DECEMBER 2015

HealthEast Community Health Implementation Plan

FY 2016-2018





Wilder Research

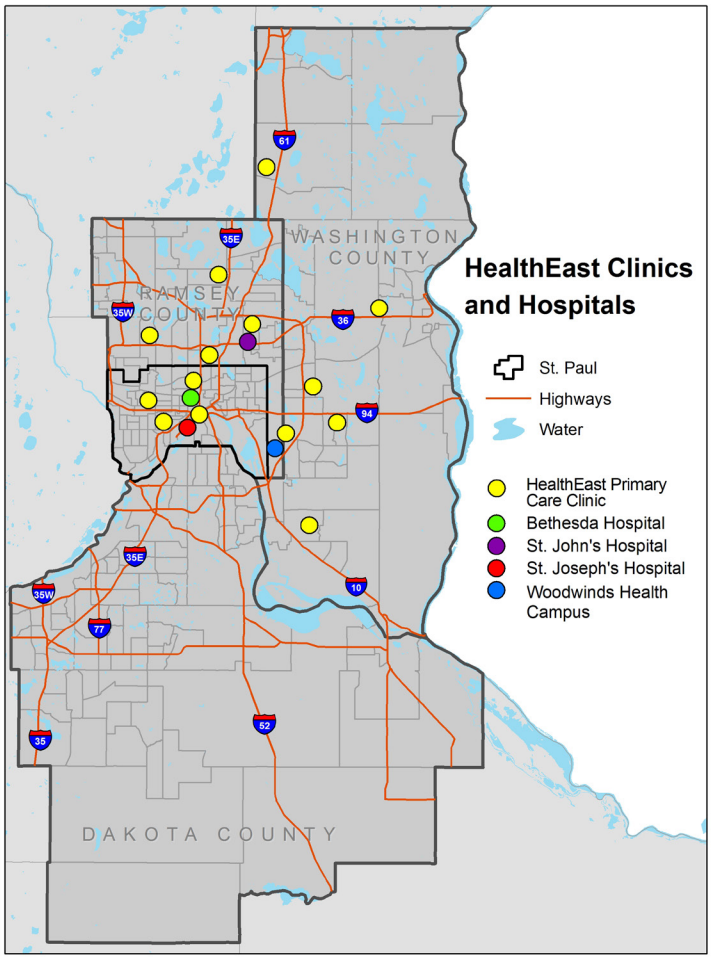
HealthEast®

Contents

HealthEast and Communities We Serve

HealthEast (www.healtheast.org) is the leading health care provider in the Twin Cities East Metro area (Dakota, Ramsey and Washington Counties). From prevention to cure, we meet the needs of the community with family health and specialty programs that span four hospitals – Bethesda Hospital, St. John's Hospital, St. Joseph's Hospital and Woodwinds Health Campus – plus 14 clinics, home care and medical transportation. HealthEast has nearly 7,500 employees and 850 physicians on staff.

Our vision is optimal health and well-being for our patients, our communities and ourselves. We are focused on a future that includes community well-being and deepening East Metro partnerships.



Background

In September 2014, HealthEast began its second Community Health Needs Assessment (CHNA) in compliance with the Affordable Care Act, which mandates hospitals to conduct an assessment every three years. HealthEast chose to complete a single assessment and implementation plan to guide the work of all four hospitals: Bethesda Hospital; St. John's Hospital; St. Joseph's Hospital; and Woodwinds Health Campus. The first phase of the CHNA (Phase I) included primary data collection and a review of secondary data to identify community health needs. This phase was completed in July 2015 and the CHNA report was adopted by the HealthEast Board of Directors in August 2015.

In the second phase of the CHNA (Phase II), the health needs identified in Phase I were reviewed and prioritized to identify the significant health needs that HealthEast will address over the next three years. The final implementation plan, which identifies the strategies that will be used to address these key priority areas, was developed by a multi-disciplinary team of HealthEast staff. Implementation of the final plan is scheduled to begin in January 2016, after receiving approval from the Board of Directors.

This report is organized into three sections: a brief description of Phases I and II of the CHNA process, including the steps used to prioritize community health needs identified during the assessment; the FY2016-2018 Community Health Implementation Plan (CHIP); and an appendix that includes the materials HealthEast stakeholders used during the prioritization process. More detailed information about the CHNA process can be found in the HealthEast Community Health Needs Assessment (CHNA) Report (available at www.healtheast.org).

Identification and prioritization of community health needs

A brief review of CHNA Phase I activities: Identification of key community health concerns

Phase I of the CHNA process used a mixed-method assessment approach to identify the community health needs of residents living in the Twin Cities East Metro (Dakota, Ramsey, and Washington counties) and to describe the demographic and socioeconomic trends that influence health outcomes. The assessment process included reviewing, compiling, and analyzing data from a number of data sources including: a) demographic

data from the American Community Survey; b) population health status and health behavior data from a variety of sources; and c) HealthEast patient records. This review of existing data was used to identify the leading causes of premature death in the east metro and disparities in health outcomes, as well as to understand the underlying health behaviors, risk factors, and social determinants that contribute to premature death and disability.

Multiple strategies were also used in this assessment phase to identify community health concerns and capture suggestions for improving health outcomes from key stakeholder groups, including: HealthEast primary care patients; HealthEast City Passport members; HealthEast care coordinators, social workers, and other professionals; local public health department staff; and Hmong, Karen, and Vietnamese members of the Wilder Foundation's Center for Social Healing program, which serves immigrants and refugees living in the Twin Cities East Metro.

A summary of CHNA Phase II activities: Prioritization of community health concerns

Although the assessment identified the leading causes of premature death and disability in the east metro, as well as health disparities in disease prevalence, morbidity, and mortality, we were purposeful in also gathering data to understand the "upstream" risk factors and socioeconomic conditions that contribute to poor health outcomes (Figure 1). Using this framework, 12 issues were brought forward to HealthEast stakeholders for consideration in the prioritization process.

1. Health conditions, risk factors, and social determinants explored through the CHNA process

Leading causes of premature death in the east metro	Upstream risk factors, socioeconomic conditions, and demographic trends influencing health and contributing to disparities
▪ Cancer ▪ Heart disease ▪ Unintentional injury ▪ Chronic lower respiratory disease ▪ Suicide ▪ Stroke ▪ Diabetes ▪ Cirrhosis ▪ Nephritis ▪ Pneumonia/influenza	Social and economic factors, physical environment: Affordable housing and housing supports; poverty; social isolation; transportation; health inequities Health behaviors/key risk factors: Aging; obesity; poor nutrition; physical inactivity; tobacco use Clinical care: Access to health services; unmet mental health needs

Issue briefs were prepared to provide HealthEast stakeholders with information about each of the health topics under consideration (see Appendix). Each issue brief summarizes key data to describe the number of people directly impacted by the issue (magnitude), highlights disparities that place disproportionate health burdens on some populations (impact), describes the ways in which the issue impacts health outcomes and quality of life (seriousness), and reports data from earlier assessment phases to describe the degree to which the health issue was a priority for east metro stakeholders from the primary data collection process (identified need). To help prioritize the greatest community health needs, ratings were developed for all criteria and assigned to each health topic (Figure 2).

2. Criteria and ratings used in the prioritization process

Rating criteria, key questions	Rating categories	Rating assigned Example: Obesity
Magnitude How many people are affected? What is the variance from key targets, when applicable? How many people will be impacted in the future?	A= 30% of the population or more B=20-29% C=10-19% D=less than 10%	**B**
Impact What populations/geographic areas experience greater burden (i.e., health disparities)?	A = disparities evident B = no disparities noted	**A**
Seriousness Does the problem lead to death, disability, or impairment of quality of life?	A = direct cause of death/ disability/impairment B = contributing cause C =general risk factor for health	**A**
Seriousness What are the emerging trends?	A = likely to worsen B = likely to stay constant C = likely to improve	**A**
Identified need Which stakeholder group(s)[a] identified this as a priority concern?	A = all stakeholder groups B = some stakeholder groups C = one stakeholder group D = no stakeholder groups	**A**

[a]*This refers to the four stakeholder groups who provided input through the assessment process: HealthEast primary care patients; HealthEast staff (care coordinators, social workers, and other staff); HealthEast City Passport members; Center for Social Healing members*

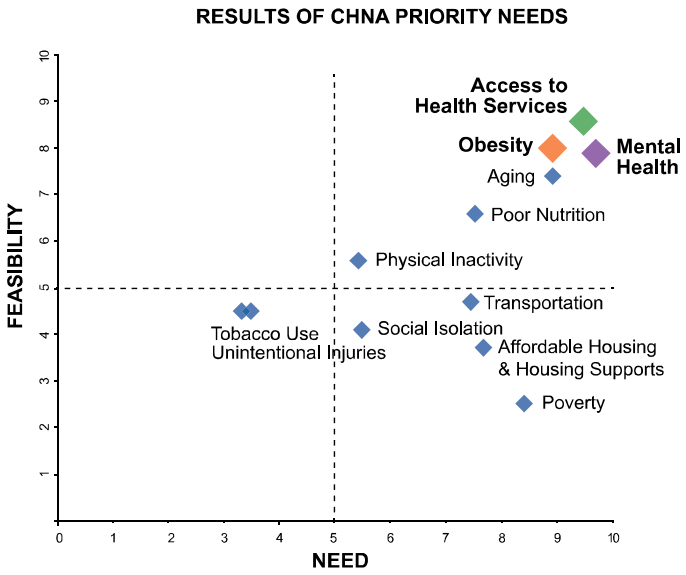
The Community Health Needs Assessment Advisory Committee members, who represent various sectors of the organization, including short-term acute care services, ambulatory services, mental health and addiction care services, care coordination, home care, equitable care, neighborhood integration, value-based improvement, community health improvement, and marketing and strategy, met to prioritize the 12 health topics under consideration, using the issue briefs and prioritization ratings as a source of information to guide their decision making. The committee also received a feasibility document describing the work that HealthEast is currently doing within the organization and in the community to better understand its capacity to respond to the identified health issues (see Appendix). Four-quadrant strategy grids were

developed for each health issue and a dot voting process was used to identify the top three priority health issues. Participants were asked to plot need (x-axis) versus feasibility (y-axis) on each strategy grid using the following quadrants:

High Need/High Feasibility: High need rating, high demand, high impact, high internal expertise or ability to partner.

Low Need/High Feasibility: Low need rating, but high internal expertise and/or ability to partner.

High Need/Low Feasibility: High need rating, but low internal expertise and/or ability to partner. This may include long term projects that have potential but require significant investment.



Low Need/Low Feasibility: Low need rating, minimal impact, low internal expertise and/or ability to partner.

Key priority areas and areas of focus

The following health issues were identified during the prioritization process as having the highest need and feasibility ratings:

1. Access to health services
2. Obesity
3. Mental health

The advisory committee, interested in addressing these priority health issues through a health equity lens, also identified a need to focus the implementation plan on meeting the needs of the following priority populations:

1. Aging residents
2. Residents in poverty
3. Populations of color

Health needs identified but not addressed

Significant needs identified through our assessment that will not be addressed in the current three-year plan are listed below.

3. Health needs identified but not addressed in the implementation plan

Community Need	Reasons Not Addressed
Affordable Housing and Housing Supports	This issue will not be addressed as a primary need, but will be impacted through our access to services priority.
Social Isolation	This issue will not be addressed as a primary need, but will be impacted through our mental health and access to services priorities.
Transportation	This issue will not be addressed as a primary need, but will be impacted through our access to services priority.
Poor Nutrition	This issue will not be addressed as a primary need, but will be impacted through our obesity priority.
Physical Inactivity	This issue will not be addressed as a primary need, but will be impacted through our obesity priority.
Tobacco	Significant progress has already been made on this issue; need identified as a low priority.
Unintentional Injury	Need identified as a low priority; unintentional injuries related to falls among the aging population will be addressed through our obesity priority.

Community Health Implementation Plan FY2016-2018

The following is HealthEast's Community Health Implementation Plan to address the needs of the communities it serves over the next three years. This plan was developed with significant contributions from HealthEast staff, providers, and leaders, as well as community members. Questions may be directed to HealthEast's Community Health entity.

Resources to address health needs

HealthEast will utilize both internal and external resources to address the significant community health needs identified through the CHNA process. First, we will look internally to our four hospitals and 14 clinics to assess expertise and determine how our existing organizational strategies can best be aligned to support our work in the community.

The Center for Community Health (CCH) will also serve as a significant resource for this implementation plan. This Center is a local collaborative between public health departments, health systems, and health plans representing more than 40 organizations across the Twin Cities seven-county metro 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.

In addition, HealthEast will leverage existing relationships with community organizations already working in neighborhoods to address unmet health needs. These organizations include the YMCA, Wilder, City of St. Paul Parks & Recreation, local police departments and school districts, the Karen Organization of Minnesota, the 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).

Goals, Objectives, and Strategies

Aligned with our HealthEast vision for optimal health and well-being, our Community Health Needs Assessment Advisory Committee and other stakeholders created three priority goals, with supporting objectives and strategies. The goals aim to reduce health disparities and improve well-being among east metro residents, particularly among aging residents, residents living in poverty, and communities of color. A number of strategies included in the implementation plan also address other community health concerns that were identified during the assessment process, but not elevated as priority issues.

PRIORITY: Obesity

GOAL: Promote healthy lifestyles and improve access to nutritious food and physical activity in order to increase the percentage of people living at a healthy weight.

OBJECTIVE 1:

Increase participation in nutrition and physical activity education in targeted neighborhoods or with priority populations.

Strategies	Target Date	Anticipated Impact
Leverage HealthEast leaders on community boards, committees, and other initiatives	Ongoing	Increased collaboration and connectivity between HealthEast and other service providers
Offer free or reduced cost wellness programs for groups in need, including diabetes prevention, Matter of Balance, Tai Chi classes, general nutrition, and food preparation	2017	People will have access to affordable nutrition and exercise programs
Assess and build awareness of culturally appropriate resources and tools that are written at an appropriate health literacy level for patients with high BMI	2016	People will have access to health information that they can understand

OBJECTIVE 2:

Improve access to healthy food.

Strategies	Target Date	Anticipated Impact
Explore food systems in east metro and identify partnership opportunities that increase healthy food choices and access to healthy food	Ongoing	Identification of potential partners to address food systems issues
Engage and educate HealthEast employees to help address obesity/food systems initiatives	Ongoing	People will have access to affordable healthy food

PRIORITY: Obesity (continued)

GOAL: Promote healthy lifestyles and improve access to nutritious food and physical activity in order to increase the percentage of people living at a healthy weight.

OBJECTIVE 3:

Increase physical activity and decrease social isolation for aging and new immigrant populations.

Strategies	Target Date	Anticipated Impact
Increase social connectedness for aging population through Passport Program	Ongoing	Aging residents will have the opportunity to connect and socialize with others

OBJECTIVE 4:

Establish community health dashboard to measure obesity.

Strategies	Target Date	Anticipated Impact
Develop internal capacity and standard work for community health dashboard	2016	Provide ongoing support for and monitoring of CHIP activities
Collaborate with other health care providers to aggregate health data to establish accurate measures of obesity	2017	Provide an accurate measure of obesity in the community

PRIORITY: Unmet Mental Health Needs

GOAL: Improve access to and awareness of culturally appropriate mental health resources and education.

OBJECTIVE 1:

Increase access for patients with mental health needs.

Strategies	Target Date	Anticipated Impact
Provide a culturally appropriate mental health and addiction program to the Karen community	Ongoing	Minority populations will have improved access to mental health and addiction care programs
Provide mental health medication financial assistance through Mental Health Alliance collaboration	Ongoing	Low income residents will have access to mental health medication
Assess and build awareness of mental health resources for Primary Care Clinic Care Guides and clinic MDs	2017	Primary care patients will receive appropriate mental health referral services

PRIORITY: Unmet Mental Health Needs (continued)

GOAL: Improve access to and awareness of culturally appropriate mental health resources and education.

OBJECTIVE 2:

Promote mental health awareness in the community.

Strategies	Target Date	Anticipated Impact
Expand anti-stigma campaign throughout HealthEast	Ongoing	People will seek the mental health services that they need
Provide leadership for community organizations and collaborations	Ongoing	Increased collaboration and connectivity between HealthEast and other service providers

OBJECTIVE 3:

Expand community-based mental health services and supports to targeted ethnic and aging populations.

Strategies	Target Date	Anticipated Impact
Expand community paramedicine program for people discharged to home who have a mental health issue	2017	The number of people who are hospitalized or seen in the ED for a mental health issue will decline
Partner with community-based organizations to create mental health supports in community setting	2018	People will have access to appropriate mental health supports in the community

OBJECTIVE 4:

Establish community health dashboard to measure well-being.

Strategies	Target Date	Anticipated Impact
Develop internal capacity and standard work for community health dashboard	2016	Provide ongoing support for and monitoring of CHIP activities
Collaborate with other health care providers to aggregate health data to establish accurate measures of well-being	2017	Provide a community-based measure of well-being

PRIORITY: Access to Services and Resources

GOAL: Improve access to and understanding of resources that positively impact health and the social determinants of health.

OBJECTIVE 1:

Reduce stressors and increase coping skills regarding basic needs.

Strategies	Target Date	Anticipated Impact
Establish cross-sector partnerships to address social determinants of health	Ongoing	Increased collaboration and connectivity between HealthEast and other service providers
Build awareness of transportation resources for targeted populations	2016	People will have knowledge of and improved access to transportation services
Explore lay community partnerships in specific care delivery and navigation models	2018	Vulnerable hospital and clinic patients will have access to community-based support systems
Partner with county, housing, and other resources to promote housing options for homeless patients to decrease readmission rate and improve health	2018	Homeless patients will have access to housing

OBJECTIVE 2:

Promote access to services in the community.

Strategies	Target Date	Anticipated Impact
Provide leadership for community organizations and collaborations	Ongoing	Increased collaboration and connectivity between HealthEast and other service providers
Expand community paramedicine program to vulnerable populations	Ongoing	The number of vulnerable people who are re-admitted to the hospital or seen in the ED will decline
Provide Faith Community Nurse Program in targeted neighborhoods and/or churches	Ongoing	Vulnerable members of the faith community will have access to medical and faith-based support
Enhance access to health care services through primary care redesign	2016	Increase access to primary care through innovation

OBJECTIVE 3:

Establish community health dashboard to measure access.

Strategies	Target Date	Anticipated Impact
Develop internal capacity and standard work for community health dashboard	2016	Provide ongoing support for and monitoring of CHIP activities
Collaborate with other health care providers to aggregate health data to establish accurate measures of access	2017	Provide a community-based measure of access

Measurement of Impact

A series of process and outcomes metrics will be developed to measure the impact of each strategy. These metrics will be reported in a community health dashboard and will be monitored by the Community Advancement department and HealthEast leadership.

About the data sources

American Community Survey

The American Community Survey (ACS) is an ongoing survey conducted by the U.S. Census Bureau to gather information about ancestry, educational attainment, income, language proficiency, disability, employment, and housing characteristics. In this report, single year estimates are used to describe state and county-level population characteristics. Pooled estimates (using data collected across multiple years) were used to ensure the estimates reported for census tract level maps were reliable.

Minnesota Student Survey

The Minnesota Student Survey is administered every three years to students in 6th, 9th, and 12th grades who attend regular public elementary and secondary schools, charter schools, and tribal schools. All public school districts in the state are invited, but not required, to participate. Students respond to the survey anonymously and can also decline to take the survey. Participation is also impacted by illness, truancy, schedule conflicts, and parent refusal.

Overall, school district participation in the MSS is quite high (88%-92% since 1998). However, school district participation does vary over time. In Dakota, Ramsey, and Washington Counties, variation in participation occurred primarily among charter schools. Indicators for 9th grade students were included in the report, as many risk factors become evident by this age and the overall participation rate is much higher among 9th grade students than 12th grade students (75% and 59%, respectively).

Metro Adult Health Survey

In 2010, the Metro Adult Health Survey was administered to a representative sample of adults who live in the following six counties in the Twin Cities Metro: Anoka County, Carver County, Dakota County, Ramsey County, Scott County, and Washington County. The survey was developed to gather county-level data about adult general health status, eating habits, physical activity behaviors, neighborhood and community characteristics, and tobacco use. The survey includes a number of items that are asked in the Behavioral Risk Factor Surveillance System (BRFSS), administered by the Center for Disease Control and Prevention (CDC) so that counties can have more reliable estimates of their county-level data.

Additional public health data sources

A variety of public health data sources were used to report disease incidence and mortality data, as well as information about health insurance coverage and risk behaviors. Not all data sources can be used to report reliable county-level estimates for specific population groups, and in those circumstances, state-level counts or estimates were used. Data sources referenced in this report include the following sources available through the Minnesota Department of Health: Minnesota County Health Tables, Minnesota Vital Statistics Trends, Minnesota Public Health Data Access System, Minnesota Cancer Surveillance System, and the Healthcare Effectiveness Data and Information Set.

HealthEast patient surveys

Surveys were administered to HealthEast primary care clinic patients at the time of check-in at five clinic locations: Cottage Grove, Rice Street, Roselawn, Roseville, and Vadnais Heights. These clinics were selected because they are located in areas where large numbers of HealthEast patients live or are located in or near neighborhoods with high concentrations of poverty. The survey included questions about overall health and barriers to health, and also included questions to learn what changes patients would make in their neighborhoods to improve health. The surveys were available in multiple languages (English, Burmese, Chinese, Hmong, Karen, Somali, and Spanish) and were completed by over 2,000 patients (21-54% of patients who had appointments scheduled during the 2-week data collection period).

HealthEast Passport member surveys

A series of seven discussion groups were convened with HealthEast care coordinators, social workers, parish nurses, and home case staff. These staff, who play key roles in helping patients access services and supports to improve health, were asked to describe the types of services available in the community, gaps in services and supports, and barriers to accessing existing resources. The discussion participants also had opportunities to offer suggestions about changes that could be made to improve the health of HealthEast patients and east metro residents.

Center for Social Healing discussion groups

The Amherst H. Wilder Foundation's Center for Social Healing provides a point of access for a flexible, culturally sensitive, and holistic system of supports for Southeast Asian residents living in Ramsey County. A series of discussion groups was conducted with Hmong, Karen, and Vietnamese residents who receive services and supports from the Center. Approximately 20 to 30 members of the Center participated in each conversation. During the discussion, members were asked to describe what it means for them to be healthy, to provide examples of challenges they face maintaining their health, and to share their ideas about changes that could be made that would help them improve or maintain their health.

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