Community Health Needs Assessment Implementation Strategy

Fiscal Year 2014 Progress Report and Fiscal Year 2015 Update

Minnesota Valley Health Center, Inc., Le Sueur, MN

Essentia Health

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Executive summary

Minnesota Valley Health Center, Inc. (MVHC) conducts a Community Health Needs Assessment (CHNA) and adopts an implementation strategy to meet the community health needs identified through the CHNA at least once every three years. The majority of the hospital facility's most recent CHNA and implementation strategy development process occurred in 2012 and early 2013. The process was coordinated with several other Essentia Health hospital facilities and was facilitated by the Essentia Institute of Rural Health. For most hospital facilities, community health profile data were compiled and presented to Community/Patient Focus Groups that were asked to identify and prioritize their community's health needs based on the data. The three highest-priority health needs for the community served by MVHC were 1) obesity, physical inactivity, and poor nutrition as risk factors for chronic diseases, such as type 2 diabetes; 2) immunizations; and 3) tobacco use primary prevention/cessation. Essentia Health's original plan was for each hospital facility to address each of their respective community's three highest priority health needs via a three year intervention, the first of which would begin in fiscal year (FY) 2014 with the others beginning in subsequent years. One of MVHC's first interventions, which focused on type 2 diabetes, was selected by participants at a Town Hall Meeting. Annual Town Hall Meetings were planned to select interventions for the second and third health needs. Further details on these plans are included in the CHNA report and implementation strategy on the hospital facility's website.[1]

In full embrace of the Triple Aim[2] of improving the experience of care, improving population health, and reducing the cost of healthcare, Essentia Health is now expanding its community health efforts and will proceed with different plans in subsequent fiscal years. This document provides a progress report on the first interventions, which will continue in FY 2015, as well as an updated implementation strategy for FY 2015. At the end of FY 2015, the implementation strategy will updated once again for FY 2016. The MVHC Board of Directors accepted the progress report and adopted (approved) the FY 2015 plans on May 27, 2014.

Fiscal Year 2014 implementation strategy progress report

1. BACKGROUND

The actions taken by the hospital facility in fiscal year (FY) 2014 to address the significant health needs identified through the most recently-conducted Community Health Needs Assessment (CHNA) include both implementation of interventions addressing the highest priority health need as well as preparatory activities for building system-wide population health improvement capacity in FY 2015. Details on the former follow directly below; the FY 2015 Update section describes the latter.

The highest-priority health need for the community served by Minnesota Valley Health Center, Inc. (MVHC) is obesity, physical inactivity, and poor nutrition as risk factors for chronic diseases such as type 2 diabetes. The hospital facility is undertaking two activities to address this health need. The first activity is the Win With Wellness BINGO program that is designed to make wellness activities fun and easy for the whole family. The second activity is a Diabetes Behavior Monitoring Program (DBMP) for individuals with a recent diagnosis of diabetes. Enhanced Type 2 Diabetes Self-Management Education was the intervention selected by community members to address the highest priority health need. The procedures described below for the DBMP update and replace those described for the selected intervention in the hospital facility's original implementation strategy.[1]

2. WIN WITH WELLNESS BINGO

2.1. Procedures

Win With Wellness BINGO is a program developed by Riverwood Healthcare Center in Aitkin, MN.[3] The program is designed to make wellness activities fun and easy for the whole family, while possibly developing healthy habits, such as eating new fruits, taking the stairs, and going for walks. The program is open to the entire community; opportunities to participate are located at Le Sueur's Corner Drug Pharmacy, Le Sueur Community Center, and the MVHC facility. At each location, community members obtain BINGO cards that list healthy, attainable lifestyle activities. Examples of these activities include: play catch, help a neighbor with a project, eat salmon or a fish you caught, fly a kite, and protect your eyes with sunglasses.[3] Participants check-off activities once they have been performed. Once all activities in a vertical, horizontal, or diagonal row are checked-off, the participant

has BINGO and may enter their name in monthly prize drawings. New BINGO cards are available quarterly. Prize recipients, prize value, and frequency of winning are monitored.

2.2. Anticipated impact

The goal of the program is to remind and incentivize community members to participate in healthy activities. The anticipated impact is thus participation in these activities. As many of the activities relate to nutrition and physical activity, participation helps to address the highest priority health need identified in the most recently conducted CHNA, as well as general wellness.

2.3. Evaluation

The hospital facility can track the number of entries submitted by location each month. The monthly count by location indicates which locations could benefit from increased program promotion. The change in the number of entries over time indicates whether performance of activities listed on the cards is changing over time in the community. Because the BINGO program is based on the honor system, the hospital facility cannot ascertain whether the activities are actually performed.

2.4. Programs and resources committed by hospital facility

The hospital facility purchased the campaign, maintains the prize entry form on its website, and provides the prizes. Online access is advertised on all three community BINGO displays and a link with wellness tips is provided. The wellness tips are updated weekly on the site. New BINGO cards with different wellness tips and suggestions are provided quarterly throughout the year by MVHC.

2.5. Collaboration between hospital facilities and other facilities

MVHC is partnering with Le Sueur Community Center and Corner Drug Pharmacy in this program. The program was promoted at the Alive and Aware Mental Health Wellness Fair and the Retail and Business Expo. The first Alive and Aware Mental Health Wellness Fair was hosted by the Community Wellness Collaborative and was held at the Le Sueur Community Center. The Retail and Business Expo is sponsored by the Le Sueur Area Chamber of Commerce.

2.6. Current status

MVHC purchased the campaign from Riverwood Healthcare Center and thus obtained copyright and reproduction rights on July of 2013. The program kicked off on September 30, 2013 at the Mental Health Wellness Fair. The table below includes the monthly tally of prize entries submitted to date at

each location. To improve the numbers submitted to MVHC, the hospital facility will review the BINGO program at every education day. Education days are 4-8 hour mandatory trainings of employees that occur monthly; each employee must attend once per year. MVHC also reintroduced the BINGO program at the Retail and Business Expo on March 21, 2014 and presented it at MVHC's open house for recent renovations.

Monthly tally of prize entries submitted to date at each location

Location	11/1/13	12/1/13	1/1/14	2/1/14	3/1/14	4/1/14
Le Sueur Community Center (LSCC)	22	6	11	12	6	58
Corner Drug Pharmacy	16	13	20	6	7	9
MVHC	36	45	27	4	33	26
MVHC Website	22	9	12	5	6	8
Total	**96**	**73**	**70**	**27**	**52**	**101**

3. DIABETES BEHAVIOR MONITORING PROGRAM

3.1. Procedures

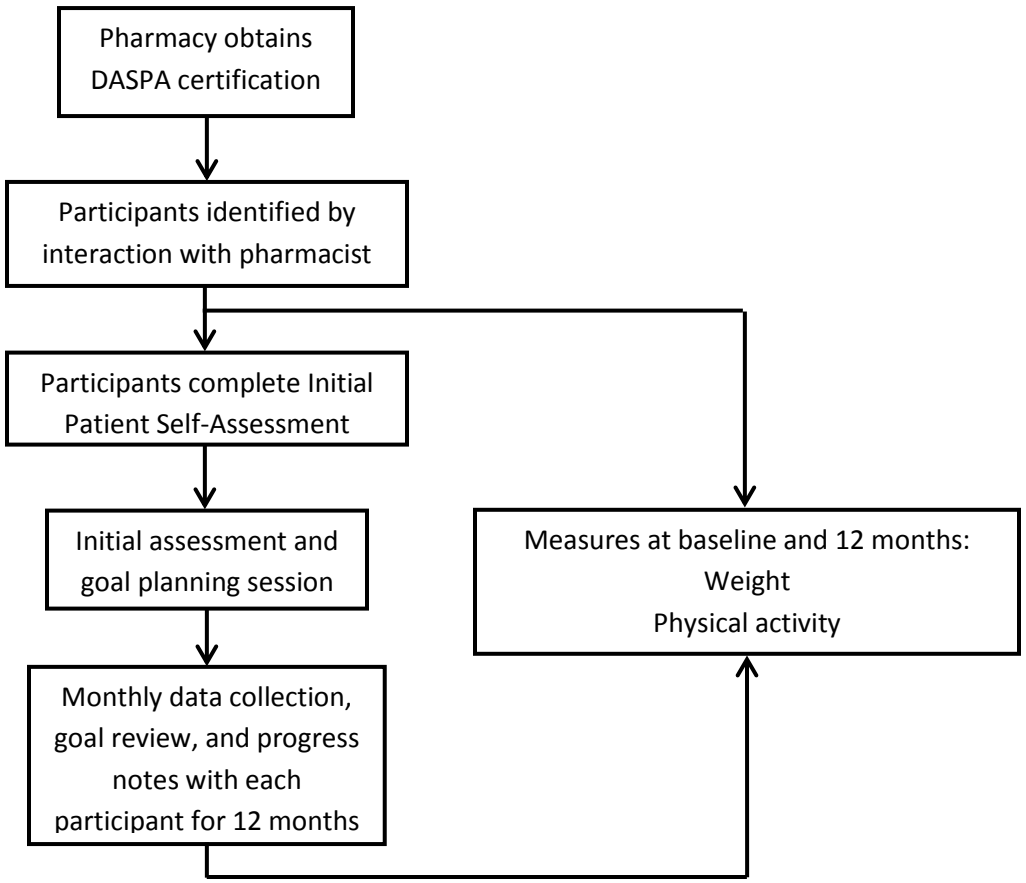
The pharmacist at Corner Drug Pharmacy has attained facility Diabetes Accreditation Standards-Practical Applications (DASPA) accreditation for his business. According to the DASPA website, the program is "designed specifically to expand patient access to diabetes management while offering community pharmacies a path to reimbursement for the provision of this service."[4] With data accumulated from the initial program session, the pharmacy plans to apply for program recognition via the American Association of Diabetes Educators (AADE) Diabetes Education Accreditation Program (DEAP). The pharmacist has no current plans to pursue certification as a diabetes educator, but AADE membership will be included with DEAP recognition.

The DBMP is shown in the figure below. The pharmacist will interview individuals with newly-diagnosed diabetes in order to obtain potential class participants. A new diagnosis of diabetes will be defined as a diagnosis occurring in the past 3 months; however, individuals with pre-diabetes and a longer history of diabetes will also be accepted into the program. Once an individual agrees to participate, an individual assessment will be done to identify knowledge deficits. The pharmacist will

ascertain teaching points focused on the individual with a behavior component. The class curriculum will then be determined based on the identified knowledge deficits of the participants.

This program addresses the community's highest-priority health need as it targets individuals with newly-diagnosed diabetes and specifically addresses issues related to physical activity, nutrition, and weight management. By supporting the pharmacy's ability to provide diabetes management services, the hospital facility is also enhancing access to healthcare in the community.

Diabetes Behavior Monitoring Program flow chart



3.2. Anticipated impact

The anticipated impact of the hospital facility's role is to support the pharmacy's ability to successfully implement the DBMP.

3.3. Plan to evaluate such impact

The plan to evaluate the hospital facility's impact is to determine whether the pharmacy attains AADE program recognition, as well as to receive reports on the total number of participants and their overall progress in the course (e.g. halfway though, completed, etc.).

3.4. Collaboration with other facilities and programs and resources committed by hospital facility

The hospital collaborates with Corner Drug Pharmacy for the program. On behalf of the hospital facility, Essentia Health will commit time of a Certified Diabetes Educator/Registered Nurse at the Essentia Institute of Rural Health (EIRH) who will support the pharmacist in program development and provide consultation as needed.

3.5. Current Status

Medical staff at MVHC, staff at EIRH, and the Essentia Health Diabetes Implementation Strategy Workgroup (name subject to change) will be kept informed on the progress of this program once the certification is achieved. Corner Drug Pharmacy provided information on the diabetes program at the Alive and Aware Mental Health Wellness Fair on September 30, 2013. Currently, the pharmacist has identified 5 participants and has begun the initial individualized assessment of those individuals.

Fiscal year 2015 implementation strategy update

1. INTRODUCTION

The Triple Aim for health care is simultaneous pursuit of three goals: "improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations."[2] Essentia Health aims to become a recognized leader in supporting population health. While Essentia Health has several ongoing initiatives directed toward population health, including the intervention described in this document, the system must undertake considerable work to achieve this goal. Consequently, Essentia Health's hospital facilities will participate in building organizational capacity for population health improvement during fiscal year (FY) 2015. The following sections include detail on this capacity building, as well as this plan's implications for the first interventions and other identified health needs.

2. HOW THE HOSPITAL FACILITY PLANS TO ADDRESS HEALTH NEEDS

2.1. System population health improvement capacity building

Essentia Health formed a system-wide CHNA Advisory Committee in fall 2013 that met for the first time on December 5, 2013. The follow-up to that meeting was a system-wide, half-day CHNA Retreat on February 17, 2014. Thirty-seven staff members from across the Essentia Health system attended some or all of this day's events. Among the multiple agenda items, the meeting included two breakout group working sessions focused on optimizing the first intervention and system-level opportunities to improve. An executive session immediately followed the larger retreat. The CHNA Advisory Committee's Charter, which changed the committee's name to the Community Health Advisory Committee, was further reviewed during this session. Based on discussions during and follow-up after the retreat and executive session, as well as other concurrent planning, Essentia Health will undertake the plans as described in Appendix B in order to build population health improvement capacity in FY 2015.

2.2. Continuation and optimization of first interventions

The hospital facility will continue the Win With Wellness BINGO program and collaborating with Corner Drug Pharmacy on the Diabetes Behavior Monitoring Program in FY 2015.

On behalf of and in conjunction with the hospital facility, Essentia Health will undertake actions as described in Appendix B to optimize implementation of the Diabetes Behavior Monitoring Program.

3. HEALTH NEEDS NOT BEING DIRECTLY ADDRESSED AND REASONS WHY

3.1. Second and third priority health needs

Essentia Health's original plan was to implement an intervention addressing the second and third highest priority health needs in each hospital facility's community in FY 2015 and FY 2016, respectively. Essentia Health will not continue with this plan and thus most hospital facilities will not directly address the second and third priority health needs given limited resources and capacity to do so effectively. As described above, all hospital facilities will work to optimize the first intervention while the system collectively builds the necessary resources and capacity for population health improvement. Ultimately, this optimization and resource and capacity building will add value by creating a platform for future community health initiatives, thus allowing Essentia Health to more effectively address health needs. The second and third priority health needs may be revisited in the future and/or addressed through other endeavors.

3.2. Other health needs

As described in the original implementation strategy,[1] the hospital facility will not directly address the seven other health needs identified system-wide due to resource constraints and the pursuit of quality over quantity.

Appendix A: Fiscal Year 2015 Implementation Strategy

ACTION: CONTINUATION AND OPTIMIZATION OF FIRST INTERVENTIONS				
Specific actions the hospital facility, or hospital organization on behalf of the hospital facility, plans to take	Anticipated impact of actions	Plan to evaluate such impact	Programs and resources the hospital facility, or hospital organization on behalf of the hospital facility, plans to commit	Planned collaboration with other organizations
1. Continue Win With Wellness BINGO program 2. Continue supporting Corner Drug Pharmacy in implementing the Diabetes Behavior Monitoring Program (DBMP)	1. Community members will participate in healthy activities 2. Corner Drug Pharmacy will successfully implement the DBMP	1. Track number of monthly prize entries submitted at each location 2. Determine whether the pharmacy attains American Association of Diabetes Educators program recognition and receive reports on participant numbers and phase	1. Maintain prize entry form on website, provide prizes, and promote program 2. Hospital facility will collaborate with Corner Drug Pharmacy, and hospital organization will commit time of a Certified Diabetes Educator/ Registered Nurse	1. Le Sueur Community Center, Corner Drug Pharmacy, and sponsors of events at which the program is promoted 2. Corner Drug Pharmacy

3. Essentia Health (hospital organization) on behalf of hospital facility will address outstanding and future diabetes intervention implementation challenges through a diabetes intervention workgroup	3. Challenges will be addressed	3. Record meeting minutes of workgroup	to support the pharmacist 3. Hospital organization staff members will be part of diabetes intervention workgroup	
ACTION: BUILD SYSTEM POPULATION HEALTH IMPROVEMENT CAPACITY				
Specific actions the hospital organization plans to take on behalf of the hospital facility	Anticipated impact of actions	Plan to evaluate such impact	Programs and resources the hospital organization plans to commit on behalf of the hospital facility	Planned collaboration with other organizations
1. Review methods used by other health systems to improve population health and wellness. Report findings to Community	• Become the market leader for health and wellness in all Essentia Health hospital markets. • Develop infrastructure	• Progress to plan and % completed ○ Develop spread plan for system ○ Identify and implement key metrics to track	• Staff time • Travel expenses	As appropriate: • Other hospital organizations • Public health • Other local community agencies

Health Advisory Committee (CHAC). 2. Assess validity of community health and wellness metrics and determine best metrics to track at county-, region-, and system-levels. Report draft metrics to CHAC for selection – tailor to individual communities afterward as needed. 3. Evaluate FY 2014 Crow Wing County Movement to determine system-wide applicability and continue evaluation of system (east and west) CHNA community health interventions. Report results to CHAC to inform future planning. 4. Develop vision for effective and sustainable health and	required to sustain grassroots health and wellness movement. • Develop community asset data base in partnership with local community agencies to support care coordination referrals. • Create a common vision and goal for our communities such as “Making the healthy choice the easy choice”. • Identify community health metrics such as years of potential life lost, obesity reduction, and improved mental health (still being developed). • Combine CHNA oversight and management with this initiative.	high level population health performance ○ Develop targets for population health recognizing geographic, demographic, and local asset variations		

wellness movement, addressing scope of impact, intervention planning, and community partnering/engagement methods. 5. Develop a community approach to identifying, tracking, and communicating health and wellness assets in relevant communities; developing partnerships; and building on existing resources. 6. While factoring in variation across the health system, identify resource needs to build community and system infrastructure, including organizational structure, role definitions, and				

Performance Management System. 7. Hold retreat with relevant stakeholders to gain consensus around new plan in first quarter and begin role out. 8. Form workgroups to improve CHNA and implementation strategy tactics across the system. Workgroups will plan process for 1) conducting FY16 CHNA and 2) developing FY17-FY19 implementation strategies; planned process to be commenced no later than July 2015.				
ACTION: Continue with population health improvement capacity				

Collaborate with Stratis Health Kim McCoy Program manager	Develop goals to incorporate the CWC team and their mission and vision into the Community Health Needs Assessment	Develop performance measures/strategy	Staff time, resources, marketing assistance and facility	The City of Le Sueur, Local EMS, Le Sueur Mayo Clinic, Stratis Health and MVHC

References

1. Minnesota Valley Health Center. "Community Health Needs Assessment." 14 June 2013. http://mvhc.org/files/1314/4890/2898/Le_Sueur_CHNA_Final_Report_WEBSITE.pdf

2. Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, and Cost. *Health Affairs.* 2008;27(3):759-769.

3. National Community Pharmacists Association. Diabetes Accreditation Standards-Practical Applications (DASPA). Accessed: Jan. 27, 2014. http://www.ncpanet.org/meetings/diabetes-accreditation-(daspa)/daspa