AUGUST 2015

HealthEast Community Health Needs Assessment (CHNA) Report

FY 2015 - 2018

HealthEast Bethesda Hospital (part of HealthEast Care System), HealthEast St. John's Hospital, HealthEast St. Joseph's Hospital and HealthEast Woodwinds Hospital

Wilder Research

HealthEast®

Background

In 2010, the Affordable Care Act (ACA) required not-for-profit hospitals to conduct Community Health Needs Assessment (CHNA) at least once every three years to assess community need and develop implementation strategies to address these concerns. Although hospitals have considerable flexibility in the approach they use to conduct the assessment, they must take input from individuals representing the interests of the community and are encouraged to work collaboratively with other hospitals and public health departments. While hospitals are not required to work to improve all needs identified through the assessment, the final report must describe whether and how the hospital plans to address the concerns identified through the assessment process.

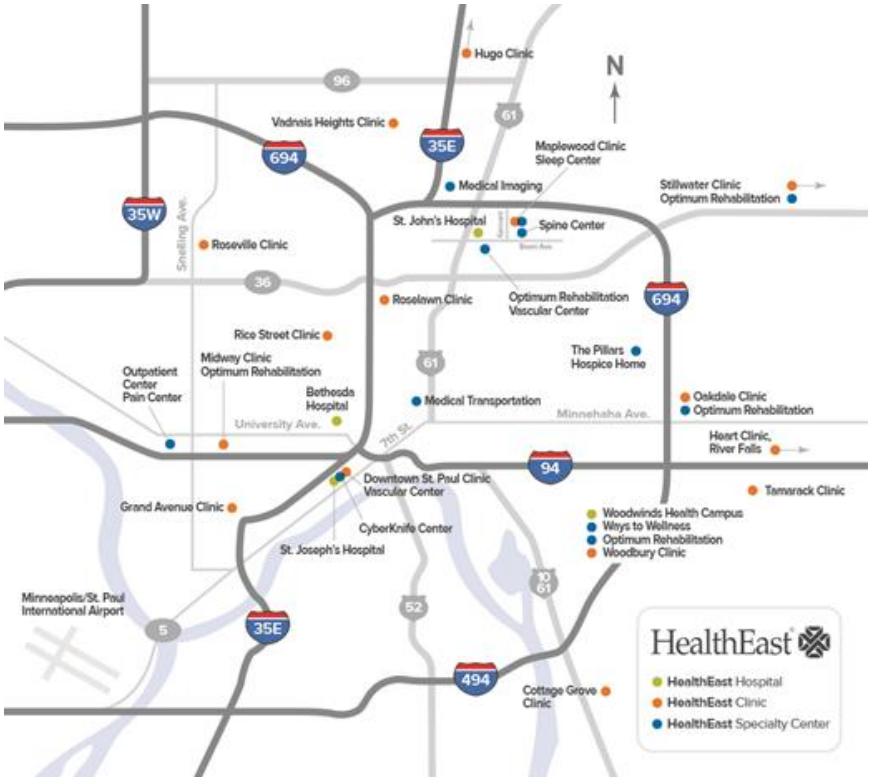
HealthEast Bethesda Hospital (part of HealthEast Care System), HealthEast St. John's Hospital, HealthEast St. Joseph's Hospital and HealthEast Woodwinds Hospital (collectively "HealthEast") contracted with Wilder Research to design and implement an assessment process that would build on work done in 2012 to better understand community health needs. This summary highlights key findings from the assessment process, including a review of secondary data, primary data collection, input from our three local public health departments, as well as a summary of identified health needs. These areas will be further refined and prioritized in order for HealthEast to focus its efforts to improve community health. The final implementation plan, which identifies the strategies that will be used to address the key priority areas, will be developed with additional input from HealthEast staff and community stakeholders and will be brought forward to the Board of Directors for final review and approval in December 2015.

HealthEast and Communities We Serve

HealthEast is the leading health care provider in the Twin Cities' east metro area, with a full spectrum of family health and medical services that includes four hospitals (Bethesda St. John's, St. Joseph's and Woodwinds Health Campus), 14 clinics, home care and medical transportation. HealthEast employs more than 7,000 people and has 1,400 physicians on staff.

HealthEast's vision is "optimal health and well-being for our patients, our communities and ourselves". HealthEast seeks to partner with other east metro organizations that support these goals in our communities. Rooted in Judeo-Christian values, HealthEast is dedicated to weaving transformative, compassionate care and a wide range of wellness and well-being initiatives into our deepening relationships with the many neighborhoods we serve.

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. The public health data was also compared with HealthEast's inpatient and clinic patient data and, therefore, "patient population" refers to consumers of health care at HealthEast facilities. Below is a map of the location of the HealthEast hospitals and clinics.



Overview of the 2015 CHNA Process

The CHNA process was designed to gather current demographic and health data from a variety of sources in order to understand the needs of east metro residents. This report contains a description of the process used for the assessment, a discussion of the types of information collected and a summary of the results.

Establish the assessment infrastructure

Gather and report descriptive secondary data

- Current demographic data from the American Community Survey and other secondary data sources.
- Population health status and health behavior data, including results from the Metro Adult Health Survey and Minnesota Student survey, as well as mortality, disease incidence, and other health data collected and made available by the Minnesota Department of Health.

Primary Data Collection

- Results from more than 1,700 surveys administered to: a) HealthEast primary care clinic patients who receive services from the Cottage Grove, Rice Street, Roselawn, Roseville, or Vadnais Heights clinic; and b) City Passport members.
- Summary of key themes identified by HealthEast care coordinators, social workers, and other professionals in a series of seven discussion groups.
- Community needs identified during discussions with Hmong, Karen, and Vietnamese immigrants and refugees who receive services and support from the Center for Social Healing, a Wilder Foundation program.
- Identify HealthEast patient data appropriate to population health and then geocode and map data to identify areas where HealthEast serves the largest numbers of patients, as well as potentially underserved areas.

Summarize Data into Significant Health Needs & Seek Approval

- Identify and summarize all findings.
- Explore potential resources for implementation strategies, both internal to the organization and in the community.

Key Findings: East Metro Resident Characteristics

Demographic Trends

In the Twin Cities east metro (Dakota, Ramsey, and Washington counties), there are three major demographic trends that set the context for the community health needs assessment:

- **A growing aging population.** Across the state and in the east metro, the percentage of aging residents is growing. By 2030, approximately 1 in 4 residents in the east metro will be age 65 and older (Figure 1). Right now, nearly one-third (30%) of residents age 65 or older have one or more disabilities. As this number increases, so will the need for a range of services, supports, and accommodations to help aging residents maintain a high quality of life.

1. Percentage of residents age 65+ living in the east metro

County	2000	2010	2014	*2020*	*2030*
Dakota	26,246 7.4%	39,816 10.0%	49,966 12.0%	*16%*	*24%*
Ramsey	59,502 12.0%	61,181 12.0%	68,974 12.9%	*17.6%*	*23.7%*
Washington	15,267 7.6%	24,984 10.5%	31,928 12.8%	*17.3%*	*25.7%*

Sources: *U.S. Census Bureau, Minnesota State Demographic Center (projections)*

- **Continued poverty.** Rates of poverty are notably higher in Ramsey County, where 17 percent of residents live at or below the federal poverty line, compared to Dakota (7%) and Washington (6%) counties. Poverty rates have decreased in Ramsey and Washington counties since the peak of the recession (2008-2010), while poverty rates have continued to increase in Dakota County, potentially due to a growing number of lower-income immigrant and refugee residents.

Rates of unemployment are approximately twice as high in Ramsey County (10%) as in Dakota (5%) or Washington (4%) counties. A lack of affordable housing is an issue for all counties; at least 25 percent of residents spend one-third of their income or more on housing costs.

- **Increasing cultural diversity.** The percentage of residents of color has increased dramatically during the past 25 years. Today, nearly one-third of Ramsey County residents are persons of color (Figures 2). This shift in diversity is shaped predominantly by changes in young adults and children. Only 5 percent of Twin Cities residents age 85 or older are people of color, compared to 41 percent of residents age 5 or younger.

2. Cultural diversity in the east metro

Race/ethnicity	Dakota	Ramsey	Washington
American Indian	<1%	<1%	<1%
Asian	4.3%	12.1%	5.3%
Black	4.7%	10.7%	3.5%
White	81.7%	66.3%	85.2%
More than one race	2.5%	3.1%	2.0%
Hispanic/Latino	6.2%	7.2%	3.5%

Source: *U.S. Census Bureau*

Neighborhood-Level Characteristics

These county-level estimates do not show the significant variation across the east metro at a neighborhood level. Maps were prepared to identify local differences in the concentration of poverty between neighborhoods, as well geographic areas where residents of color and aging residents tend to live.

Health Trends

The 10 leading causes of premature death in the Twin Cities east metro include a number of chronic conditions (e.g., cancer, heart disease, stroke, diabetes, chronic lower respiratory disease), unintentional injury, acute illness (e.g., pneumonia/ influenza), and suicide. In many of these areas, the overall trends suggest that the counties are meeting Healthy People 2020 goals[1] for disease prevalence and/or mortality rates. However, a closer look shows that there are often stark inequities where residents of color have poorer health outcomes and higher mortality rates.

Many of these chronic diseases can be prevented by changes in health behavior. Residents who follow a healthy diet, maintain a healthy weight, exercise regularly, and

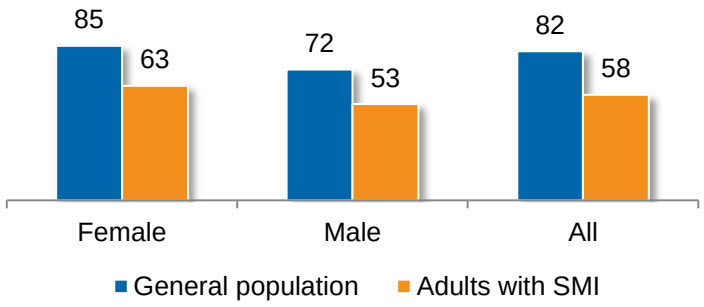
[1] Healthy People 2020 is the federal government's prevention agenda for building a healthier nation. The vision of Healthy People 2020 is to have a society in which all people live long, healthy lives. The overarching goals of Healthy People 2020 are to: attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve the health of all groups; create social and physical environments that promote good health for all; and promote quality of life, healthy development, and healthy behaviors across all life stages. (https://www.healthypeople.gov/2020)

who avoid tobacco products are at lower risk of these chronic health conditions. Analyses of HealthEast's primary care clinic data show that one-third of adult clinic patients are obese (32%) and an additional 20 percent of patients are overweight. This is higher than county-wide estimates, but differences may be the result of missing data (BMIs were not available for 11 percent of patients) or suggest that patients who are overweight/obese are more likely to seek services at primary care clinics.

Suicide is the fifth leading cause of premature death in the state. A total of 660 residents died as a result of suicide in 2012. Statewide, the age-adjusted rate of suicide has increased from 2000 and is now close to the national average. The National Institute of Mental Health (NIMH) estimates that 19 percent of adults experience a diagnosable mental illness. Data from the Minnesota Department of Health show that adults with serious mental illness (SMI) experience poorer health outcomes, dying approximately 20 years earlier than the average for the general population (Figure 3).

Analyses of HealthEast primary care clinic data show that 15 percent of patients who reside in Ramsey County have been treated for, or identified themselves as having, a mental illness. The prevalence of mental illness was much lower among Washington County residents seen at HealthEast primary care clinics (6%). These differences may due, at least in part, to missing data and underreported mental health concerns among patients.

3. Median age at death for adults with serious mental illness (SMI)



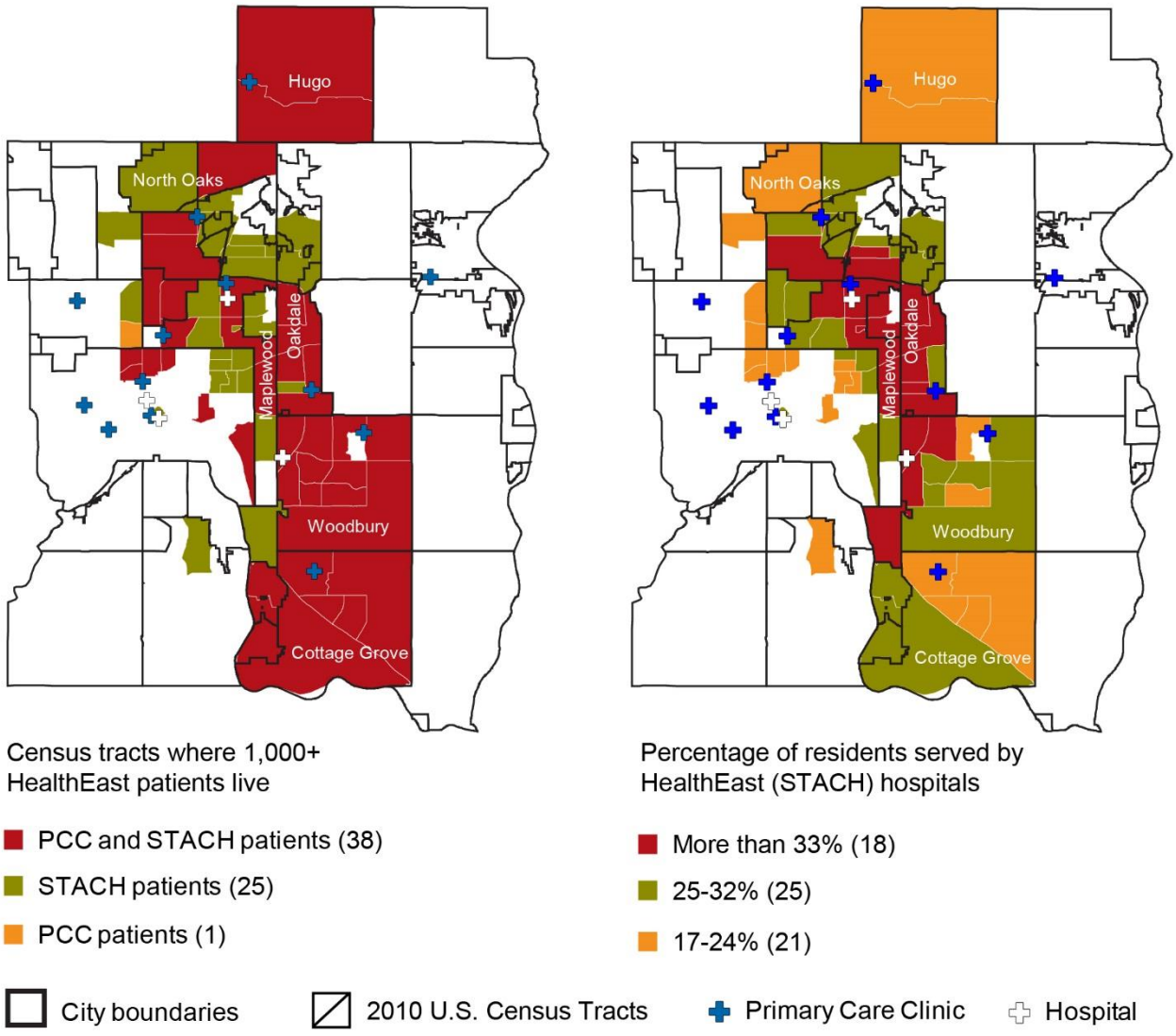
Source: *Minnesota Department of Health, Advancing Health Equity Report (2014). Data analysis of adults enrolled in Minnesota health care program (2003-2007).*

Falls and poisoning are increasingly becoming causes of unintentional injuries and death. The Minnesota Department of Health attributed these trends to a growing aging population at greater risk for falls, and the increased abuse or misuse of prescription drugs. HealthEast has a falls prevention program in place; however, screening data used to identify patients at high risk of falls was not readily available. Bethesda Hospital serves many patients who have experienced injury and require long-term care and rehabilitation.

Mapping of HealthEast Patient Data

Mapping was also done to identify the geographic areas (i.e., census tracts) where the largest numbers of HealthEast patients live. While HealthEast serves residents across the east metro, some of the areas where it has the farthest reach are in suburban Ramsey and Washington counties (e.g., Cottage Grove, Vadnais Heights, Woodbury, and Maplewood (Figure 4).

4. Census tracts where more than 1,000 HealthEast patients live (left) and where HealthEast reaches the highest percentage of residents (right)



Exploratory analyses were conducted by HealthEast to identify key characteristics of some of the patients who are among the highest utilizers of services. These include patients who have had seven or more emergency department visits during the 24-month period and patients with at least one 30-day hospital readmission during that timeframe. Over half of patients readmitted to the hospital within 30 days (56%) are adults age 65 or older. Emergency department patients tended to be younger and more diverse, often seeking care for pain.

Summary of Key Findings

The review of demographic data, current population health trends, and HealthEast patient data revealed some important findings that should be considered when identifying priority areas and developing implementation strategies.

- As the number of aging residents increases, the east metro will need to have the services and supports in place to help aging residents maintain a high quality of life in their homes and as they require more intensive assistance.
- Because of the growing cultural diversity within the east metro, it is important for HealthEast to continue to provide culturally-appropriate services, including strategies to develop a health care work force that is more reflective of the population it serves. Because of linguistic barriers, social isolation is also a concern for immigrant and refugee populations.
- Although at a county-level, the east metro appears to be meeting many of the Healthy People 2020 goals, there are pervasive health inequities based on race and income. Upstream efforts are needed to address these social determinants of health and improve the conditions of neighborhoods where lower-income residents tend to live.
- Some of the geographic areas where HealthEast serves the largest number of patients are in suburban communities in Ramsey and Washington counties. Although HealthEast has clinics and hospitals in high-poverty areas of St. Paul, these are not the areas with the largest numbers of patients who seek services.
- Locally-driven solutions are needed to improve the health of residents. The mapping of demographic data demonstrates that there are notable differences in rates of poverty and demographic characteristics of residents by census tract. While HealthEast priorities may apply across the full region, the strategies used to address these interests should reflect the priorities of local residents.

Key Findings: Primary Data Collection

Rationale for Methodology

The review of demographic data and HealthEast patient data showed that there are key populations and geographic areas where HealthEast may wish to focus its efforts to have the potential greatest impact. A multi-method data collection approach was used to gather information from key populations from geographic areas that were home to large numbers of HealthEast residents or medically underserved populations; aging residents; new immigrant and refugee populations; and HealthEast patients with the need for care coordination or other support services to improve/maintain their health (Figure 5).

5. Targeted populations and data collection methods

Target population	Data collection methods
HealthEast patients living independently in the community in need of care coordination services and/or support.	Discussion groups with HealthEast staff
Geographic areas where HealthEast a) serves a large number of residents or b) serves medically underserved populations	Clinic patient surveys collected during a 2-week period at the following clinics: Cottage Grove; Downtown St. Paul; Rice Street; Roselawn; Roseville; Vadnais Heights. Review of internal patient data.
Aging residents	Surveys administered to City Passport members
New immigrant/refugee populations	Discussion groups with Wilder's Center for Social Healing clients and staff

Summary of Key Findings

There are populations who are more likely to experience poor health outcomes, who are disengaged from health care services, and who have more complex medical issues and who are more likely to benefit from care coordination services. These populations of interest include: residents with multiple chronic conditions/comorbidities; aging residents, including residents living with dementia or Alzheimer's Disease; immigrant and refugee populations, particularly first-generation residents; residents with mental illness and/or substance abuse problems; persons experiencing homelessness; and residents who require long-term medical care, such as the patients who receive care at Bethesda Hospital.

Residents and staff were asked to identify barriers to residents improving or maintaining their health and to suggest changes that could be made to improve the health of residents. The most common concerns raised across groups included:

- Lack of indoor areas for physical activity; need for more sidewalks/paths
- Social isolation; lack of informal support
- Lack of affordable, accessible transportation
- Limited access to affordable, healthy foods
- Difficulty accessing appropriate mental health services
- Care coordination challenges
- Lack of affordable housing, low-cost programs and other resources for residents living in poverty and/or experiencing homelessness

Feedback from Local Public Health Departments

A required component of the CHNA process is to gather feedback from local public health departments. While the IRS requirements do not specify that hospitals and local public health departments collaborate to develop implementation strategies, directors from all counties were interested in opportunities to work together and to consider how their work aligns.

The local public health department representatives noted a few concerns that emerged in their recent assessments that fell beyond their scope, but were areas where hospitals and health care systems may be better positioned to take action:

- Improving access to mental health services, including screening and diagnostic assessments
- Working collaboratively to increase participation in the Child and Teen Checkups Program to reduce childhood obesity and help youth feel comfortable seeking ongoing preventive care
- Increasing workforce diversity by engaging youth in learning about health care careers and increasing hiring and retention of employees who better reflect the demographic characteristics of east metro residents

HealthEast contacted the following local public health department representatives: Rina McManus, Director, Saint Paul-Ramsey County Department of Public Health; SuzAnn Stenso-Velo, Planning Specialist, Health Policy & Planning, Saint Paul-Ramsey County Department of Public Health; Jocelyn Ancheta, Policy and Planning Manager, Saint Paul-Ramsey County Department of Public Health; Sue Mitchell, Saint Paul-Ramsey County Department of Public Health; Melanie Countryman, Epidemiologist/Senior Informatics

Specialist, Dakota County Department of Public Health; Lowell Johnson, Director, Washington County Public Health; and Tommi Goodwin, Washington County Public Health.

Identified Significant Health Needs

The assessment follows an iterative process that uses data from a wide range of sources and then solicits feedback from a broad group of stakeholders (Figure 5). The process began with a comprehensive review of local demographic and health data to identify health status, health disparities and inequities that contribute to poorer health outcomes. This included a review of the data available for the leading causes of death in the east metro counties, as well as common risk factors that contribute to poor health, including obesity, physical inactivity and tobacco use.

The data showed that across multiple measures of health, wellness, and disease prevalence, our residents of color and residents with lower levels of income have poorer health outcomes. Therefore, a health equity focus is needed to ensure that any strategies developed to improve the health and well-being of all patients are also effective in reducing health inequities between populations based on race, income and place.

Criteria Used for Identifying Health Needs

Based on a review of the data summarized above, the HealthEast community health needs assessment team, including Wilder Research staff, used the following criteria in order to focus on the most significant health needs: level of need; evidence of disparities; potential impact; emerging trends; opportunities for collaboration. The team identified the significant health needs that HealthEast will consider when prioritizing efforts to improve the health and well-being of our community. These needs are described in the next section.

Significant Health Needs Identified

Diseases and Conditions

- **Mental Health:** According to the Substance Abuse and Mental Health Administration, mental health was consistently identified as a serious concern among community residents, as well as HealthEast patients and staff. Accessing appropriate services is a challenge across the spectrum of care, from early

screening and diagnostic assessments to mental health services for residents with serious and persistent mental illness. Public health departments have also identified the lack of mental health services as a significant community need.

- **Chronic Diseases – Cancer, Heart Disease, and Chronic Lower Respiratory Disease:** These chronic conditions continue to be the top ranking causes of premature death for east metro residents. Mortality rates for both cancer and heart disease have steadily decreased during the past 20 years, but disparities persist. Cancer mortality rates are notably higher among American Indian and African American residents, compared to other communities. Mortality rates due to heart disease are at least twice as high for American Indian residents than for other cultural communities.

- **Unintentional Injury:** Minnesota ranks fifth in the nation for fall-related deaths, in part due to a growing aging population.

Healthy Behaviors & Risk Factors

- **Obesity:** Obesity is a risk factor for many of the most common causes of premature death. Approximately one-third of HealthEast primary care clinics patients are obese (based on BMI), placing them at higher risk for a range of chronic diseases and poorer health outcomes. HealthEast patients and community residents identified limited opportunities for physical activity and difficulty accessing healthy foods as some of the most common barriers to overall health.

- **Aging:** With a fast-growing aging population, there is increased demand for services that help aging residents maintain a high quality of life in their homes. Ambulatory difficulties and other disabilities can make it more challenging for aging residents to leave their homes, potentially leading to social isolation.

- **Tobacco:** Use of tobacco by residents continues to contribute to chronic disease and premature death.

Social Determinants of Health

- **Social Isolation:** Both aging residents and those who are new immigrants or refugees report experiencing social isolation.

- **Access to Healthy Food:** This is a concern, especially in the underserved areas of St. Paul and in certain suburban areas.

- **Poverty:** This is especially remarkable in the medically underserved areas of St. Paul and also focused in certain suburban areas.
- **Transportation & Housing:** Access to transportation and affordable housing is a consistent theme expressed by both HealthEast patients and Care Managers.
- **Access to health services:** Having access to language interpretation and culturally appropriate services is a barrier for immigrant and refugee residents.

Resources to Address the Needs

As HealthEast develops the community health improvement plan, HealthEast will look to both internal and external resources that are potentially available to address the significant health needs identified through the CHNA process. To begin, HealthEast will look internally to HealthEast's four hospitals and 14 clinics to determine expertise that matches the needs. In addition, there are other major health systems within the east metro community that may have resources that could address the needs.

The Center for Community Health (CCH) is a significant resource. This is a collaborative between local public health departments, health systems, and health plans representing over 40 organizations across the seven-county metro Twin Cities area. The mission of CCH is to improve the health of our community by engaging across sectors and serving as a catalyst to align the community health assessment process and the development of action plans to impact priority health issues and increase organizational effectiveness. Together, we can work across sectors to improve community health and well-being.

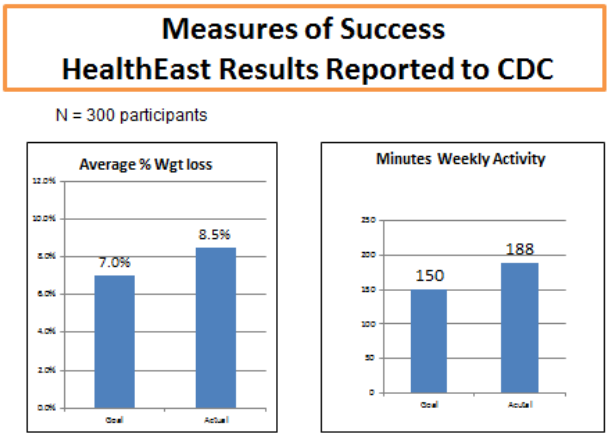
HealthEast will also leverage existing relationships with community organizations already working in neighborhoods, partnering to address unmet needs. These include organizations such as the YMCA, Wilder, City of St. Paul Parks & Recreation, police departments, school districts, Karen Organization of Minnesota, Hmong American Partnership and the Metropolitan Area Agency on Aging.

Finally, HealthEast will work with Ramsey, Washington, and Dakota County public health departments to identify potential resources and opportunities to coordinate efforts through their Statewide Health Improvement Plans (SHIP) and Community Health Improvement Plans (CHIP).

HealthEast Results from FY 2012 – 2015

The CHNA conducted in 2012 described the characteristics of east metro residents, summarized the health and health behavior data available, and synthesized feedback from HealthEast patients and community stakeholders. After reviewing results from the assessment, gathering other feedback from community stakeholders and HealthEast staff, and considering how to best align the assessment results with current strategies and resources, HealthEast decided to focus its initial efforts on developing a community benefit infrastructure and implementing a targeted pre-diabetes prevention program. A falls prevention program also was implemented to respond to some of the needs of aging residents.

HealthEast chose to implement the evidenced-based diabetes prevention program (DPP) developed by Centers for Disease Control and Prevention. HealthEast partnered with the Minnesota Department of Human Services to train our own Lifestyle Coaches to facilitate the program, *We Can Prevent Diabetes.* The target audience for this program is Medicaid recipients who are diagnosed with pre-diabetes and its intent is to remove all barriers that may hinder access and participation in the program. Additionally, HealthEast partnered with the YMCA to provide a similar program to Medicare recipients called *I Can Prevent Diabetes.* Data from all DPP cohorts are reported to CDC national registry. The results from the programs from 2012 – 2015 are below.



Another community health need identified in the FY 2012 assessment was premature death due to unintentional injury from falls. Falls are the leading cause of both hospitalized and ER-treated injury. HealthEast also knows that fear of falling among older residents is associated with depression, isolation, increased frailty and decreased mobility and that Minnesota ranks fifth in the nation in falls-related deaths. HealthEast also learned that:

- The average cost of hospitalization from a fall is $17,483.
- 2009 fall fatalities in Minnesota resulted in more than $255 million in medical expenses.

In FY 2013, HealthEast launched a system-wide falls prevention plan for patients in our hospitals, clinics and home health care program. Community Outreach responded by developing and implementing an evidenced-based community program called Matter of Balance. This was done in partnership with the Metropolitan Area Agency on Aging and local community centers and organizations, such as Hmong American Partnerships. The demand exceeded expectations as the senior population responded to these affordable and effective classes. As a result, HealthEast continues to partner and offer classes to east metro seniors.

To date, 228 seniors have participated in the program and those who report a "**fear of falling that interferes with daily activities" decreased from 21% to 17%**. The class has also been conducted in Cambodian and Hmong.

Next Steps in the CHNA Process

Adoption by HealthEast Board of Directors; Posting for Community

The HealthEast Board of Directors reviewed and adopted the full CHNA report on August 13, 2015. The report will be available to the general public on the HealthEast website, www.healtheast.org on or before August 31, 2015.

Prioritizing Health Needs Developing Implementation Strategies

HealthEast will take the next four months to conduct the final steps in the assessment process by reviewing the significant health needs and prioritizing the top needs that will be addressed over the next three years. HealthEast will then develop implementation strategies and a plan for FY 2015 – 2018 as HealthEast strives toward its vision of optimal health and well-being for the community.

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- **Melanie Ferris, Research Specialist, Wilder Research**
- **Nick Stuber, Research Associate, Wilder Research**

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- John Swanholm, Vice President of Community Advancement, Director of HealthEast Foundation
- Joan Pennington, HealthEast System Director, CHNA Project Lead
- Amy Fehrer, IRB Program Manager
- Mee Cheng, Community Health Evaluations Coordinator
- Melissa Short, Director Enterprise Reporting
- Ann Warner, Manager Data Engineering
- Susan Mehle, Director Data Science

A special thank you to the HealthEast Community Health Needs Assessment (CHNA) Advisory Committee:

- Scott North, Senior Vice President, President Acute Care Hospitals
- Dr. John Kvasnicka, Vice President, Executive Medical Director
- Debra Hurd, Vice President, Acute Care Nursing
- Brian Gager, Vice President, Acute Care Operations
- Paul Torgerson, Senior Vice President, Chief Administrative Officer, General Counsel
- Tracy Miland, System Director of Strategic Planning, Brand Development and Marketing
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- Mary Pynn, Vice President, Chief Clinical Quality Officer
- Elizabeth Anderson, System Director of Equitable Care
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- Rina McManus, Director, Saint Paul-Ramsey County Department of Public Health
- SuzAnn Stenso-Velo, Planning Specialist, Health Policy & Planning, Saint Paul-Ramsey County Department of Public Health
- Jocelyn Ancheta, Policy and Planning Manager, Saint Paul-Ramsey County Department of Public Health
- Sue Mitchell, Saint Paul-Ramsey County Department of Public Health
- Melanie Countryman, Epidemiologist/Senior Informatics Specialist, Dakota County Department of Public Health
- Lowell Johnson, Director, Washington County Public Health
- Tommi Goodwin, Washington County Public Health
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- Sarah Bergman, Community Benefit and Evaluation, Allina Health

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