Amery Hospital & Clinic

HealthPartners®

Community Health Needs Assessment
November 2018

Prepared by:

The Improve Group

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About HealthPartners

HealthPartners is the largest consumer-governed, non-profit health care organization in the nation with a mission to improve health and well-being in partnership with members, patients and the community. For more information, visit healthpartners.com.

Mission, Vision and Values

Our mission – to improve the health and well-being of those we serve – is the foundation of our work. And that work is guided by our vision and values, creating a culture of Head + Heart, Together.

Mission

To improve health and well-being in partnership with our members, patients and community

Vision

Health as it could be, affordability as it must be, through relationships built on trust

Values

Excellence, compassion, partnership, integrity

Executive Summary

Amery Hospital & Clinic is part of HealthPartners, the largest consumer-governed, non-profit healthcare organization in the nation with a mission to improve health and well-being in partnership with members, patients and the community. Amery Hospital & Clinic serves western Wisconsin with a behavioral health center, obstetrics and gynecology, pediatrics, primary and specialty clinics. This report describes the current Community Health Needs Assessment (CHNA) process and results for Amery Hospital & Clinic.

Between 2016 and 2018, HealthPartners and Amery Hospital & Clinic engaged with local public health partners in Barron and Polk Counties, as well as local coalitions, the Center for Community Health (CCH) and community partners to conduct a comprehensive CHNA. The CHNA identifies the significant health needs of the community as well as measures and resources to address those needs. The results will enable community partners to more strategically establish priorities, develop interventions and direct resources to improve the health of people living in the community.

This assessment meets all of the federal requirements of the Patient Protection and Affordable Care Act (ACA) and the Internal Revenue Service final regulations. It was approved by the Amery Hospital & Clinic Board on November 28, 2018. In accordance with federal requirements, this report is made widely available to the public on our website at www.amerymedicalcenter.org/community_health_needs_assessment.aspx.

Community served

While Amery Hospital & Clinic serves patients from everywhere, more than 80 percent of the people we serve live in Barron and Polk Counties. Throughout this report, we refer to these two counties as “our community” and primarily use data from these counties. In total, our community has approximately 90,000 residents. Amery Hospital & Clinic is located in the city of Amery in Polk County with satellite clinics located in Clear Lake and Luck also in Polk County and Turtle Lake in Barron County. In 2017, Amery Hospital reported about 850 inpatient admissions from patients living in Barron and Polk Counties.

Methodology

In 2018, HealthPartners and Amery Hospital & Clinic contracted with The Improve Group to analyze and report on the data describing the communities we serve. HealthPartners provided The Improve Group with the definitions of each hospital’s service area, the indicators to study for the health and demographic data summaries and data collected during community conversations. Community input was collected in partnership with HealthPartners and through community conversations and multiple surveys. The Improve Group then gathered secondary data from public sources, analyzed community input data and developed summary reports to guide a prioritization process.

Prioritized needs

The HealthPartners CHNA Team included representatives from each HealthPartners hospital and HealthPartners leadership. In September 2018, the CHNA Team met to review the data and prioritize the community health needs across the system.

HealthPartners collectively prioritized community health needs using a process informed by the Hanlon method and other commonly used prioritization methods. Each hospital shared its 4 or 5 priority topic areas and rationale for each topic area based on: *size, seriousness, equity, value and change*. HealthPartners hospitals worked in a thorough, facilitated large and small group process to reach consensus on top priorities using both the criteria described above and community input data. The five priorities are of equal importance and are presented in alphabetical order. The five priority areas and priority area definitions are:

Access to care

Access to care refers to having equitable access to appropriate, convenient and affordable health care. This includes factors such as proximity to care, access to providers, cost, insurance coverage, medical transportation, care coordination within the health care system and cultural sensitivity and responsiveness.

Access to health

Access to health refers to the social and environmental conditions that directly and indirectly affect people's health such as housing, income, employment, education and more. These factors, also referred to as social determinants of health, disproportionately impact low income communities and communities of color.

Mental health and well-being

Mental health and well-being refers to the interconnection between mental illness, mental health, mental well-being and the associated stigma. Poor mental health is associated with poor quality of life, higher rates of chronic disease and a shorter lifespan.

Nutrition and physical activity

Nutrition and physical activity refers to equitable access to nutrition, physical activity and food and feeding choices. Poor nutrition and physical inactivity are major contributors to obesity and chronic diseases such as diabetes, heart disease and stroke, which disproportionally impact low income communities and communities of color.

Substance abuse

Substance abuse and addiction are the excessive use of substances including alcohol, tobacco, prescription drugs, opioids and other drugs in a manner that is harmful to health and well-being.

Next Steps

Amery Hospital & Clinic and HealthPartners will continue to work collaboratively with the community to develop shared goals and actions that address the highest priority needs identified in the CHNA. These shared goals and actions will be presented in our implementation strategy, which is a required companion report to the CHNA. Each need addressed will be tailored to the hospital's programs, resources, priorities, plans and/or collaboration with governmental, non-profit or other health care organizations.

About the Community Health Needs Assessment (CHNA) process

Background and goals

We all play a role in making sure our communities are a place where all people have what they need to reach their full health potential. One of our priorities at HealthPartners and Amery Hospital & Clinic is to routinely assess the health of our community to see what is going well and where we can work together to do better.

The CHNA process is an opportunity for us to identify the significant health needs of the community and the measures and resources required to address those needs. HealthPartners worked with local health departments, local coalitions, the Center for Community Health (CCH) and community partners to conduct a comprehensive Community Health Needs Assessment (CHNA). Our next step is to develop an implementation plan for the period 2019 to 2021 to address the CHNA priorities.

This CHNA was conducted in accordance with requirements identified in the Patient Protection and Affordable Care Act and the Internal Revenue Service final regulations released on December 29, 2014. This CHNA was designed to:

- Meet federal government and regulatory requirements;
- Review secondary health and demographic data describing Amery Hospital & Clinic's community;
- Gather input from community members on health needs and priorities, including input from members of underserved, low income and minority populations;
- Analyze the secondary data and community input data; and
- Prioritize the health needs of the community served by HealthPartners and Amery Hospital & Clinic.

Methodology

HealthPartners collaborated across the six hospitals for the CHNA:

- Amery Hospital & Clinic (Amery, WI)
- Hudson Hospital & Clinic (Hudson, WI)
- Lakeview Hospital (Stillwater, MN)
- Park Nicollet Health Services including Park Nicollet Methodist Hospital (St. Louis Park, MN)
- Regions Hospital (St. Paul, MN)
- Westfields Hospital & Clinic (New Richmond, WI)

HealthPartners and Amery Hospital & Clinic engaged with local public health partners in Barron and Polk Counties, as well as local coalitions, the CCH and community partners to conduct a comprehensive CHNA. Amery Hospital & Clinic works collaboratively with the Polk County Health Department (Polk United) and the Barron County Public Health Department (Thrive Barron County) in conducting a CHNA every three years to identify priority health issues from primary and secondary data sources.

In 2018, HealthPartners and Amery Hospital & Clinic contracted with The Improve Group to analyze and report on the data describing the communities we serve. HealthPartners provided The Improve Group with the definitions of each hospital's service area, the indicators to study for the health and demographic data summaries and data collected during community conversations. Community input was collected in partnership with HealthPartners through community conversations and multiple surveys. The Improve Group then gathered secondary data from public sources, analyzed community input data and developed summary reports to guide a prioritization process.

Core data health indicator sources

Core health data indicators for this report were collaboratively selected by the CCH for inclusion in CHNAs conducted in the Minneapolis-St. Paul metropolitan area. The CCH is a collaborative between public health agencies, non-profit health plans and not-for-profit hospital/health systems in the seven-county metropolitan area. The list of indicators was updated based on a pilot testing process that occurred in 2017. HealthPartners hospitals in western Wisconsin adopted the list of indicators established by CCH and identified additional indicators and relevant themes from community input.

Secondary data in this report is specific to Barron and Polk Counties. When data specific to the county is not available, regional and state-level data is presented. Comparison data is included where available.

Additional data sources include:

- American Community Survey (ACS), an ongoing survey by the U.S. Census Bureau;
- Behavioral Risk Factor Surveillance System (BRFSS), a national survey by the Centers for Disease Control and Prevention (CDC);
- Youth Risk Behavior Survey (YRBS), a national survey by the CDC;
- United Way ALICE report;
- Data from local and county partners; and
- Data from the Wisconsin Department of Health Services and other state agencies.

This report also includes data collected by HealthPartners, including:

- HealthPartners Electronic Health Records (EHR);
- IMPACT Survey, a survey on mental illness stigma, developed and analyzed by HealthPartners; and
- Family Community Survey, a survey on health behaviors of children, developed and analyzed by HealthPartners.

Community input data

As part of its CHNA process, Amery Hospital & Clinic and its partners worked collaboratively with Polk and Barron Counties to engage community members and health care providers in the process to gather input on what their top health concerns are.

The community input in this report includes:

County priority data: Each county in the Amery Hospital & Clinic service area has determined the top health priorities for its community through a county-level Community Health Assessment process (CHA).

Barron County community survey data: In 2018, Barron County conducted a community survey about health needs and barriers to health for its Community Health Assessment. A total of 815 community members participated in the survey.

Polk County community survey data: In 2015, Polk County conducted a community health survey about health needs and barriers to health for its 2016 Community Health Assessment. A total of 650 surveys were completed by county residents.

Provider survey: In 2018, HealthPartners surveyed health care providers to understand their perceptions of leading health needs and community resources available to help their patients. The survey also asked providers to identify barriers they face in addressing health needs and resources to better serve their patients. Twenty-three health care providers completed the survey, including 11 who practice at Amery Hospital & Clinic.

HealthPartners approach to equity

At HealthPartners, a top priority is to make sure everyone has equal access to excellent and reliable health care and services, to work toward a day where every person, regardless of their social circumstances, has the chance to reach their best health. This requires us to identify and work toward eliminating health disparities, defined by the CDC as "preventable differences in the burden of disease, injury, violence or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities."

Our commitment to health equity shaped our approach to our CHNA and will continue to shape our approach as we develop an implementation plan to address community health needs in partnership with our community. This includes considering factors such as race, ethnicity, age, gender identity, socioeconomic status and education levels when setting priorities and developing implementation plans.

CHNA prioritization process

The HealthPartners CHNA Team included representatives from each HealthPartners hospital and HealthPartners leadership. On September 14, 2018, the CHNA Team met to review the data and prioritize the community health needs across the system.

HealthPartners collectively prioritized community health needs using a process informed by the Hanlon method and other commonly used prioritization methods. Each hospital shared its 4 or 5 priority topic areas and rationale for each topic area based on:

- Size: Number of persons affected, taking into account variance from benchmark data and targets;
- Seriousness: The degree to which the problem leads to death, disability and impairment of one's quality of life (mortality and morbidity);
- Equity: Degree to which specific groups are affected by the problem;
- Value: The importance of the problem to the community; and
- Change: What is the same and what is different from your previous CHNA?

HealthPartners hospitals worked in a thorough, facilitated large and small group process to reach consensus on top priorities. The CHNA Team considered the criteria described above as well as community input data in these discussions. The five priorities are of equal importance and are presented in alphabetical order. The five priority areas are:

Access to care

Access to care refers to having equitable access to appropriate, convenient and affordable health care. This includes factors such as proximity to care, access to providers, cost, insurance coverage, medical transportation, care coordination within the health care system and cultural sensitivity and responsiveness.

Access to health

Access to health refers to the social and environmental conditions that directly and indirectly affect people's health such as housing, income, employment, education and more. These factors, also referred to as social determinants of health, disproportionately impact low income communities and communities of color.

Mental health and well-being

Mental health and well-being refers to the interconnection between mental illness, mental health, mental well-being and the associated stigma. Poor mental health is associated with poor quality of life, higher rates of chronic disease and a shorter lifespan.

Nutrition and physical activity

Nutrition and physical activity refers to equitable access to nutrition, physical activity and food and feeding choices. Poor nutrition and physical inactivity are major contributors to obesity and chronic diseases such as diabetes, heart disease and stroke, which disproportionally impact low income communities and communities of color.

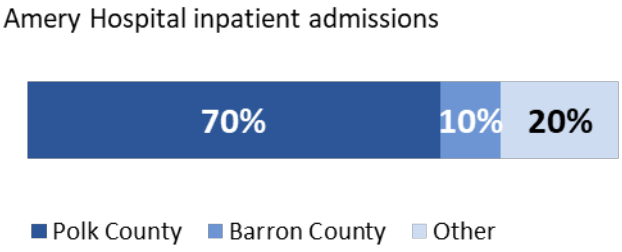
Substance abuse

Substance abuse and addiction are the excessive use of substances including alcohol, tobacco, prescription drugs, opioids and other drugs in a manner that is harmful to health and well-being.

HealthPartners discussed and considered additional or alternative priorities during the prioritization process, including: older adult health/aging, maternal and child health, environmental health and injury and violence. These needs were not selected as top five priorities in the consensus building process, however, the themes will be considered in the implementation for the selected priority areas.

About the community we serve

People served

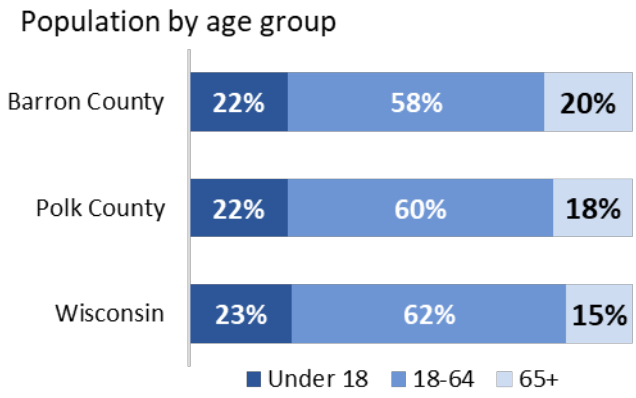


Source: HealthPartners Electronic Health Records, 2017

While we serve patients from everywhere, more than 80 percent of the people we serve live in Barron and Polk Counties. Throughout this report, we refer to these two counties as "our community" and primarily use data from these counties.

In total, our community has approximately 90,000 residents. In 2017, Amery Hospital reported about 851 inpatient admissions from patients living in Barron and Polk Counties.

Population by age



Source: US Census Bureau, American Community Survey, 2012-16

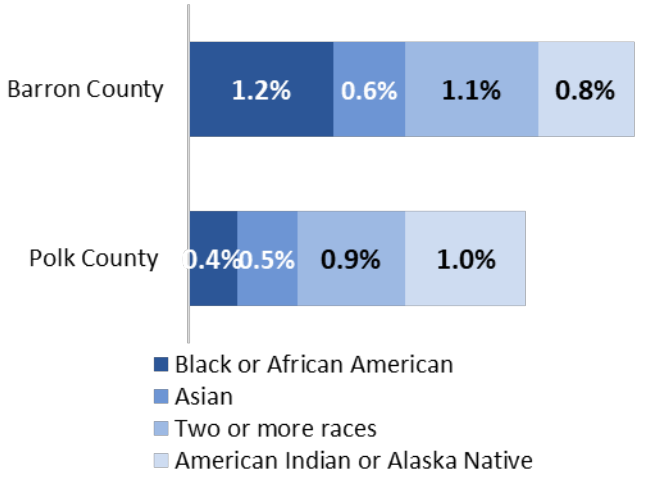
We know that people have different health needs at different stages in their life. Throughout the CHNA process, we considered how each need, asset and barrier impacts different age groups.

The median age of our community is 44 years old in Barron County and 45 years old in Polk County. About 1 in 5 people in our communities is under 18 and nearly 1 in 5 is over 65.

However, communities in Barron and Polk Counties are aging, with the number of adults over age 65 expected to increase significantly over the next decade. Our implementation plan will address this demographic change.

Race and ethnicity

Population by race, not including people who identify as white.



Source: US Census Bureau, American Community Survey, 2012-16

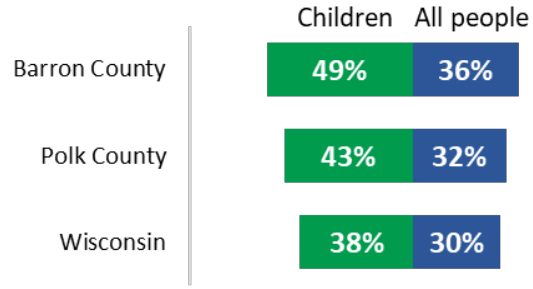
People of color are disproportionately impacted by social and environmental conditions that affect people's health.

More than 95 percent of residents identify as white and non-Hispanic. About 4 percent of residents identify as American Indian, Asian, black or African American or identify as two more races. Two percent of people in our community identify as Hispanic or Latino.

Barron County has experienced a significant increase in the number of Somali residents over the past decade. According to the American Community Survey, more than 1,000 Barron County residents identify as foreign-born, many of whom likely represent this influx of Somali community members.

Poverty

Percentage of people with household incomes **at or below 200% of the federal poverty level.**



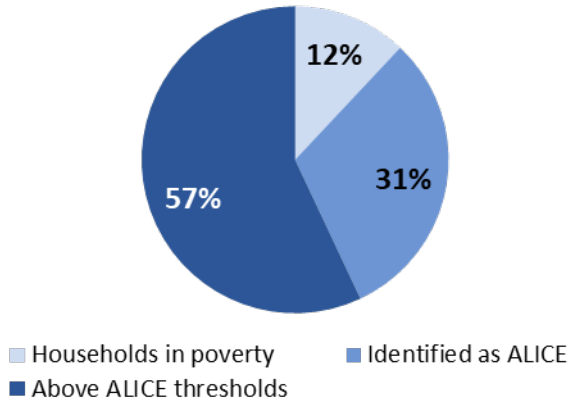
Source: US Census Bureau, American Community Survey, 2012-16

People who are experiencing poverty face health disparities. People who live in households earning at or below 200 percent of the federal poverty level (FPL) are considered low income.

One in 3 Barron and Polk County residents is living in a low-income household. Nearly 1 in 2 children live in a low-income household.

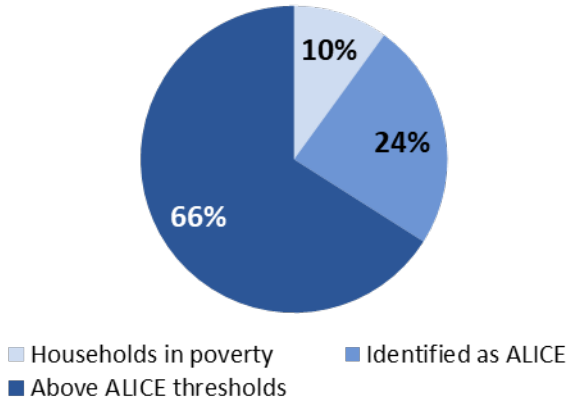
Poverty rates in our communities are 2 to 3 times higher for people of color than for people who identify as white. Poverty rates are nearly 4 times greater for Barron County residents who identify as American Indian than the community overall.

Percentage of households in **Barron County** considered **Asset Limited, Income Constrained, and Employed (ALICE).**



Source: United Way ALICE Report Point-in-Time Data, 2016

Percentage of households in **Polk County** considered **Asset Limited, Income Constrained, and Employed (ALICE).**



Source: United Way ALICE Report Point-in-Time Data, 2016

In addition, 31 percent of Barron County households and 24 percent of Polk County households are considered ALICE (Asset Limited, Income Constrained, and Employed) households. These are households that earn more than 100 percent of the FPL but less than the cost of living. In Barron County, a family of four is an ALICE household if it earns less than $58,836 per year. In Polk County, the ALICE threshold for a family of four is $59,136 per year.

Education status

Percentage of high school students who **graduate in four years.**

Source: US Department of Education, EDFacts, 2015-16

An individual's education level can impact their health. People with less than a high school education are more likely to experience health disparities than people with higher education levels. Higher levels of education are also strongly associated with higher incomes.

In our communities, nearly 9 in 10 students graduate from high school in four years. Ten percent of Barron County adults and 7 percent of Polk County adults do not have a high school diploma. Fewer than 20 percent of adults in our communities have a bachelor's degree or higher.

Priorities and definitions

The following sections describe the health priorities identified during the CHNA process, all of which include data related to equity.

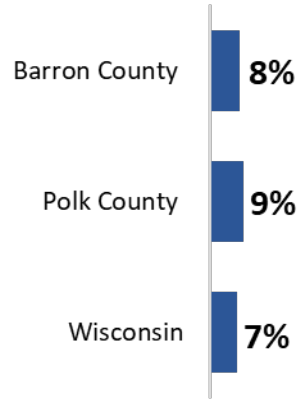
Priority: Access to care

Access to care refers to having equitable access to appropriate, convenient and affordable health care. This includes factors such as proximity to care, access to providers, cost, insurance coverage, transportation, care coordination within the health care system and cultural sensitivity and responsiveness.

The following indicators provide a snapshot of conditions in our community that influence access to care.

Health insurance access and cost

Percentage of residents who **do not have health insurance.**



Source: US Census Bureau, American Community Survey, 2012-16

According to the American Community Survey, 8 percent of residents in Barron County and 9 percent of residents in Polk County do not have health insurance.

Data on health insurance coverage shows racial and economic disparities. According to the Wisconsin Department of Health's Family Health Survey, low income families are 3 times more likely to be uninsured than wealthier households. Latino and American Indian families are 3 to 4 times more likely to be uninsured than white families.

Despite having insurance, many people find it difficult to pay for insurance premiums, co-pays and deductibles. One in 10 people in our community said it has been difficult to pay for health insurance.

Cost of care

"People who actually have 'insurance' are not able to utilize [it] as it's not affordable. … I personally work for the largest health care insurance company and cannot afford to go to the doctor except for my annual preventative care visit."

– Community survey participant

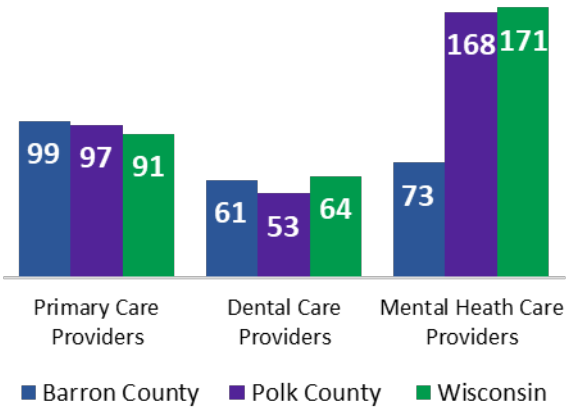
When people cannot afford to pay for insurance or other health care costs, they are less likely to get the care they need. According to the Polk County community health survey, 1 in 10 Polk County residents said they sometimes delay medical care or skip prescription medications because of cost and high deductibles.

Health care providers indicated that unaffordable insurance coverage and health care costs are major barriers to care for many patients.

The cost of care, including insurance and other health care costs, was a common concern in the Barron County community survey. Many community members cited the cost of care as a barrier to health.

Availability of care

Number of **health care professionals** per 100,000 residents.



Source: US Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File. 2014

"Coming from a small community, access to adequate health care is difficult. Also, due to the poor economic environment, it is hard to afford health care."

– Community survey participant

The availability of physicians is an important factor that affects access to care, especially in rural communities.

Both Barron and Polk Counties rank slightly above Wisconsin's state average for ratio of primary care physicians to residents. However, parts of both counties are designated as low-income population Health Professional Shortage Areas (HPSAs). This means there is a physician shortage for the area's population with family incomes below 200 percent of the FPL and a population-to-physician ratio greater than 3,000 residents per full-time provider.

In addition, Barron County is designated as a high-needs geographic HPSA for mental health with a ratio of mental health providers far lower than both Polk County and the state average.

Transportation and scheduling

"[The community needs] affordable transportation services to people who cannot drive themselves to appointments or for groceries."

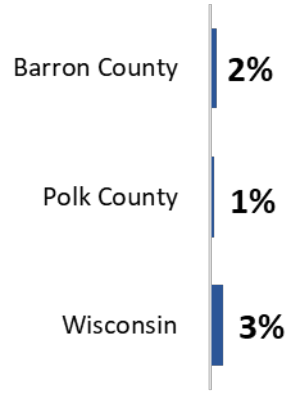
– Community survey participant

Barron County and Polk County are largely rural counties, which can present barriers to accessing care due to scheduling and transportation.

Community residents indicated that scheduling and travel time to appointments are barriers to getting health care. Health care providers cited the location of clinics and the transportation challenges as barriers to accessing care.

Other barriers to care

Percentage of population 5 years and older who speak English **less than "very well."**



Source: US Census Bureau, American Community Survey, 2012-16

In other parts of the HealthPartners system, both community residents and health care providers cited language issues and lack of cultural competency among health care providers as significant barriers to accessing health care. Patients also face barriers when scheduling appointments and communicating with providers.

These barriers are especially significant for community members who do not speak English as a primary language. Approximately 3 percent of people over age 5 in our community speak primarily a language other than English.

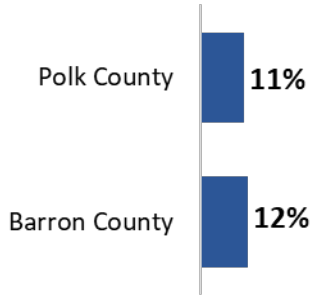
Priority: Access to health

Access to health refers to the social and environmental conditions that directly and indirectly affect people's health such as housing, income, employment, education and more. These factors, also referred to as social determinants of health, disproportionately impact low income communities and communities of color.

The following is a snapshot of conditions in our communities that influence our health. Extensive research exists providing the link between these conditions and health.

Food insecurity

Percentage of adults who worried that their **food would run out** before they had money to buy more in the last 12 months.



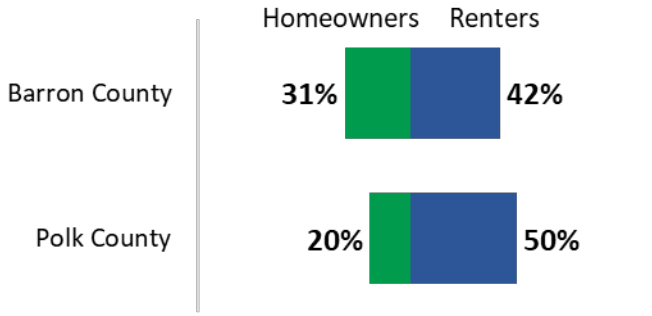
Source: Feeding America, 2014

People experiencing food insecurity do not have consistent access to an adequate amount of healthy food. Expenses for food are one of the first reductions people make under economic stress. People who experience food insecurity may forego purchasing an adequate amount of food for other expenses such as housing and health care.

In 2014, more than 1 in 10 Barron and Polk County community members indicated they were experiencing food insecurity. This means they worried their food would run out before they had money to buy more.

Housing cost burden

Percentage of households that use more than **30% of their income** on housing costs.



Source: US Census Bureau, American Community Survey, 2012-16

People are considered "housing cost burdened" when they spend more than 30 percent of their income on housing costs. High costs of housing can compete with health care and basic needs such as food.

According to the American Community Survey, 31 percent of Barron County homeowners and 20 percent of Polk County homeowners are housing cost burdened. The percent of renters who are housing burdened is much higher, especially in Polk County, where 50 percent of renters spend more than 30 percent of their income on housing costs.

Housing insecurity and homelessness

"[The community needs] more affordable housing for the community. The rental properties have higher rent than the local economy can support. Need more support for efforts like the Benjamin's House Emerg[ency] Shelter, etc."

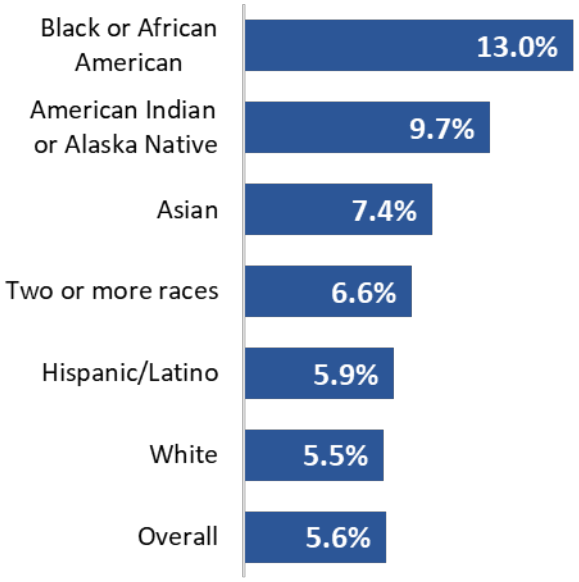
– Community survey participant

According to the Wisconsin Homeless Management Information System (HMIS) database, between October 2015 and September 2016, Polk County emergency shelters served 163 people and Barron County shelters served 138 people.

Barron County community members talked about the need for more affordable housing and supports for people who are experiencing homelessness.

Unemployment disparities by race

Unemployment rates by race, estimated with Barron and Polk Counties combined.



Source: US Census Bureau, American Community Survey, 2012-16

According to the Wisconsin Department of Workforce Development, the unemployment rate in our community is approximately 4 percent, which is on par with the average rate in Wisconsin in 2018. However, significant unemployment disparities exist by race.

While 2018 county-level unemployment rates by race are not available, data from the ACS is useful for estimating employment disparities in our community over the past few years. For example, the unemployment rates among American Indians in our community is more than 3 times higher than the unemployment rates among people who identify as white.

Barron County community members said good jobs that pay a living wage are a need in the community.

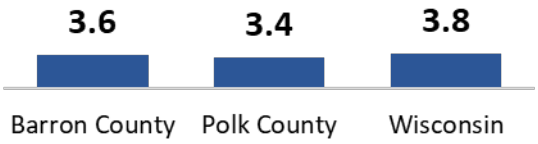
Priority: Mental health and well-being

Mental health and well-being refers to the interconnection between mental illness, mental health, mental well-being and the associated stigma. Poor mental health is associated with poor quality of life, higher rates of chronic disease and a shorter lifespan.

The following is a snapshot of conditions in our community that influence our mental health and well-being.

Adults with frequent poor mental health days

Average number of days in which adults **report feeling down, depressed or hopeless** in the last 30 days.



Source: Wisconsin Behavioral Risk Factor Surveillance System, 2016

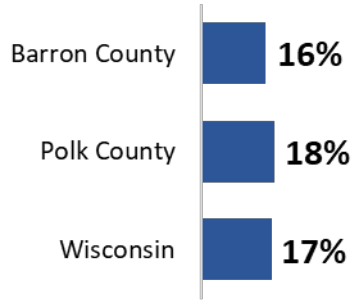
Residents in Barron and Polk Counties report feeling down, depressed or hopeless an average of 3.6 and 3.4 days per month or more than 10 percent of the time.

According to the Polk County community health survey, 15 percent of Polk County residents said they had poor mental health, defined as feeling sad or depressed on three or more days in the past two weeks. However, more than half of Polk County residents said they had not felt sad or depressed on any days in the past two weeks.

Mental health ranked as the highest concern among Amery Hospital's health care providers and Barron County community members. Community residents expressed concern, indicating there are limited resources in western Wisconsin to promote well-being and help with mental health problems.

Adult mental health: depression diagnosis

Percentage of Medicare fee-for-service beneficiaries that have been told by a doctor or health professional that they have **depression**.



Source: Centers for Medicare and Medicaid Services, 2015

While not representative of the whole community, the percent of people who receive Medicare fee-for-service who have been diagnosed with depression provides a snapshot of mental health needs for some of our more vulnerable community members. In our community, about 17 percent of Medicare fee-for-service beneficiaries have been diagnosed with depression.

HealthPartners health care providers routinely screen patients for depression. According to 2017 EHR data, about 8 percent of the patients from our community were experiencing mental health symptoms that are consistent with depression.

Youth mental health

"There are too many young people in our community who suffer from childhood trauma without access to mental health care. If this problem is not fixed, it will continue to get worse."

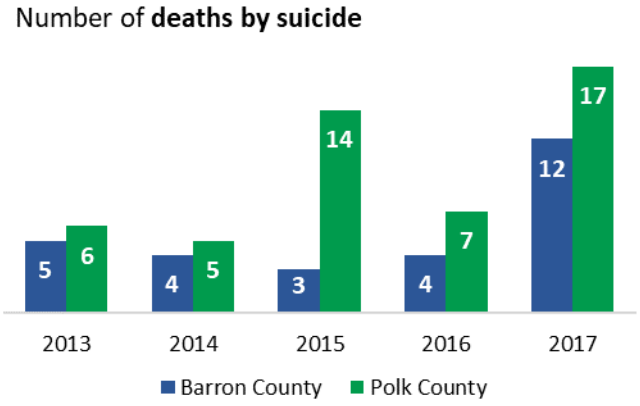
– Community survey participant

There is limited data about mental health among youth in our community. The 2015 Polk County community health survey found that 16 percent of Polk County youth had seriously considered suicide in the past year.

Across the state, 27 percent of high school students said they feel sad or hopeless on more than half of the days.

Amery Hospital health care providers cited concern about the lack of mental health therapists—especially for youth—and long wait times to see them. Insurance issues were also cited as a barrier to accessing mental health services.

Suicide rate

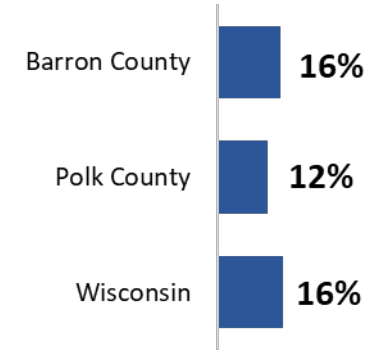


Source: Barron and Polk County's medical examiners, 2013-17

Death by suicide is significant concern for our community. According to each county's medical examiner, 28 Barron County adults and 49 Polk County adults died by suicide from 2013 to 2017. According to the CDC, death by suicide has increased 25 percent in Wisconsin since 1999. Although suicide can affect all people, men who are white and age 45 to 54 are one of the most affected groups in the state of Wisconsin.

Contributors to poor mental health: social isolation

Percentage of adults **without adequate emotional support**.



Source: Behavioral Risk Factor Surveillance System, 2006-12

"Lack of transportation for my rural family limits our participation in community. This leads to isolation and contributes to mental health challenges."

– Community survey participant

Social and emotional support are important contributors to overall health and well-being. According to the HealthPartners IMPACT Survey, 88 percent of adults in the St. Croix Valley believe mental health has a large impact on a person's overall health and well-being.

In our community, 16 percent of Barron County adults and 12 percent of Polk County adults indicate they do not have adequate social and emotional support most or all of the time.

Contributors to poor mental health: stigma

"To help strengthen our community, reduce the stigma associated and help those with mental health to live with the condition—as they are not the mental health illness."

– Community survey participant

The stigma associated with having a mental illness can also negatively affect mental health. The need to reduce stigma related to mental health was a leading theme that emerged from the community. According to the IMPACT Survey, only 64 percent of adults in the St. Croix River Valley are comfortable talking with others about their mental illness.

In the St. Croix River Valley, 92 percent of adults believe reducing stigma is important to their community.

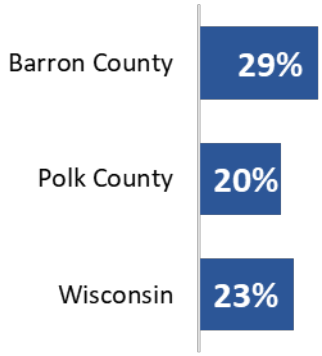
Priority: Nutrition and physical activity

Nutrition and physical activity refers to equitable access to nutrition, physical activity and food and feeding choices. Poor nutrition and physical inactivity are major contributors to obesity and chronic diseases such as diabetes, heart disease and stroke, which disproportionally impact low income communities and communities of color.

The following is a snapshot of nutrition and physical activity behaviors in our community.

Adult fruit and vegetable consumption

Percentage of adults who eat the **recommended 5 servings of fruits and vegetables.**



Source: Behavioral Risk Factor Surveillance System, 2005-09

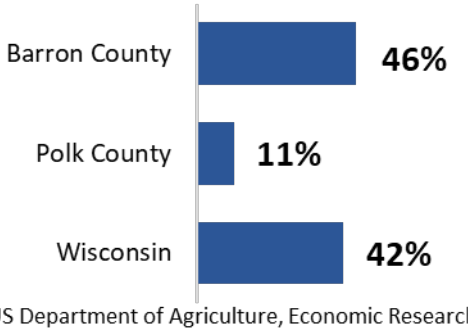
A diet rich in fruits, vegetables, whole grains and lean proteins is a key protective factor in preventing chronic disease.

Twenty-nine percent of Barron County adults and 20 percent of Polk County adults eat the recommended 5 servings of fruits and vegetables.

According to the 2017 Youth Risk Behavior Survey, only 30 percent of Wisconsin youth report eating 2 or more servings of fruit per day, and only 14 percent report eating vegetables 3 or more times per day.

Access to healthy food: food deserts

Percentage of population living in neighborhoods that are considered **food deserts.**



Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2015

"[We need] better access to healthy foods for all income levels to help reduce chronic diseases."

- Community survey participant

Participants in the community conversations said having access to affordable, nutritious food is important for supporting a healthy community.

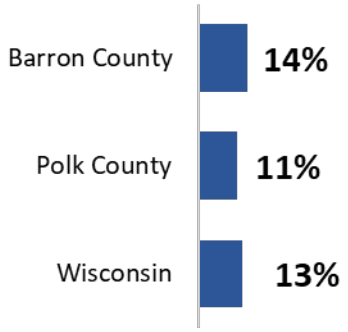
A neighborhood is considered a food desert if 33 percent of the population lives more than 1 mile from a supermarket or large grocery store (10 miles for rural communities).

According to the U.S. Department of Agriculture, 46 percent of Barron County residents and 11 percent of Polk County residents live in neighborhoods considered food deserts.

According to the HealthPartners Family Community Survey, Amery and Amery-area parents identified a lack of lower prices for healthy foods and a lack of options to buy farm-fresh foods as the most important barriers needing to be addressed in order to help their families eat better.

Access to healthy food: SNAP households

Percentage of households receiving **SNAP benefits.**



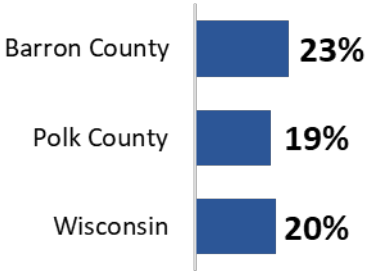
Source: US Census Bureau, American Community Survey, 2012-16

Even when healthy food is available locally, it may not be affordable. Many people in our community receive food supports such as SNAP benefits.

The percentage of households receiving SNAP benefits ranges from 11 percent in Polk County to 14 percent in Barron County.

Adults with no leisure time physical activity

Percentage of adults age 20 and older reporting **no leisure time or physical activity.**



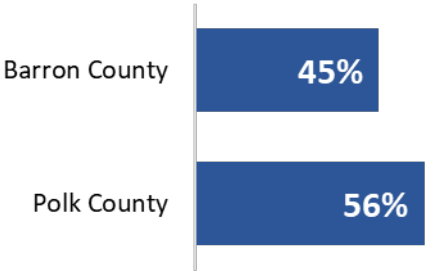
Source: Centers for Disease Control and Prevention, 2013

Physical activity means exercise and other activities which involve bodily movement. This includes playing, working, active transportation, household chores and recreational activities. The current recommendation for adults is 150 minutes of moderate activity a week.

While many Wisconsin residents are getting at least some physical activity, 23 percent of Barron County adults and 19 percent of Polk County adults report they do not get any leisure time physical activity.

Youth physical activity

Percentage of high school students who were **physically active** for 60 minutes or more on 5 or more days.



Source: Youth Risk Behavior Survey, 2013

It is recommended that youth be active 60 minutes or more at least 5 days a week.

About half of youth in our community are getting enough activity. Forty-five percent of Barron County high school students and 56 percent of Polk County high school students get the recommended amount of physical activity.

In 2017, only 49 percent of Wisconsin youth were physically active for 60 minutes on 5 or more days per week, a slight decrease from 2013.

Access to activity opportunities

"[A healthy community means] providing green space, trails, opportunities for growth, development & physical activity for all ages."

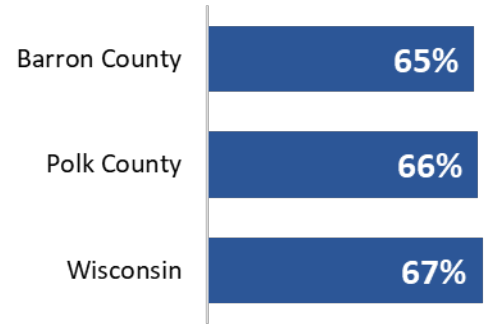
- Community survey participant

In order to be physically active, people need to have adequate opportunities to be active. This includes access to recreation and fitness facilities, as well as local trails and sidewalks. Community members in both counties said there are not enough safe places in their communities to be physically active.

According to the HealthPartners Family Community Survey, Amery and Amery-area parents identified a lack of safe, open spaces to be physically active and a lack of free, low-cost or discounted places to be physically active as the most important barriers to address to help their families be more physically active.

Unhealthy weight

Percentage of adults who are **overweight or obese** based on BMI.



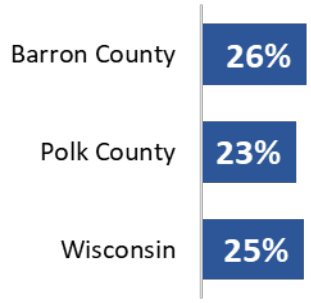
Source: Behavioral Risk Factor Surveillance System, 2006-12

Being overweight or obese puts people at higher risk for heart disease, diabetes and other chronic conditions. According to self-reported height and weight, approximately two-thirds of adults in our community are overweight or obese.

The percent of HealthPartners patients who are at an unhealthy weight is higher than self-reported data. According to clinical measures, slightly more than 70 percent of patients in our community are overweight or obese according to Body Mass Index (BMI).

Chronic diseases

Percentage of adults 18 and over who have ever been told by a doctor that they have **high blood pressure or hypertension.**

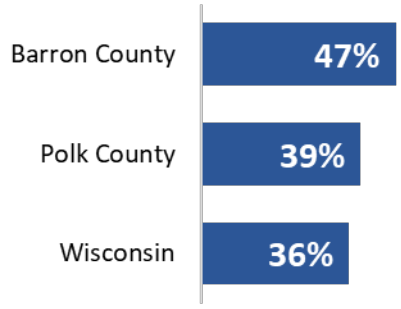


Source: Behavioral Risk Factor Surveillance System, 2006-12

Chronic diseases associated with poor nutrition and lack of physical activity include diabetes, heart disease, stroke and some cancers. This includes the risk factors of high cholesterol and hypertension.

Uncontrolled high blood pressure puts people at higher risk for heart disease and stroke. One in 4 adults in our community has been told by a health care professional that they have high blood pressure.

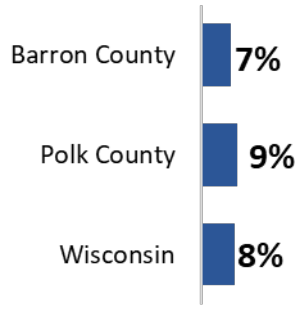
Percentage of adults 18 and over who have ever been told by a doctor that they have **high cholesterol.**



Source: Behavioral Risk Factor Surveillance System, 2006-12

Across our community, 44 percent of adults have been told they have high cholesterol. This rate is higher than the average rate in Wisconsin of 36 percent. The rate of adults with high cholesterol is higher in Barron County than in Polk County.

Percentage of adults over 20 who have ever been told by health professional that they have **diabetes.**

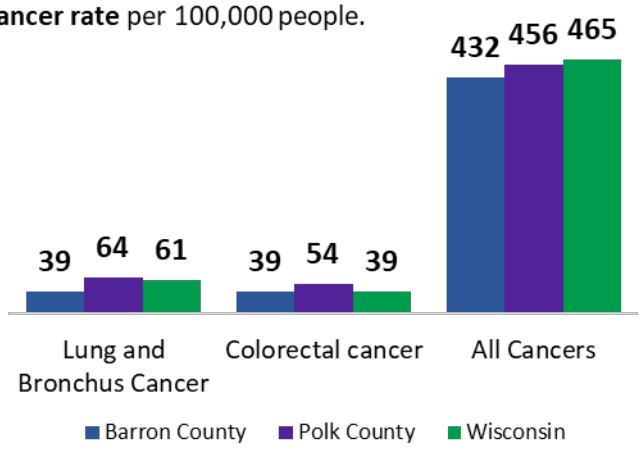


Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2013

In our community, almost 8 percent of adults over age 20 have been told by a health care provider that they have diabetes, which is consistent with the state average in Wisconsin.

Cancer rates

Cancer rate per 100,000 people.



Source: Wisconsin Dept. of Health Services, Division of Public Health, 2017

Compared to the state average, cancer rates per 100,000 people are lower in our community.

Lung cancer rates range from 39 per 100,000 residents in Barron County to 64 per 100,000 in Polk County. Colorectal cancer rates range from 39 per 100,000 in Barron County to 54 per 100,000 in Polk County.

While Barron County lung and colorectal cancer rates are lower than the state average rates of 39 and 61 per 100,000 people, Polk County has higher rates of both cancer types.

At 95 cases per 100,000 people, Polk County's breast cancer rates are lower than the statewide rate of 127 per 100,000 people, while Barron County's rate is 138 per 100,000.

The opposite is true for prostate cancer rates. At 77 per 100,000 people, Barron County prostate cancer rates are lower than the statewide rate of 100 per 100,000 people, while Polk County's rate is 134 cases per 100,000.

Both breast cancer and prostate cancer rates are age- and sex-specific population adjusted.

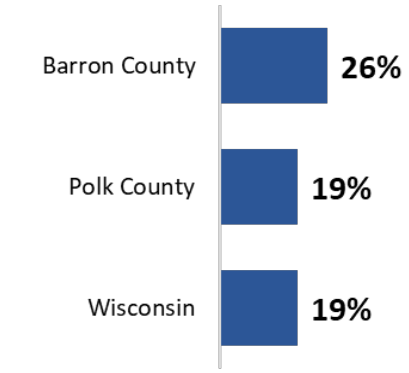
Priority: Substance abuse

Substance abuse refers to the excessive use of substances including alcohol, tobacco, prescription drugs, opioids and other drugs in a manner that is harmful to health and well-being.

The following is a snapshot of substance abuse concerns in our communities.

Tobacco use

Percentage of adults who **currently smoke**.



Source: Behavioral Risk Factor Surveillance System, 2006-12

Tobacco use is associated with many chronic diseases and health conditions, including respiratory disease, heart disease and cancer.

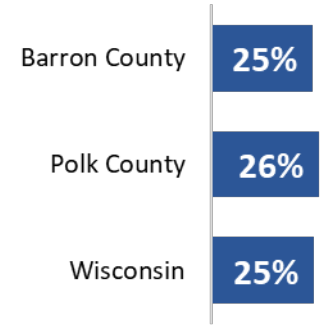
The adult smoking rate in Barron County is much higher than in Polk County and Wisconsin overall: 26 percent compared to 19 percent.

According to HealthPartners EHR data, 23 percent of Barron County patients and 17 percent of Polk County patients are current smokers. Smokeless tobacco use is also a concern among HealthPartners patients, with 6 percent of Barron County patients and 4 percent of Polk County patients identifying as current smokeless tobacco users.

According to the Youth Risk Behavior Survey, 17 percent of Wisconsin youth report using any form of tobacco, including cigarettes, cigars, smokeless and vape products in 2017. In addition, 11 percent of youth report using electronic vapor products. With the exception of electronic vapor products, youth smoking has declined since 2013.

Adult excessive drinking

Percentage of adults who report **drinking excessively** within the last 30 days.



Source: Behavioral Risk Factor Surveillance System, 2006-12

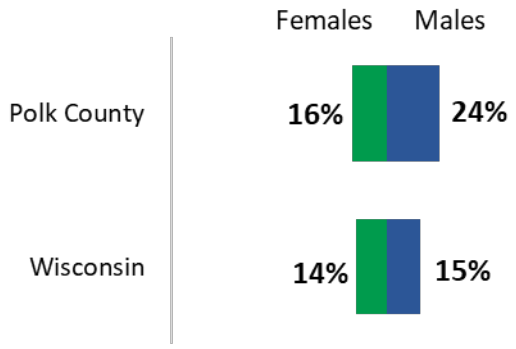
Excessive drinking is defined as 2 or more drinks per day for men and 1 or more drinks per day for women. In our community and across Wisconsin, approximately 1 in 4 adults drinks excessively.

"Drug and alcohol use is highly prevalent."

– Provider survey participant

Youth alcohol use

Percentage of high school students who report **using alcohol** prior to the age of 13.



Source: Youth Behavioral Risk Survey, 2013 and 2015

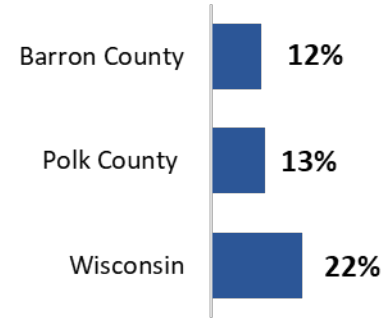
Underage drinking can affect youth, their families and the community. Youth who drink alcohol are more likely to experience problems at school, illness, physical and sexual violence, accidents, injury and even death.

In Polk County, 15 percent of teenage girls and 20 percent of teenage boys started using alcohol before age 13. These rates are slightly higher than overall state rates.

According to the Youth Behavioral Risk Survey, nearly 20 percent of Barron County high school students reported having at least one drink of alcohol in the last 30 days in 2015.

Youth marijuana use

Percentage of high school students who report **using marijuana** within the last 30 days.



Source: Youth Behavioral Risk Survey, 2010-2011; 2015

There is little data about illicit drug use among adults and youth in our community. Data from 2010 indicates 12 percent of high school students in Barron County used marijuana in the past 30 days. In 2015, 13 percent of Polk County high school students reported using marijuana. High school students in both counties use marijuana at lower rates than Wisconsin high school students overall.

Illicit drug use including prescription drug use

"Find a solution for the meth and other drug issues and addictions, so these people can be productive members of the community"

– Community survey participant

Substance abuse, including of illicit drugs such as methamphetamine, was a significant concern for Barron County community members and health care provider survey participants. Providers and community members said there is a culture of promoting substance abuse in the community. This includes community norms related to excessive drinking.

Methamphetamine abuse is the most significant substance abuse issue in Barron and Polk Counties. According to the Wisconsin Department of Justice, Barron County had 103 meth-specific crime lab cases in 2016. Polk County had 63 meth-specific crime lab cases in 2016.

There is increasing concern about opioid use in our community and across the state. According to the Wisconsin Department of Health Services, 8 babies out of every 10,000 births were born addicted to opioids in 2014.

Evaluation of Impact, 2016-2018 CHNA Implementation Strategy

This section was added to the CHNA report on 12/7/2019

The Community Health Needs Assessment conducted in 2015 identified the following priorities in our community:

1. Mental and Behavioral Health
2. Access and Affordability of Health Care
3. Chronic Disease and Illness Prevention
4. Equitable Care

Amery Hospital developed a Community Health Implementation Plan with supporting objectives and action steps to address these priority needs and to serve as the implementation roadmap for fiscal years 2016, 2017 and 2018. Through collaboration, engagement and partnership with our communities, we addressed these priorities with a specific focus on health equity in special populations. The following is a summary of impact over the past three years:

Priority #1: Mental and Behavioral Health

Goal	Strategies/Activities	Progress and Key Results		
		2016	2017	2018
Reduce stigma surrounding mental illnesses	Implement Make It Ok anti-stigma campaign	More than 500 people have been trained Make it OK Ambassadors in the St. Croix Valley. Ambassadors have reached 5,483 in St. Croix Valley through presentations, events and community outreach.		
	Integrate Make It Ok into employee wellness programs for hospital	Make It OK campaign was included in employee communications, and Ambassador trainings and Make It OK presentations were offered for staff throughout the care system and in the community on an ongoing basis.		
	Support efforts to raise stigma awareness including participating in annual NAMI walk and the "Back of the Door Campaign" poster series	Annual participation and support of NAMI walk and poster campaign continue.		
Improve access to mental	Develop strategies to improve patient and community connection to mental and behavioral health care including seeking funding for a navigation model.	Amery Hospital has embedded therapists into the care system to serve patients immediate needs for mental health services.		

health services	Develop partnerships and model to embed behavioral health in primary care	
	Evaluate and develop inpatient treatment capacity for behavioral health care in the St. Croix Valley area	Due to critical access status we cannot increase number of patient beds, however we have increased capacity to serve wider age-range of patients (now 18 years and up, previously 45 years and up).
	Improve processes for behavioral health patients in emergency department	A Mental Health Therapist is embedded in clinics to improve patient access. Televideo Crisis Stabilization process has been developed. Emergency Department staff received additional training on mental health crisis situations. Upgrades to Emergency Department patient rooms to create a safe environment for individuals experiencing a mental health crisis.
	Actively participate and represent one of six hospitals that comprise the Valley Co-op Behavioral Health Team	Behavioral Health staff continues to participate and represent Amery Hospital at the Valley Co-op Behavioral Health Team.
	Reduce intake timeline for behavioral health inpatient admission	Reduced intake timeline to just a few hours, down from one day with changes to process and forms in 2016.
	Expand mental health services coverage to satellite clinics	Starting in 2016, there has been a therapist at each satellite clinic one day per week.
Increase education around mental and behavioral health	Offer and promote ongoing education classes including classes on stigma, depression, dementia, and various other mental health issues	Make it OK campaign and a variety of free mental health-focused community education classes taught by Behavioral Health staff continue to reach hundreds of people through events and presentations.
	Offer “Beating the Blues” online program for both patients and employees to learn ways to better manage mod, stress and anxiety	Amery Hospital continues to promote and offer the free Beating the Blues online program for members and patients.
	Provide safe, comfortable, and engaging environments for individuals with memory loss and their care partners through Memory Cafes	In partnership with the Aging and Disability Resource Center of Polk and Barron County, Amery Hospital has supported the establishment of a Memory Café in Amery.
	Support and offer staff education on mental and behavioral health issues including mental health crisis training for Hospital and Emergency Department staff	Monthly lunch-and-learns on a variety of mental and behavioral health topics provided by Behavioral Health have been available to hospital and clinic staff each year, including mental health first aid. Though specific mental health crisis training for Emergency Department staff did not occur in 2016-2018, it was completed in 2019.

	Participate in "Success by 6," which aims to support parents and children ages 0-6 to have the necessary physical, mental, emotional and social development to successfully grow and learn	Amery Hospital continues to participate and have representation in Success by 6.
Reduce drug use and risky and unhealthy alcohol use	Support Clayton community's Mock Crash Event, organized for high school students, which demonstrates the cause and effects of drunk driving	Amery Hospital continues to participate and support these events and education opportunities annually.
	Support Amery community driver's education by providing drinking and driving education.	
	Screen for risky and unhealthy drug use in prenatal, well child, and annual preventative care visits and offer education and appropriate resources to patients	Screening and education in clinic settings continue. Healthy Beginnings Program began in 2018 with a social worker available in clinic.
	Participate in Brief Screening Intervention Training for Healthcare providers in Polk County	Staff participated in this training in 2017.
	Offer evidence-based programming on alcohol and drug diversion to adolescents and their families via court order or parental request	This continues in primary care setting.
	Conduct mass media campaigns that raise awareness on the social and economic impact of alcohol impaired driving and binge drinking to emphasize responsible drinking/moderate drinking levels	Ongoing campaigns through Polk County Health Department are supported through collaborative work by Amery Hospital staff that participate in the Substance Abuse Workgroup.
Reduce tobacco use and exposure.	Screen for tobacco use in prenatal, well child, and annual preventative care visits and offer cessation education to patients and the community	Screenings continue in the clinic setting and Healthy Beginnings Program began in 2018 with a social worker available in clinic to support tobacco cessation in expectant mothers.
	Employ a certified tobacco counselor	Two providers are certified tobacco counselors and tobacco cessation resources are offered at all Valley hospitals.
	Participate in the Tobacco Free Living Coalition	Amery Hospital continues to participate in this coalition.

Priority #2: Access and Affordability

Goal	Strategies/Activities	Progress and Key Results		
		2016	2017	2018
Improve connections of people to health care and community resources	Compile local community resources and share with staff, partners and patients via multiple methods including web and staff training.	A complete resource guide was not recommended by the community advisor and was duplicative to work being done by public health partners. Staff training and resources are provided on a topic-specific basis and through employee communications.		
	Continue to support employee wellness through: annual health fair, health screenings, quarterly lunch and learns, garden club, and various other events.	Employee Wellness is aligned with key health priorities through health assessments and claims data. Employee communications engage employees with health champions identified, trained, and mobilized. Annual health fair and opportunities for wellness-related lunch and learns continue.		
	Continue to financially support community organizations and programs that help connect people to services, including Baby & Me classes.	Amery Hospital provides in-kind and financial support annually to numerous organizations that connect people to services, such as Baby & Me.		
Increase access, affordability and quality of primary and preventative healthcare	Provide community residents with transportation services within a 15-mile radius to the health campus for a nominal fee	Over 1300 patients utilize this service annually.		
	Continue providing direct access lab testing which helps to lower out-of-pocket expenses for consumers/patients who are uninsured or have a high deductible or need more frequent testing than their health insurance plans will cover	Direct access lab testing continues.		
	Continue financial counseling program (1.0 FTE) to help secure a payment source for un-insured and under-insured patients. Specifically, the Patient Financial Services Representative will help patients with financial assistance applications, setting up payment plans, enrolling in government programs, finding other sources of payment, or accessing services beyond medical care.	Financial counseling services continue and currently 3.0 FTE are dedicated to provide these services.		
	Continue Scholarship Program to help increase the number of qualified providers in the community; seven scholarship awards will be offered to graduating high school seniors	Scholarship program continues and seven scholarship awards have been awarded each year.		
	Utilize the electronic medical record (EMR) system, which reduces the opportunity for error, expedites the	EMR use continues.		

	patient transfer process, and allows for easier scheduling of appointments	
	Continue Total Cost of Care Task Force efforts to reduce the total cost of care for patients served by the hospital	This task force continues to meet to try and reduce the total cost of care for patients served by the hospital.
	Expand clinic hours and services to satellite clinics	Expanded services include behavioral health therapist at satellite clinics one day per week. Several providers now have later clinic hour available at the Amery Clinic and this is expected at satellite clinics in 2020.
	Continue athletic trainer presence at Luck and Amery High Schools to support athlete health and sports medicine	Amery Hospital athletic trainers were in both Amery and Luck School Districts, providing over 2000 hours of athletic training and support for a minimal fee.
Improve quality of care	Collaborate around quality improvement to identify and improve quality gaps including training in quality improvement for leaders.	Hospital engages in ongoing performance and quality improvement projects focused on improving the patient experience. Specific focus has been on falls prevention and patient experience. All leaders trained in performance improvement methods.

Priority #3: Chronic Disease and Illness Prevention

Goal	Strategies/Activities	Progress and Key Results		
		2016	2017	2018
Make better eating and physical activity easy, fun and popular for children and families through the PowerUp Initiative	Consult with community partners and provide resources to create a healthier food and physical activity environment through open gyms, farmer's markets, school policy and practice changes, improving foods at community and school events and concessions	8 open Gyms were held in partnership with Amery school district.	8 open Gyms were held in partnership with Amery school district.	8 open Gyms were held in partnership with Amery school district, 15 were held in partnership with Clear Lake School District, 3 open skates were held in partnership with Amery Youth Hockey.
	Engage the community in PowerUp partnerships through shared leadership with the community and engaging communications and outreach.	At a Valley level: Over 97,400 people exposed at community events and through communications.	At a Valley level: Over 124,500 people exposed at community events and through communications.	At a Valley level: Over 98,000 people exposed at community events and through communications.
	Focus community attention on healthier communities for children through PowerUp for Kids Week and ongoing community outreach.	At a Valley level: 1,334 kids attended events during PowerUp Week.	At a Valley level: 1,040 kids attended events during PowerUp Week.	At a Valley level: 1,526 kids attended events during PowerUp Week.
	Deliver PowerUp School Challenge and School Change Toolkit in all interested schools in target school districts in Polk County.	733 students participated (Amery School District)	730 students participated (Amery School District)	1046 students participated (Amery and Clear Lake School District)

	Provide ongoing educational opportunities for kids and families including cooking classes and educational resources.	Cooking classes are offered in Amery 9-12+ times per year.
Improve the health of children beginning in early childhood, through the Children's Health Initiative	Develop and implement Children's Health Initiative strategies including: Read, Talk Sing resources; Social Emotional Development identification; Promote drug and alcohol free pregnancies; Breast-Feeding Promotion; Standard Workflows; OB-Pediatric coordinated care; Postpartum Depression; Decrease Teen Pregnancy; Supporting High-Risk Families; Early Childhood Experience screening	Amery Hospital implements the Reach Out and Read program during well-child visits, infancy through age 5.
Increase access to fruits, vegetables, and healthy food	Continue to increase healthier, less processed food options in hospital café and meetings	Amery Hospital follows 80/20 beverage guidelines to keep sugar sweetened beverages to no more than 20% of total beverages offered in cafeteria.
	Support Community Gardens	Amery Hospital continues to partner with the City of Amery to offer 18 gardening plots at the community garden located on Amery Hospital grounds. (Number of beds increased from 12 to 18 in 2018).
	Offer Community Supported Agriculture (CSA) and other sources of local produce at the hospital	This goal was not met, but continues to be evaluated for feasibility.
	Reduce Sugar Sweetened Beverages in hospital and clinic campuses to no more than 20% of total beverages and foods offered	Amery Hospital follows 80/20 beverage guidelines to keep sugar sweetened beverages to no more than 20% of total beverages offered in cafeteria. At this time, no guideline are in place for foods offered.
	Reduce high sugar/low nutrient foods in hospital and clinic campuses to no more than 20% of total beverages and foods offered	
	Create food and beverage guidelines for hospital and clinic meetings	This goal was not met, but continues to be evaluated for feasibility.
	Consult with and support community partners to reduce high sugar/low nutrient food and sugar sweetened beverage offerings at community events (see PowerUp)	Partnered with Amery School District to implement healthy food options at a number of school and community events.

Increase access to physical activity	Increase availability of free and low-cost physical activity options for children and families (See PowerUp)	8 open Gyms were held in partnership with Amery school district.	8 open Gyms were held in partnership with Amery school district.	8 open Gyms were held in partnership with Amery school district, 15 were held in partnership with Clear Lake School District, 3 open skates were held in partnership with Amery Youth Hockey.
	Partner with local, state and national park, recreation clubs, youth sports and others to increase opportunities for youth and family physical activity (See PowerUp)	PowerUp in the Parks Passport was created in partnership with Minnesota DNR to promote youth and family physical activity in local, regional and state parks. A Parks Rx was handed out at clinics to facilitate the conversation about physical activity. At two special events held at local state parks, 240 participants attended.		
Provide health education and support to patients and community members	Collaborate to provide high quality Diabetes education to patients and families, including standardized processes and educational materials	Diabetes education is offered regularly and diabetes prevention classes are offered monthly. Amery Hospital also participated in the Diabetes Expo in 2017.		
	Continue to educate hospital and clinic staff on diabetes education principles through trainings, newsletters and communication through EPIC	Education provided on teaching tools, home glucose meters and patient skills prior to outpatient education, treating hyperglycemia, treating diabetes as a disease, and de-stigmatizing the disease through language usage.		
	Provide expectant parent classes and breastfeeding classes four times per year at no charge	Expectant parents/pre-natal and breastfeeding classes reach over 30 parents each year.		
	Provide ongoing educational opportunities for kids and families including cooking classes and educational resources (See PowerUp)	Cooking classes are offered in Amery 9-12+ times per year.		
	Employ hospital dietitians to promote nutrition awareness and education to patients, their families, and the community	Registered dietitians offer two different medical nutrition therapy classes with a focus on healthy weight and diabetes prevention. Additional nutrition classes on various topics are taught 1-2 times per year.		
	Provide diabetes and new parent education and support groups; continue to review opportunities in relation to programming and service line development	Expectant parents/pre-natal and breastfeeding classes reach over 30 parents each year. Monthly diabetes support group reach over 100 individuals annually.		
	Provide Lactation Support; encouraging breastfeeding and providing access to certified lactation consultants and breastfeeding education	Lactation support continues to be provided along with breastfeeding classes reaching over 30 parents each year. In 2018, a weekly breastfeeding support group began.		

	Provide a wide variety of community education classes and support groups	Since 2016, Amery Hospital has offered at least one free community education class every month. Registered dietitians also offer two different medical nutrition therapy classes with a focus on healthy weight and diabetes prevention. Monthly diabetes support groups are held and in 2018 a weekly breastfeeding support group began.
Improve health awareness, knowledge and literacy in the community	Participate in and support community health fairs and events to share health information and resources with the community	Amery Hospital participates in about 5 health fairs annually with focus on heart health, stroke prevention, wound healing, diabetes education, and nutrition. Classes focused on diabetes prevention, healthy eating, obesity, physical activity and mental health are offered at least once per month at Amery Hospital, and promoted at all Valley hospitals.
	Host health outreach events to specific populations to share health information and resources with the community (Hops for Health; Women's Event; Diabetes event etc.)	

Priority #4: Equitable Care

Goal	Strategies/Activities	Progress and Key Results		
		2016	2017	2018
Improve capacity to deliver equitable care	Train leaders and staff in diversity, health literacy and cultural humility.	HealthPartners Diversity and Inclusion Team has been guiding the process for all employees through MyLearning to increase cultural humility. All leaders were trained with tools addressing diversity, inclusion and bias to bring back to their teams. Diversity, inclusion and bias are embedded into our approach to care.		
Facilitate improved access to services and resources for low income and diverse populations.	Increase number of PowerUp, diabetes and other hospital materials available in other languages (Spanish)	The PowerUp Family Magazine is available in Spanish. Additional classroom and family materials for the PowerUp School Challenge are available in Spanish, Somali and Hmong.		
	Support community organizations and programs that help connect people to services.	Amery Hospital provides in-kind and financial support annually to numerous organizations that connect people to services, such as Baby & Me.		
	Increase availability of free and low-cost physical activity options for children and families (See also PowerUp)	8 open Gyms were held in partnership with Amery school district.	8 open Gyms were held in partnership with Amery school district.	8 open Gyms were held in partnership with Amery school district, 15 were held in partnership with Clear Lake School District, 3 open skates were held in partnership with Amery Youth Hockey.

Align efforts and collaborate with community partners.	Actively participate in Polk County Community Health Improvement Plan and taskforces for priority areas	Amery Hospital continues to participate in Polk United and the workgroups focusing on priority areas, including: Mental Health Task Force, Nutrition & Physical Activity, and Substance Abuse.
	Actively participate in the Mental Health Taskforce of Polk County	

Next Steps

Amery Hospital & Clinic and HealthPartners will continue to work collaboratively with the community to develop shared goals and actions that address the top five priority needs identified in the CHNA. These shared goals and actions will be presented in our implementation strategy, which is a required companion report to the CHNA. Each need addressed will be tailored to the hospital's programs, resources, priorities, plans and/or collaboration with governmental, non-profit or other health care organizations.

While Amery Hospital & Clinic and HealthPartners hospitals jointly prioritized systems-level needs, the U.S. Department of the Treasury and the IRS require a hospital organization to separately document the implementation strategy for each of its hospital facilities. The board of each hospital must approve the implementation strategy by May 2019.

Contact Information

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Sources

This study primarily used health and demographic data packaged and analyzed by Community Commons. Data from Community Commons was retrieved in June 2018 from www.communitycommons.org.
Data retrieved from Community Commons includes the following:

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Appendix

Community Committee Participation

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Building Resilience: Preventing Diseases of Despair	Funded by the Catalyst Initiative of the Minneapolis Foundation, this guided community conversation focused on Building Resilience: Preventing Diseases of Despair. The group explored strategies for primary prevention of addiction and suicide. It was an all-day event centering community voices, emergent research and trauma-responsive approaches to supporting individual and collective resilience.	9/18/2018	DeDee Varner Pakou Xiong Thia Bryan
Center for Community Health (CCH) Assessment and Alignment Workgroup	This subgroup of CCH services as a catalyst to align the community health assessment process.	Monthly	DeDee Varner
Center for Community Health (CCH) Collective Action Collective Impact (CACI)	This is one of two subgroups from CCH. The CACI subgroup is charged with developing and implementing an improvement project to address a *shared priority* based upon the community health needs assessments of the participating CCH organizations in the 7-county Twin Cities metropolitan area.	Monthly	Pakou Xiong Libby Lincoln Amy Homstad
CACI - May's Mental Health Month (MMHM) Committee	A subcommittee of the CACI subgroup of CACI, this group is tasked with carrying the planning and inventory of May's Mental Health Month Activities across the 7metro county sectors.	Monthly	Pakou Xiong

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Center for Community Health (CCH) Steering Committee	The Center for Community Health (CCH) is a collaborative between public health agencies, non-profit health plans and not-for-profit hospital/health systems in the 7-county metropolitan area in Minnesota. The mission is to advance community health, well-being and equity through collective understanding of needs and innovative approaches to foster community strengths.		Nancy Hoyt-Taff Marna Canterbury
Dakota County Healthy Communities Collaborative (DCHCC)	The mission of the DCHCC is to bring together health care providers, county staff, school representatives, faith communities, nonprofit staff and other organizations to support the health and well-being of Dakota County citizens. The goal of the DCHCC is to identify needs, connect community resources and create solutions	Monthly	DeDee Varner Libby Lincoln
Hmong Community Stroke Education and Awareness Initiative	Originally initiated from Regions Hospital Stroke Center to raise awareness of high rates of stroke in the Hmong community, through St. Paul School partnerships, this group has turned into a Hmong Stroke Translation project with funding from the Regions Foundation to translate 8 selected American Heart Association stroke documents into Hmong and to make them ethnically appropriate.	Monthly	Pakou Xiong

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Mental Health and Wellness Action Team (MHWAT)	Part of the Saint Paul-Ramsey County Public Health (SPRCPH) Community Health Improvement Plan (CHIP), SPRCPH formed an authentic, community-engaged Mental Health and Wellness Action Team (MHWAT) that informs the work of our department in responding to the integrated health care needs of St. Paul and Ramsey County residents and greater communities. Ramsey County's MHWAT is one of 5 SPRCPH Community Health Improvement Goals.	Monthly	Pakou Xiong
MHWAT Wellness Group	This is 1 of 4 subgroups of the MHWAT. The MHWAT Wellness Group's purpose is to increase mental well-being for students, families and school staff in Ramsey County by focusing on components of mental well-being for adolescent students.	Monthly	Pakou Xiong
Minnesota Department of Health Healthy Minnesota Partnership	The Healthy Minnesota Partnership brings community partners and the Minnesota Department of Health together to improve the health and quality of life for individuals, families, and communities in Minnesota. The Healthy Minnesota Partnership has been charged with developing a statewide health improvement plan around strategic initiatives that ensures the opportunity for healthy living for all Minnesotans and that engages multiple sectors and communities across the state to implement the plan.	5x/year	Donna Zimmerman (representing Itasca Project) DeDee Varner
Minnesota Department of Health Mental Well-Being & Resilience Learning Community	This group's purpose is to expand understanding about a public health approach to mental health by profiling current community initiatives across a continuum of public health-aligned strategies.	Monthly	DeDee Varner

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
St. Paul-Ramsey County Community Health Services Advisory Committee	This board advises, consults with or makes recommendations to the Saint Paul City Council and the Ramsey County Board of Health on matters relating to policy development, legislation, maintenance, funding and evaluation of community health services.	Monthly	Dr. Kottke
St. Paul Ramsey County Public Health Statewide Health Improvement Program Community Leadership Team Meetings	The Minnesota Department of Health provides funding to Saint Paul-Ramsey County Public Health through the Statewide Health Improvement Partnership (SHIP) to work with a variety of partners to improve the health of our community. Saint Paul-Ramsey County Public Health is in its fourth cycle of SHIP funding. It has three goals: increasing physical activity; improving access to healthy foods; and reducing the use of and exposure to tobacco.	4x/year	DeDee Varner
Forces of Change Affecting Community Health	The Center for Community Health hosted this dialogue for community leaders. This event aimed to increase collaboration and richness of conversation about health, broadly defined, across the Minneapolis-Saint Paul metropolitan region. Sixty participants contributed insights and exchanged ideas.	10/25/2017	DeDee Varner Marna Canterbury Nancy Hoyt Taft Pakou Xiong Libby Lincoln
East Metro CHNA/CHA Pilot Workgroup	Dakota County Public Health, Washington County Public Health, Saint Paul-Ramsey County Public Health, HealthEast, Regions Hospital and Lakeview Hospital are meeting to align respective community needs assessments, which are all due in 2018.	Monthly	DeDee Varner Sidney Van Dyke Heather Walters Libby Lincoln Amy Homstad Marna Canterbury Andrea Weiler

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Community Health Action Team (CHAT)	CHAT meets monthly to discuss and address unmet community health needs in the area through action, networking and educational opportunities. Attendees are from Stillwater Area School District and Washington County partners.	Monthly	Andrea Weiler
East Metro Mental Health Roundtable	The East Metro Mental Health Roundtable and the associated Mental Health Alliance and Measurement Committees are focused on examining and improving the mental health system for adults in the East Metro. This study looks at a variety of metrics for the adult mental health system in the East Metro to identify patterns, needs and opportunities for improvement.		Megan Remark Wendy Waddell
Central Corridor Anchor Partnership	The Central Corridor Anchor Partnership is a group of colleges, universities, hospitals and health care organizations located near the Green Line in Minneapolis and St. Paul. We have invested greatly in our physical infrastructure to serve our patients, students and employees, and are anchored to the health, vitality and growth of the neighborhoods around us.	Quarterly	Megan Remark Ruth Bremer
Catholic Charities Higher Ground Steering Committee	The Catholic Charities Higher Ground Steering Committee meets to support the work of Higher Ground, a shelter for adults with 171 shelter spaces and 80 Pay-For-Stay beds.	Every other month	Chris Boese John Clark Mona Olson Wendy Waddell Rachelle Brambach Katie Paulson

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
REASN	The Racial Equity Action Support Network (REASN) brings together racial equity champions and advocates from community, nonprofit and government organizations across Minnesota, providing them a space for support in doing the challenging work of creating racial equity and to strategically advance new thinking and action in their work.	Quarterly	Sidney Van Dyke
Healthcare for the Homeless	The Healthcare for the Homeless group is part of Westside Community Health Services. They provide primary care to homeless patients who discharge from Regions and those who utilize the Higher Ground Homeless shelter. This group meets to discuss how Regions Care Management and Healthcare for the Homeless can work better together and communicate effectively to best provide care for our shared patients.	Quarterly	Rachelle Brombach
East Metro Coordination of Care	The East Metro Community is part of the Lake Superior Quality Innovation Network (LSQIN) Coordination of Care initiative, which is a community-based collaborative designed to improve coordination of care and care transitions and reduce readmissions for Medicare beneficiaries and all patients in Minnesota. In addition to the monthly informational meetings, there are several work groups that work on various topics related to reducing re-admissions.	Monthly	Rachelle Brombach Mona Olson
West Metro CHNA Collaborative	North Memorial & Maple Grove Hospital, Allina, Park Nicollet Health Services and Hennepin Health are meeting to align respective community needs assessments, which are due in 2018 and beyond.	Ad hoc	Libby Lincoln Amy Homstad

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Scott County Health System Collaborative	The Health System Collaborative brings together representatives of area health systems, schools and community organizations to identify and address the health needs of the community.		Libby Lincoln
SHIP Community Leadership Team	The SHIP Community Leadership Team oversees the work being done in Scott County under the state SHIP grant.		Libby Lincoln
Brooklyn Center Health Resource Center Advisory Committee (BCHRC)	The BCHRC Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the Health Resource Center.	Monthly	Libby Lincoln
Richfield Health Resource Center Advisory Committee (RHRC)	The RHRC Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the Health Resource Center.	Monthly	Libby Lincoln
Northwest Hennepin Healthy Community Partnership	The Partnership is a collaboration of health care, school, county and community organizations that come together to address the needs of the northwest Hennepin community.	Monthly	Libby Lincoln
Central Clinic Advisory Committee	The Central Clinic Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the clinic.	Quarterly	Libby Lincoln
Dakota County School Mental Health Practice Group	The Mental Health Practice Group is a collaboration of providers of mental health services in the Dakota County schools. They meet to share best practices and coordinate services.	Monthly	Libby Lincoln

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Diamondhead Clinic Advisory Committee	The Diamondhead Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the clinic. It meets 3 to 4 times a year.	Quarterly	Libby Lincoln
Health and Wellbeing Advisory Committee (HWA)	The Health and Wellbeing Advisory Committee serves as the eyes and ears for Lakeview Hospital and provides resources and services to meet the health and well-being needs of the community.	Quarterly	Marna Canterbury Andrea Weiler
Healthier Together Pierce & St. Croix Counties	Healthier Together is a community coalition comprised of local health systems, public health agencies, local businesses, media, education, government and community members. Healthier Together provides strategic and collaborative framework for health improvement activities throughout the two-county region of Pierce and St. Croix Counties, Wisconsin.	Monthly	Jacob Hunt
Hudson School District Wellness Committee	The Hudson School District Wellness Committee is a group that meets three times throughout the school year to develop planning on student wellness. Areas that are addressed include mental health and well-being and physical activity/nutrition.	Three times a year	Jacob Hunt
Physical Activity Action Team-Healthier Together	The goal of the physical activity action team is to decrease the percentage of the population in Pierce and St. Croix Counties that is overweight or obese. In order to achieve this goal, the action team is trying to increase physical activity and decrease food insecurity/improve nutrition through changes to policy, systems, environment and community support.	Monthly	Jacob Hunt

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Alcohol Action Team-Healthier Together	The goal of the alcohol action team is to decrease alcohol abuse in Pierce and St. Croix Counties. In order to achieve this goal, the action team is trying to decrease adult and youth alcohol use through changes to policy, systems, environment and community support.	Every other month	Jacob Hunt
Thrive Barron County	Thrive Barron County is a coalition of the Barron County Health Department, community partners and health care partners that works together to conduct periodic community health assessments, evaluate the findings and develop strategies to address top health priorities in Barron County, Wisconsin.	Monthly	Katy Ellefson
Polk United	Polk United is a coalition of the Polk County Health Department, medical centers and community partners that works together to evaluate community health needs and develop and implement activities in Polk County, Wisconsin.	Monthly	Katy Ellefson
Polk County Nutrition & Physical Activity Workgroup	This subcommittee of Polk United works specifically on the priority area of nutrition and physical activity by developing and implementing plans and activities to address obesity and chronic disease. It is comprised of key stakeholders in Polk County.	Monthly	Katy Ellefson
Mental Health Task Force of Polk County	The Mental Health Task Force of Polk County is a non-profit organization committed to addressing community mental health needs cooperatively. The task force is comprised of mental health care providers, government and law enforcement representatives, human service agencies, school personnel and community members.	Monthly	Heather Erickson, Kesha Marson

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Polk County Substance Abuse Workgroup	This subcommittee of Polk United works specifically on the priority area of substance abuse by developing and implementing plans and activities to substance abuse issues. It is comprised of key stakeholders in Polk County.	Monthly	Brian Francis

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