since 1993

- Diabetes education services provided and coordinated across HealthEast Care System: 14 clinics, four hospitals and home care
- Diabetes Care staff have a partnership with HealthEast Care Guides (medical home model)
- HealthEast has developed resources to improve the affordability of diabetes care to assist the growing number of individuals who are uninsured or underinsured and is in a favorable position to secure financial support for diabetes prevention programs.

Building on the existing community based diabetes prevention program, HealthEast is in a position to make a significant impact within our community. We will do this using the scientific methodology, Plan, Do, Check, Act or PDCA.

GOAL: Impact the health & wellness of the community



Target Audience: Aging population (Passport Members); Underserved population (Clinic Medicaid patients)

Area: East Metro (Ramsey, Dakota, Washington Counties)

Method: CDC's Evidenced-based best practice Diabetes Prevention Program implemented by HealthEast Diabetes Care

Partners: Minnesota Department of Health; YMCA; Lion's Clubs; CHNA partners.

Metrics: Weight, physical activity, # sessions attended, Hgb A1c; BP; LDL cholesterol; admissions to HealthEast hospitals; readmissions to HealthEast hospitals

Health Needs Not Addressed

As HealthEast develops the Community Health Improvement work, we will explore how we are already meeting the needs of the community throughout the organization. We will also identify community partners already embedded in the community with whom we can partner to address unmet needs. We will also consider the following priorities of patients and community residents based on the findings from the needs assessment from the Wilder Research “Framework to Address the Health and Wellness Needs of East Metro Residents.”

- **Adopt a comprehensive view of health and wellness**

HealthEast patients, support people, and key informants consistently described health as more than the absence of illness, but instead describe health more holistically, with an emphasis on quality of life, social connectedness, spirituality, and maintaining independence.

- **Expand patient and community knowledge of services**

Patients, support people, and cultural informants identified a lack of knowledge of the health care system as a major barrier to accessing care.

- **Improve Care Coordination**

HealthEast patients and Passport member described experiences with perceived lack of care coordination for medical and non-medical needs.

- **Work with culturally-specific organizations and non-profits**

A key role for these community organizations may be to facilitate discussions with community members and HealthEast, to assist with meaningful engagement, particularly with cultural communities.

- **Expand culturally competent services**

Limited access to health care providers of color was identified as a major concern among communities of color. They perceive a need for expanding workforce, at all levels, to be more culturally-representative and provide additional training for providers, staff, and interpreters to provide more culturally responsive services.

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- Amy Leite Bennett, Research Associate, Wilder Research

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- Cathy Barr, HealthEast Senior Vice President, Executive Sponsor CHNA
- Joan Pennington, HealthEast System Director, CHNA Project Lead
- Ann Poole, HealthEast Foundation Relations Manager, CHNA Project Lead
- Mark Laliberte, HealthEast Research Assistant, CHNA Data Collection Lead
- Anne Sonnee, HealthEast System Director - Communications, CHNA Communications Lead

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- Diane Holmgren, Saint Paul-Ramsey County Department of Public Health
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- Bonnie Brueshoff, Public Health Director, Dakota County Department of Public Health
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- Sue Hedlund, Deputy Director, Washington County Department of Public Health & Environment
- Stephanie Lenartz, Associate Planner, Washington County Department of Public Health
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Steering Committee

- Cindy Bultena, Patient Care Executive – Woodwinds Health Campus
- Lia Christiansen, Operations Executive – Bethesda Hospital
- Roger Green, Vice President - Strategy, Policy, Marketing & Communications (retired)
- Scott Hinrichs, Vice President – Spiritual Care / Mission
- Deb Hurd, Patient Care Executive - St. John’s Hospital
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- Kelly Macken-Marble, Operations Executive - HealthEast Clinics
- Matt Michel, System Director - Research & Medical Education
- Mike Nass, Vice President & Chief Financial Officer
- Helen Strike, Patient Care Executive - St. Joseph’s Hospital

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- Kay Baker, Director - Community Relations
- Kathy Geier, Director – Quality Measurement & Reporting
- Susan Mehle, System Director - Research
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