Hudson 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

Hudson Hospital & Clinic is part of HealthPartners, 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. Hudson Hospital & Clinic serves western Wisconsin with emergency, birth, rehabilitation and imaging centers, specialty clinics, cancer care, heart care, orthopedics and a nationally acclaimed healing arts program. This report describes the current Community Health Needs Assessment (CHNA) process and results for Hudson Hospital & Clinic.

Between 2016 and 2018, HealthPartners and Hudson Hospital & Clinic engaged with local public health partners in St. Croix and Pierce 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 the federal requirements of the Patient Protection and Affordable Care Act (ACA) and the Internal Revenue Service final regulations. It was approved by the Hudson Hospital & Clinic Board on December 18, 2018. In accordance with federal requirements, this report is made widely available to the public on our website at www.hudsonhospital.org/community/.

Community Served

Hudson Hospital & Clinic is located in the city of Hudson in St. Croix County, Wisconsin. While we serve patients from everywhere, 80 percent of the people we serve live in St. Croix and Pierce Counties. In total, our community has approximately 127,600 residents. In 2017, Hudson Hospital reported 1,693 inpatient admissions from patients living in St. Croix and Pierce Counties.

Methodology

In 2018, HealthPartners and Hudson 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 the 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 Healthier Together 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 a modified 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
Hudson 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

CHNA background and goals

HealthPartners mission is to improve health and well-being in partnership with our members, patients and community. One of the ways we bring the mission to life is to work with community partners to better understand what contributes to and stands in the way of good health and how we can work together to improve health outcomes.

The Community Health Needs Assessment (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 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 the 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 Hudson 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 Hudson Hospital & Clinic.

Methodology

HealthPartners collaborated across six hospitals within its family of care 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 Hudson Hospital & Clinic engaged with local public health partners in St. Croix and Pierce Counties, as well as local coalitions, the CCH and community partners to conduct a comprehensive CHNA. Hudson Hospital & Clinic is a member of Healthier Together Pierce & St. Croix Counties (Healthier Together), a community coalition comprised of local health systems, public health agencies, local businesses, media, nonprofits, education, government and community members. Hudson Hospital & Clinic has collaborated as a long-term member of Healthier Together to facilitate and support the assessment of community health priorities in St. Croix and Pierce Counties, Wisconsin.

In 2018, HealthPartners and Hudson 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 Healthier Together 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 health data indicators

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 Twin Cities 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 identified through community input.

Secondary data in this report is specific to St. Croix and Pierce 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 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 the CHNA process, HealthPartners and Hudson Hospital & Clinic partnered to conduct community input activities to understand top health priorities.

The community input for this report includes:

County priority data: St. Croix and Pierce County Public Health, as members of Healthier Together, collaborate to facilitate and support the assessment of community health priorities in St. Croix and Pierce Counties, Wisconsin, and publishes this as a Community Health Assessment (CHA).

Healthier Together Pierce & St. Croix Counties Community Health Survey: In 2015 and 2018, Healthier Together sought community input through a residential survey and community dialogues. The survey measured perceptions residents have of community strengths, leading health concerns and access to resources. In 2015, 1,363 participants responded to the survey (815 from St. Croix County and 548 from Pierce County). In 2018, 1,072 participants responded to the survey (704 from St. Croix County and 368 from Pierce County).

Community dialogues: In 2016, Healthier Together hosted community dialogues focused specifically on mental health, obesity/overweight and alcohol abuse. Through guided discussions, participants shared their visions for health in the community, clarified aspects of the priority health areas and brainstormed strategies for supporting community health. Approximately 120 people participated in these community dialogues and focus groups. Other HealthPartners hospitals also held community dialogues with additional demographics in other geographic locations.

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 they need to better serve their patients. Twenty-three health care providers completed the survey, including 13 who practice at Hudson 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 towards 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 a modified Hanlon method and other commonly used prioritization methods. Each hospital shared its 4 - 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.

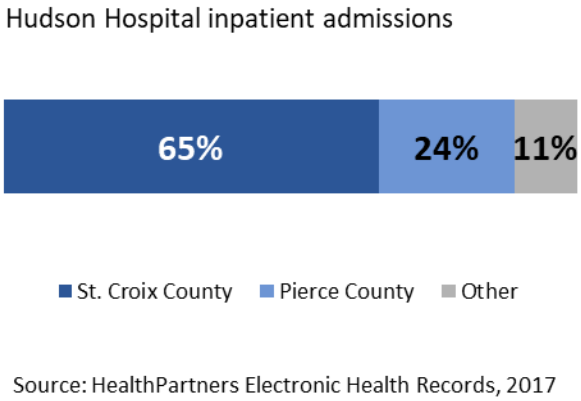
Substance abuse

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

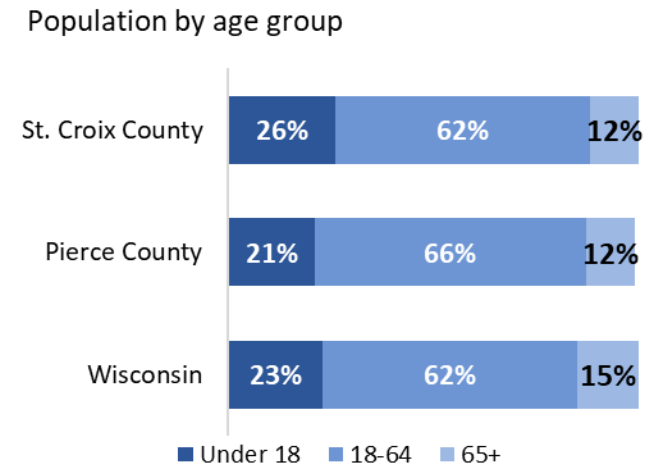


Source: HealthPartners Electronic Health Records, 2017

While we serve patients from everywhere, 89 percent of the people we serve live in St. Croix and Pierce 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 127,600 residents. In 2017, Hudson Hospital reported 1,693 inpatient admissions from patients living in St. Croix and Pierce Counties.

Age and population



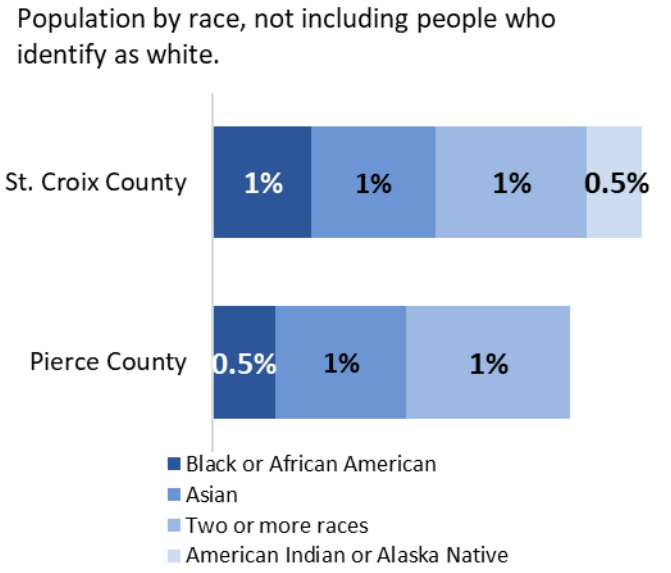
Source: US Census Bureau, American Community Survey, 2012-16

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 in our community is 38 years old. About 1 in 4 people in our community is under 18 and 1 in 8 is over 65.

However, our community is an aging community, 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



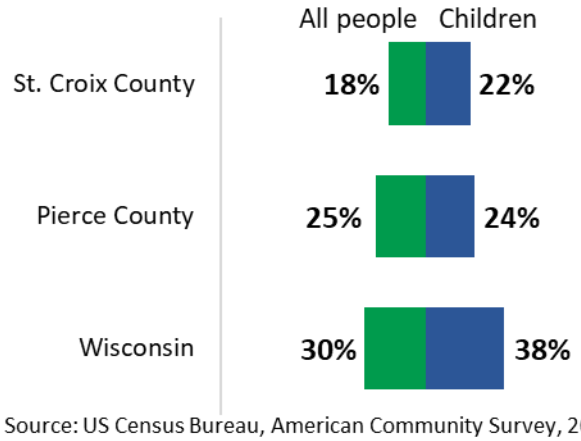
Source: US Census Bureau, American Community Survey, 2012-16

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

Although most people in St. Croix and Pierce Counties identify as white, it is still important to acknowledge people of color are disproportionately impacted by social and environmental conditions that affect people's health.

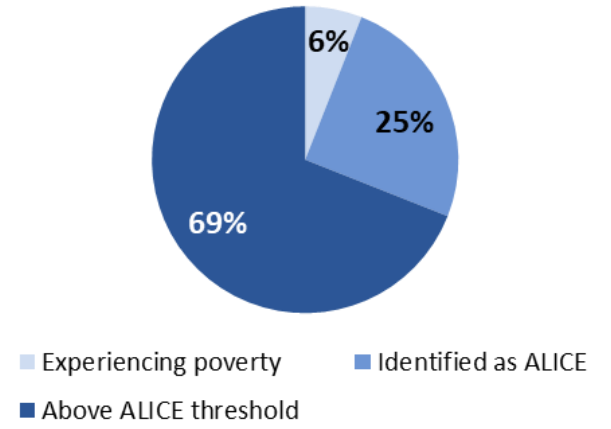
Poverty

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



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

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



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

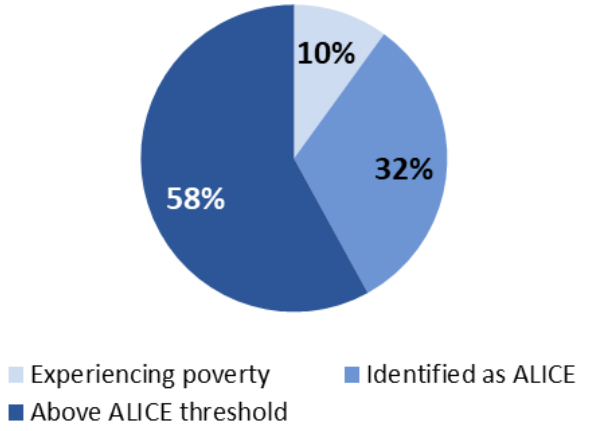
People who are experiencing poverty face health disparities. People who live in households earning at or below 200 percent of the federal poverty level (FPL) are considered low income.

About 1 in 5 people in St. Croix County and 1 in 4 people in Pierce County are currently living in a low-income household. Poverty rates for children are similar to those of the general population.

Twenty-five percent of St. Croix County households and 32 percent of Pierce County households are considered ALICE (Asset Limited, Income Constrained, Employed) households. These are households that earn more than 100 percent of FPL, but less than the cost of living. In St. Croix County, a family of four is considered an ALICE household if they earn less than $69,288 per year. The income threshold for Pierce County is $71,628 per year.

Poverty rates in our community are significantly higher for people of color than for people who identify as white. Poverty rates are more than 3 times greater for people who identify as black or African American and 10 times greater for American Indians than people who identify as white.

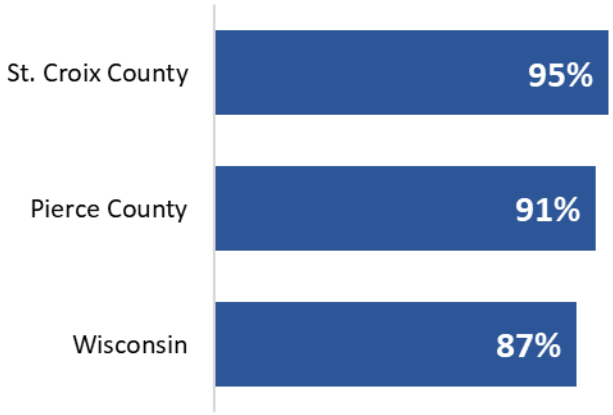
Percentage of households in **Pierce County** considered **Asset Limited, Income Constrained, and Employed (ALICE).**



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

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 community, more than 9 in 10 students graduate from high school in four years. About 5 percent of adults over 25 in our community do not have a high school diploma.

Thirty-three percent of St. Croix County adults and 27 percent of Pierce County adults have a bachelor's degree or higher.

Priorities and definitions

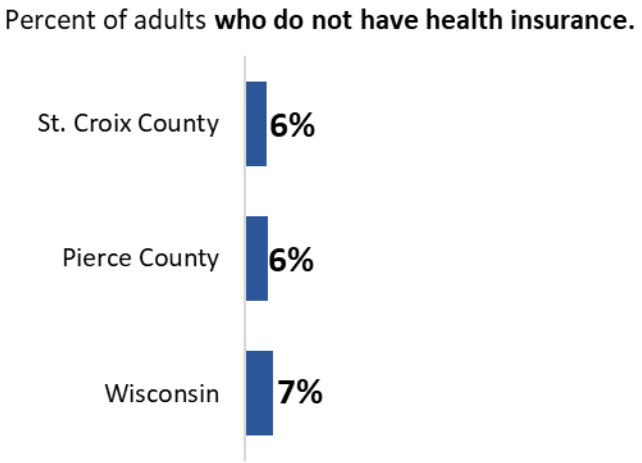
The following sections describe the health priorities identified during the CHNA process, all of which include data related to equity.

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, medical 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.

Cost of care and insurance



Source: US Census Bureau, Small Area Health Insurance Estimates. 2016.

"We lack affordable health insurance. With only one insurance provider offering coverage in the county our prices are way out of line with other nearby counties"

– Community survey participant

"[Barriers to accessing care include] the lack of providers, beds and insurance coverage."

– Provider 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 American Community Survey, 6 percent of St. Croix and Pierce County residents do not have health insurance.

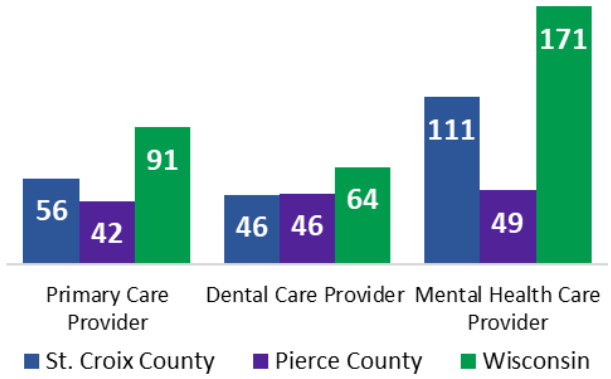
Health insurance coverage shows racial and economic disparities. According to the Wisconsin Department of Health Services' Family Health Survey, low income families are 3 times more likely to be uninsured than wealthier households. Hispanic/Latino and American Indian families are 3 to 4 times more likely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

Even with insurance, many people find it difficult to pay for out-of-pocket costs such as co-pays and deductibles.

Health care providers identified several barriers to accessing care including affordability, availability and accessibility. Access to care was also identified as a top need on the Healthier Together Community Health Survey.

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 St. Croix and Pierce Counties rank well below Wisconsin's ratio of primary care physicians, dentists and mental health providers to residents. The ratio of providers to residents suggests there may not be enough health care professionals to meet the community's health needs.

This data was supported by numerous community survey respondents who indicated limited access to affordable mental health or dental care, especially for youth, low income individuals and older adults.

Patients may 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 4 percent of people over age 5 in St. Croix County and 3 percent in Pierce County speak a primary language other than English.

Transportation and scheduling

"[Our community needs] reasonable (low cost) transportation for individuals who do not have the means for transportation to and from medical appointments not available in Hudson."

– Community survey participant

Many patients face additional barriers in accessing care. Health care providers cited the location of clinics and medical transportation challenges as barriers to accessing care. Several community survey participants also expressed this concern.

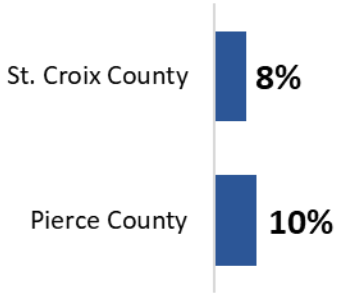
Priority: Access to health

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 community 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.



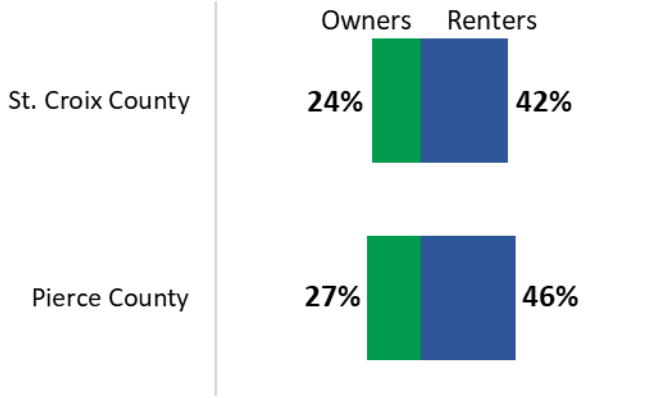
Source: Feeding America, 2016

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

Eight percent of St. Croix County residents and 10 percent of Pierce County residents said they are food insecure. Fifteen percent of community survey participants said the ability to get healthy food was one of the three most important health concerns in their counties.

Housing cost burden

Percentage of homeowners and renters who use **30% or more of their income on housing costs.**



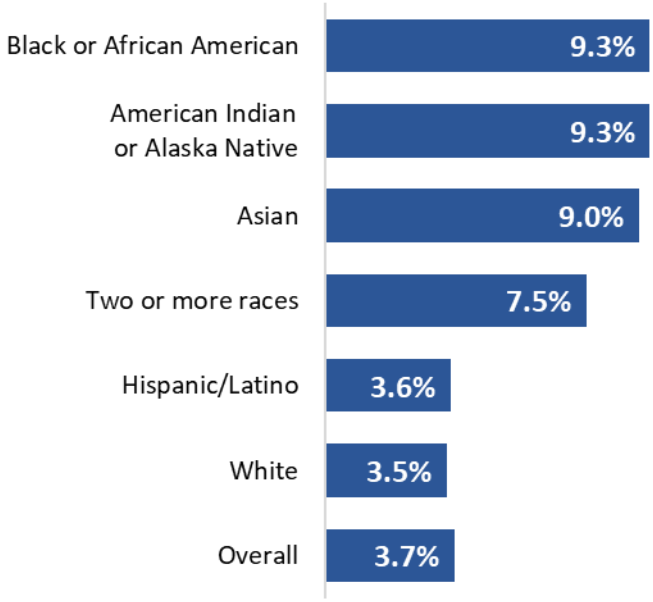
Source: US Census Bureau, American Community Survey, 2012-16

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

According to the American Community Survey, between 24 and 27 percent of homeowners in our community are housing burdened. These numbers are both similar to state averages.

Unemployment

Unemployment rates by race, St. Croix and Pierce Counties combined.



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

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

While current county-level unemployment rates by race are not available, data from the American Community Survey is useful for identifying employment disparities. According to this data, unemployment rates among people who identify as black or African American, American Indian or Asian are nearly than 3 times higher than for people who identify as white or Hispanic/Latino.

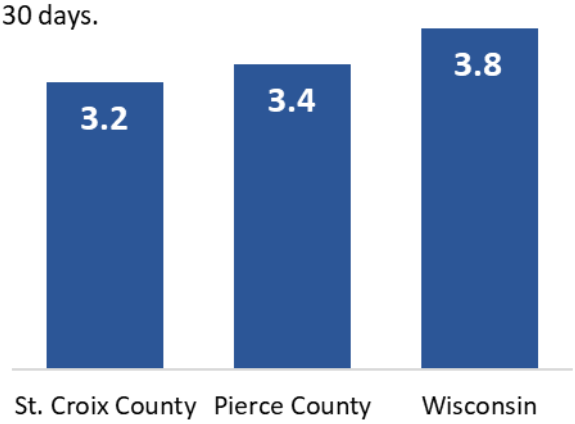
Priority: Mental health and well-being

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.

Adult mental health

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



Source: Behavior Risk Factor Surveillance System, 2016

"The mental health system is very broken. Long waits to even get in to see someone for 'emergency' situations adding additional stress to already stressed families."

- Community survey participant

Residents in St. Croix and Pierce Counties report feeling down, depressed or hopeless more than 3 days over the past 30 days, or more than 10 percent of the time.

HealthPartners health care providers routinely screen patients for depression. According to 2017 EHR data, 5 percent of patients from St. Croix County and 4 percent of patients from Pierce County were experiencing mental health symptoms consistent with depression.

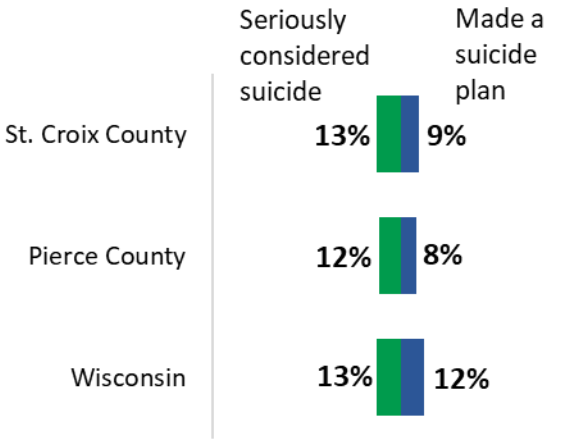
Death by suicide is a significant concern for our community. According to the Wisconsin Department of Health Services, 10 St. Croix County adults and 1 Pierce County adult died by suicide in 2015. According to the CDC, death by suicide has increased 25 percent in Wisconsin since 1999. Although suicide 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.

While many residents identified community strengths such as a resource guide and targeted programming, they also cited many needs related to mental health services. These include more mental health providers, more accessible locations and reduction of financial barriers.

Health care providers echoed the community, saying a better referral process is needed. Another common theme from the health care providers was the need for quicker and easier access to services.

Youth mental health

Percentage of youth who experienced **suicidal thoughts** in the past year.



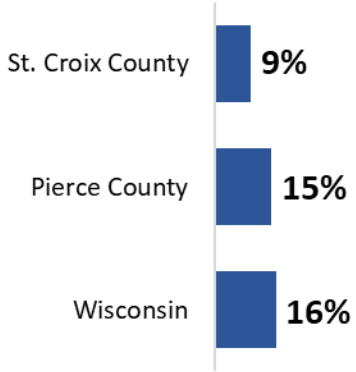
Source: Youth Risk Behavior Survey, 2013

Data indicates the percentage of youth experiencing suicidal thoughts in the past year was either similar to or slightly lower than the state average. Twelve to 13 percent of high school students said they had considered suicide, and 8 to 9 percent said they made a suicide plan.

Among those who were concerned about access to mental health services and providers in the county, several indicated an even greater need for youth services.

Contributors to poor mental health: social isolation

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



Source: Behavioral Risk Factor Surveillance System, 2006-12

Social and emotional support are important contributors to overall health and well-being. According to the HealthPartners IMPACT Survey, 86 percent of adults believe mental health has a large impact on a person's overall health and well-being.

Social and emotional support are also linked to educational achievement and economic stability. Nine percent of St. Croix County and 15 percent of Pierce County adults report they lack adequate social or emotional support.

Contributors to poor mental health: stigma

"Mental health stigma real or perceived it an issue that must be addressed."

- Community survey participant

The stigma associated with having a mental illness can also negatively affect mental health. Reducing stigma related to mental health was a leading theme that emerged from the community.

According to the IMPACT Survey, only 65 percent of adults in St. Croix County are comfortable talking with others about their mental illness.

In St. Croix County, 91 percent of adults believe reducing stigma is important to their community.

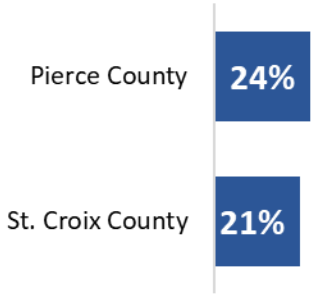
Priority: Nutrition and physical activity

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 and factors in our community.

Fruit and vegetable consumption

Percentage of adults who report eating **5+ servings of fruit and vegetables** each day.



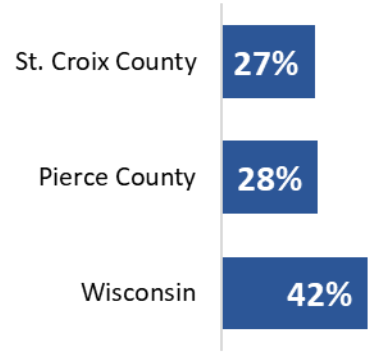
Source: Behavioral Risk Factor Surveillence System, 2005-2009

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

In St. Croix County, only 1 in 5 adults eats the recommended servings of fruits and vegetables. This number is slightly higher for Pierce County, at 1 in 4 adults. 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

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

"[They] cannot afford to feed their families fresh fruits and veggies because the food stamp money does not accommodate for purchasing local or fresh food shelf life."

– Community survey participant

Several community survey participants indicated accessing affordable, healthy food was an important issue in St. Croix and Pierce Counties.

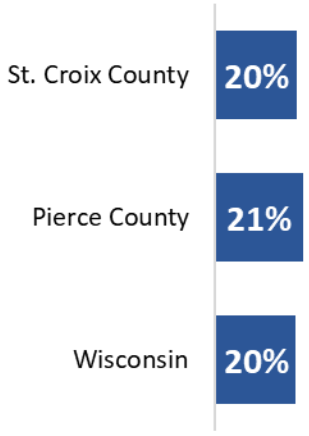
According to the U.S. Department of Agriculture (USDA), 27 percent of St. Croix County residents and 28 percent of Pierce County residents live in neighborhoods considered food deserts. A neighborhood is considered a food desert if 33 percent of the population lives more than one mile from a supermarket or large grocery store (10 miles for rural communities).

Even when healthy food is available locally, it may not be affordable. Six percent of residents in St. Croix County and 9 percent in Pierce receive Supplemental Nutrition Assistance Program (SNAP) benefits. Only 51 St. Croix County and 21 Pierce County retailers accept SNAP.

According to the HealthPartners Family Community Survey, parents in St. Croix County identified a lack of lower prices for healthy foods and a lack of options to buy farm-fresh foods as the most important barriers to address to help their families eat better.

Adult physical activity

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



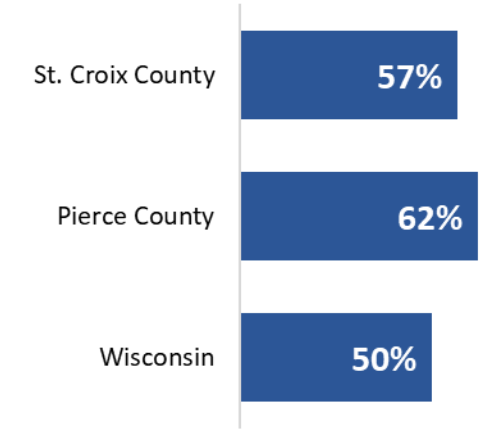
Source: Centers for Disease Control and Prevention, 2013

Physical activity is defined as exercise and other activities that involve bodily movement. Physical activity 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, almost 1 in 5 residents in St. Croix and Pierce Counties report getting no leisure time physical activity, which is consistent with the state average.

Youth physical activity

Percentage of youth who were **physically active** for 60 minutes or more on at least 5 or more days.



Source: Youth Risk Behavior Survey, 2013

Youth should be active 60 minutes or more at least 5 days a week. Compared to the state average of 50 percent, more young people in St. Croix and Pierce Counties meet this recommendation at 57 and 62 percent, respectively.

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

Access to activity opportunities

"[Our community needs] options for more low-cost opportunities to exercise. I see people use walking paths, biking paths, playgrounds, pools, etc. when they are affordable and easily accessible."

- Community survey participant

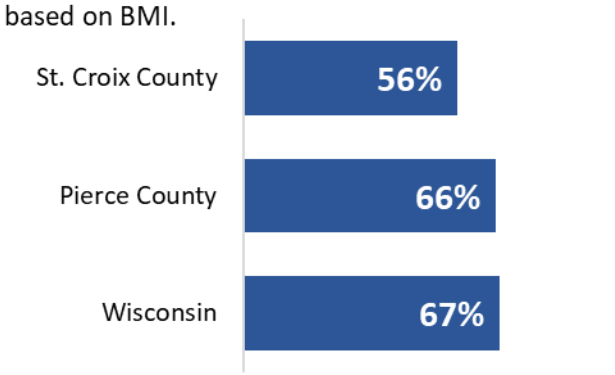
Both St. Croix and Pierce Counties have a higher number of recreation or fitness facilities per resident than the state average, with 16 recreation and fitness facilities in St. Croix County and 7 recreation and fitness facilities in Pierce County. However, factors such as transportation and cost can make accessing these facilities challenging. Community members still do not feel there are adequate opportunities to be physically active in the community.

Many community survey participants indicated a need for increased opportunities for physical activity including safer biking and walking paths.

According to the HealthPartners Family Community Survey, parents in St. Croix County 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.



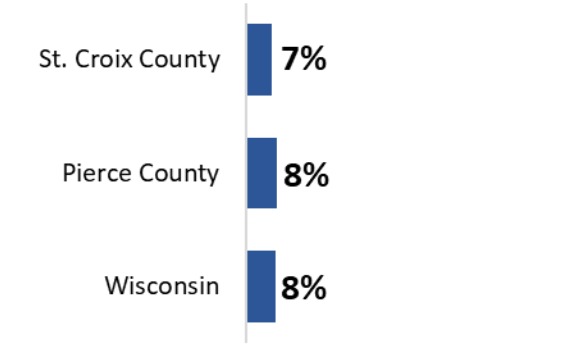
Source: Behavioral Risk Factor Surveillance System, 2011-12

Being overweight or obese puts people at higher risk for heart disease, diabetes and other chronic conditions. According to self-reported height and weight, between 56 and 66 percent of adults in our community are overweight or obese. In St. Croix County, however, HealthPartners clinic data indicate overweight and obesity rates are as high as 68 percent. Data collected by HealthPartners clinics in 2017 is similar to self-reported data from Pierce County residents.

While both counties have lower rates than the state average, both community survey participants and providers identified obesity as a top concern for the community.

Chronic disease

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



Source: Centers for Disease Control and Prevention, 2013

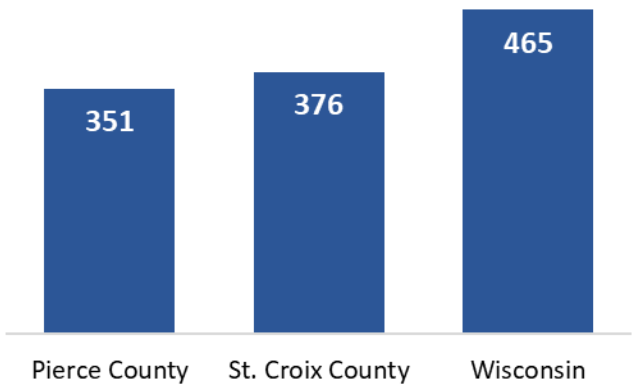
Several chronic diseases, including diabetes, are associated with poor nutrition and lack of physical activity.

Between 7 and 8 percent of adults over age 20 in our community have been told by a health professional that they have diabetes.

Uncontrolled high blood pressure and high cholesterol put people at higher risk for heart disease and stroke. In our community, 29 percent of St. Croix County adults and 25 percent in Pierce County have been told by a health care professional that they have high blood pressure, which is higher than the state average. Across our community, 33 percent of St. Croix County adults and 23 percent of Pierce County adults have high cholesterol. These rates are slightly lower than the Wisconsin rate of 36 percent.

Cancer rates

Cancer rates per 100,000 people, all cancer types.



Source: Wisconsin Department of Health Services, Division of Public Health, 2017

According to the Wisconsin Department of Health Services, from 2009 to 2013, more than 11,286 Wisconsin residents died of cancer. The incidence of all cancers in our community are lower than the Wisconsin rate overall, with St. Croix County experiencing a slightly higher incidence than the rest of our community.

Breast and prostate cancers have the highest incidence of any cancer type among women and men. Breast cancer rates range from 104 cases per 100,000 people in St. Croix County to 115 cases per 100,000 people in Pierce County. Prostate cancer rates are also lower than the state average with 84 cases per 100,000 people in St. Croix County and 32 cases per 100,000 people in Pierce County.

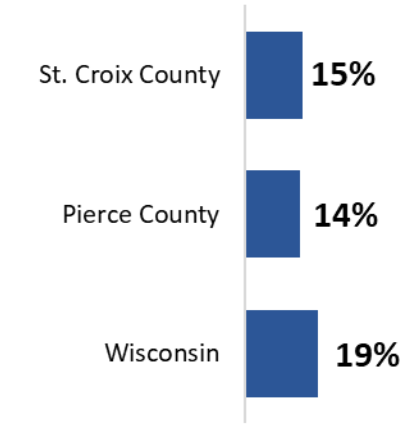
Priority: Substance abuse

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 cigarettes**.



Source: Behavioral Risk Factor Surveillance System, 2006-12

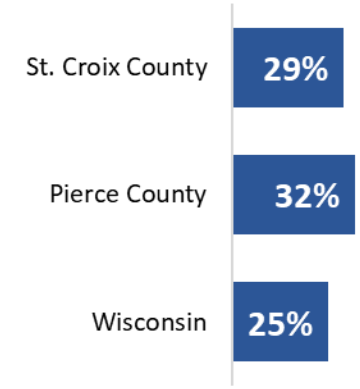
Tobacco use is associated with many chronic diseases and health conditions including respiratory disease, heart disease and cancer.

The adult smoking rates in our community are lower than Wisconsin overall: 14 to 15 percent compared to 19 percent.

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

Adult alcohol use

Percentage of adults who **report drinking excessively** in the past 30 days.



Source: Behavioral Risk Factor Surveillance System, 2006-12

Excessive drinking is defined as two or more drinks per day for men and one or more drinks per day for women. Adults in our community are more likely to drink excessively than in Wisconsin overall. 29 percent of St. Croix County adults and 32 percent of Pierce County adults report drinking excessively in the past month compared to 25 percent across Wisconsin.

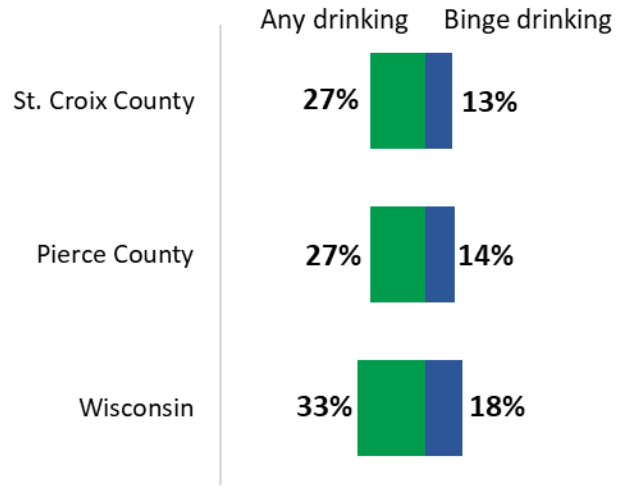
"Alcohol abuse is hands down the most significant issue both in our county and in our state. Because it is such a part of the way we live, we have become desensitized to the significance of the problem."

- Community survey participant

Community members identified alcohol abuse and excessive drinking as top health concerns during the Healthier Together community dialogues and on the Community Health Survey.

Youth alcohol use

Percentage of youth who report **using alcohol** in the past 30 days.



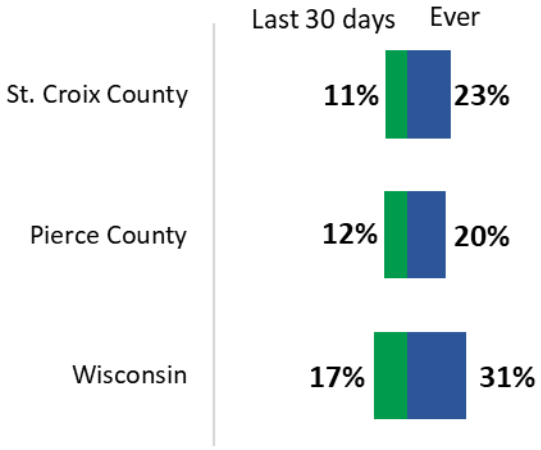
Source: Youth Risk Behavior Survey, 2013

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 St. Croix and Pierce Counties, 27 percent of youth report any alcohol use in the past month and 13 to 14 percent report binge drinking. These rates are lower than the state average.

Illicit drug use including prescription drug use

Percentage of high school students who report **using marijuana**.



Source: Youth Risk Behavior Survey, 2013

According to the Youth Risk Behavior Survey, the percent of high school students reporting marijuana use is lower than the state average. However, 23 percent of high school students in St. Croix County and 20 percent in Pierce County said they have used marijuana at least once.

While little data is available on illicit drug use in St. Croix and Pierce Counties, numerous community survey participants identified drug use and limited treatment options as key concerns. Drug abuse was tied for the number one health concern on the Community Health Survey.

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 December 17, 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

Hudson Hospital & Clinic 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 and 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 and clinic	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	Participation in the annual NAMI walk continues, with approximately 300 HealthPartners employees participating in 2018.
Improve access to mental health services	Update and distribute the Mental Health Guide Pierce & St. Croix Counties	The mental health guide continues to be updated for Pierce and St. Croix Counties. The guide was last updated in June of 2019, and includes over 30 resources for mental health services.
	Develop partnerships and models to embed behavioral health in primary care	Evaluation continues in partnership with Amery Regional Medical Center and Regions.
	Evaluate and develop inpatient treatment capacity for behavioral health care in the St. Croix Valley area	The evaluation and discussion on inpatient treatment capacity is ongoing throughout the St. Croix Valley Area.
	Improve processes for behavioral health patients in emergency department and outpatient clinics.	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.
	Represents one of six hospitals that comprise the Valley Co-op Behavioral Health Team	Hudson Hospital continues to have representation on the Valley Co-op Behavioral Health Team.
Increase education around mental and behavioral health	Offer and promote ongoing community education classes including classes on stigma, depression and various other mental health issues	Make It OK ambassador trainings continue to be offered. Mental Health First Aid is also being offered at various locations throughout western Wisconsin. About 261 adults have been trained in Mental Health First Aid, along with over 500 Make It OK Ambassadors trained in the St. Croix Valley. Through the Make It Ok campaign, thousands have been reached via the ambassador team, community outreach and events.
	Support and offer staff education on mental and behavioral health issues including mental health crisis training for Hospital and Emergency Department staff	Staff education includes, but is not limited to, restraint and de-escalation training (Work Place Violence). Trainings for mental health crises occur when a need arises.
	Offer "Beating the Blues" online program for both patients and employees to learn ways to better manage mood, stress and anxiety	Hudson Hospital continues to promote and offer the free "Beating the Blues" online program for members, patients and employees.

	Participate in Pierce - St. Croix CARES Coalition to create a responsive and effective system for promoting and protecting our children's wellbeing	CARES continues to provide resources for the Healthier Together Mental Health task force as needed. CARES continues to work with the Healthier Together mental health task force in schools.
	Offer Substance Abuse, Withdrawal and Detox Training to employees	Changes in prescribing practices reduce the number of opioid pills with reductions being achieved over time. All Valley hospital sites now have prescription medication collection stations.
Reduce risky and unhealthy alcohol and drug use	Actively participate in ongoing discussions and exploration of changing alcohol abuse through public policy	The Alcohol Abuse action team through Healthier Together continues exploring policy and ordinances in the community, and recently assessed Hudson's readiness for change. 12 key community stakeholders interviewed by Healthier Together's alcohol action team, to determine the Hudson Community's readiness for change regarding youth alcohol consumption. Next steps will involve implementation planning.
	Support Hudson community's Mock Crash Event, organized for high school students, which demonstrates the cause and effects of drunk driving	The emergency department helped set up the education ER scene in 2015. This event is done every 3 years, but will happen in again in 2019 due to the construction of the new Hudson High School.
	Support and partner with community efforts to educate the public with awareness programs, such as the Parents Who Host Lose the Most Campaign	*Parents Who Host Lose the Most* campaign has been supported by St. Croix County Health and Human Services between April and June from 2015-2018. 2018 is the last year that the Wisconsin Department of Health Services will sponsor the campaign.
Reduce risky and unhealthy alcohol and drug use	Serve as a SHARPS Disposal Drop Site for the community. Residents are able to safely dispose of hypodermic needles and lancets.	SHARPS disposal drop services continue to be offered at the hospital.
	Operate Programs for Change, an outpatient chemical addiction treatment and recovery care program, which offers parents and family members the opportunity to participate in educational lectures, group discussion, and family treatment groups free of charge in support of their loved one	Programs for Change continues to operate in western Wisconsin. Programs for Change expanded to Westfields Hospital & Clinic, offering participants access to primary and specialty care, a psychiatric nurse practitioner and internal health therapist in 2016.

	Train staff on prescription drug abuse, diversion and chemical health.	Changes in prescribing practices reduce the number of opioid pills with reductions being achieved over time. All Valley hospital sites now have prescription medication collection stations.
Reduce the use and exposure of tobacco among youth and adults	Employ a certified tobacco cessation therapist	Tobacco cessation therapy is offered through registered respiratory therapists and a certified respiratory therapist.
	Offer tobacco cessation education to patients and the community	Tobacco cessation classes are promoted across the Valley for patients and the community. Tobacco cessation resources are offered at all Valley hospitals
	Participate in the Tobacco Free Living Coalition	The Tobacco Free Living Coalition continues working on tobacco free activities for the western region and 6 counties. They conduct compliance checks (WINS) in the region along with leading quarterly coalition meetings
Enhance suicide prevention efforts	Participate in Suicide Prevention Coalition	St. Croix County Public Health continues to operate. Many of its initial goals have been met.

Priority #2: Access and Affordability

Goal	Strategies/Activities	Progress and Key Results		
		2016	2017	2018
Improve connection 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.		

	Provide a Health Resource Center (HRC) promoting health knowledge and inspires continuous personal wellness. The HRC can assist callers/visitors with their health concerns and provide direct links to health care resources	The health resource center program no longer operates.
Increase access and affordability of primary and preventative healthcare	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
	Hospital van transport services to the health campus are available to community residents within a 15-mile radius	Hospital van transport services continue to operate, but does so under a new route system with an 8 mile radius.
Increase access and affordability of primary and preventative healthcare	Enrollment Assistance, Information and Referral Services are available to help secure a payment source for un-insured and under-insured patients. Provide Patient Account Representatives to helps patients enroll in government programs, find other sources of payment, or access services beyond medical care	Hudson Hospital continues to refer patients to other enrollment assistance resources, primarily through the county.
	Continue Scholarship Program to help increase the number of qualified providers in the community. Two scholarship awards are offered to graduating high school seniors	The scholarship program continues to be implemented and now offers 5 scholarship awards to Hudson and surrounding area high school seniors
	Plan and implement the Methodist Hospital Family Medicine Residency Program Rural Training Track that is expected to add an additional physician to a northwestern Wisconsin region every year	HealthPartners continues to offer the Methodist Hospital Family Medicine Residency Program Rural Training at Westfields, Amery, and Methodist Hospitals.
Increase access and affordability of primary and preventative healthcare	Utilize the electronic medical record system, which reduces the opportunity for error, expedites the patient transfer process, and allows for easier scheduling of appointments	The hospital continues to utilize electronic medical records (EMR)

	Support access to diabetes care and education taking into consideration income and high deductible insurance plans	The hospital supported diabetes education through price reductions and scholarships for patients who could not afford education programs due to income and/or high deductible insurance plans. The program provides individual and group sessions with certified diabetes educators, registered nurses, and registered dieticians, people with diabetes come to a greater understanding of the toll that uncontrolled diabetes can take on the body.
Improve quality of care	Collaborate around quality improvement to identify and improve quality gaps including training in quality improvement for leaders	Hudson Hospital engages in ongoing performance and quality improvement projects focused on improving the patient experience. All leaders are trained in key 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 PowerUp Initiative	Deliver PowerUp School Challenge and School Change Toolkit in all interested schools in the Hudson School District	The PowerUp School Challenge program continues being delivered each spring in all Hudson schools, both public and private. School Challenge has been delivered to over 25,000 children to date throughout the St. Croix Valley.		
	Engage the community and develop PowerUp partnership through website resources, social media, ongoing newsletters and communications, community outreach and opportunities to advise and participate in priority program development	PowerUp continues to partner through social media, web resources, and other ongoing communications. PowerUp also has a steering committee, which provides opportunities to advise and participate in program development.		

	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	Hudson Hospital continues to support open gym sponsorships in Hudson and Houlton. 150 Open Gyms were held in partnership with school districts in 2016. 143 Open Gyms or Open Skates were held in partnership with school districts and other community organizations 2017.
	Focus community attention on healthier communities for children through PowerUp for Kids Week and ongoing community outreach	Hudson Hospital continues to partner with local organizations each May to celebrate PowerUp week, through offering opportunities to eat better and move more. These organizations have included the YMCA, WESTconsin Credit Union, Art Doyle's Spokes and Pedals, Willow River State Park and the Hudson Library.
	Provide ongoing educational opportunities for kids and families including cooking classes and educational resources	DIRO Outdoors partnered with the community health team to provide educational classes for families to be active outside in all months of the year, including winter.
Improve the health of children in early childhood through 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	Hudson Hospital implements the Reach Out and Read program during child-checkups at Hudson Physicians patients, infancy through age 5. Over 900 children's books were bought for the Reach Out and Read program in 2018. Books are also provided to expecting mothers at OB visits. All children from 2 months to 5 years are screened at regular intervals during well-child visits for social and emotional developmental delays. Hudson continues to support 'Healthy Beginnings', which promotes drug, alcohol and tobacco free pregnancies by universally screening all pregnant women and offering support. Family centered care continues to screen for postpartum depression, as well as encouraging using only human milk for feedings during the first 6 months by offering resources and support services.
Improve oral health	Participate in Healthier Together Oral Health Task Force	Community health assisted in the beginning stages of this task force, but dental health did not remain a top health priority for the Healthier Together coalition beyond 2015.

	Contribute and participate in the creation of the oral health backpack program. Students from each school district across the county receive a backpack with food supplies as well as a toothbrush, fluoride toothpaste, floss, a timer and oral health education/resources.	Supplies were provided by monetary donations from each local hospital to cover the school districts in the hospital's area. Candy Trade in collections were done every year at valley hospitals and dental clinics. The program reached 350 – 400 students in St Croix County each year. In 2018, over 300 pounds of candy were collected and sent overseas.
	Contribute in local community meetings to promote the safety and health benefits of community water fluoridation	Initially, Hudson Hospital had representation at the community meetings for water fluoridation. The meetings consisted of people from the state of Wisconsin and the DNR. A state and regional fluoridation educator spoke at a recent Oral Health Care meeting and spoke on behalf of community water fluoridation.
Increase access to physical activity	Participate in Healthier Together Physical Activity Task Force	Obesity and physical activity are prioritized, and Hudson Hospital's community health representative actively participates in this task force. Hudson Hospital will continue to have active involvement in this task force. Over 1700 students across St. Croix and Pierce County participated in the National Walk to School Day in the fall of 2018.
	Obtain and assist in the implementation of the Community Opportunity Grant and Active Schools Core 4+	Pedometer data was obtained, and determined that most students don't get enough steps. A Core 4+ presentation was developed and attempts are being made to implement in school activities and wellness policy improvements.
	Support and promote community efforts to encourage physical activity including providing materials for National Walk to School Day for all school districts in St. Croix County	The hospital continues to support schools in the National Walk to School Day efforts in partnership with Healthier Together, through providing assistance, resources and materials. Over 1700 students across St. Croix and Pierce County participated in the National Walk to School Day in the fall of 2018.
	Partner with local, state and national park, recreation clubs, YMCA, youth sports, schools and others to increase opportunities for youth, families and general community to be physically activity	PowerUp in the Parks Passport was created in partnership with the 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. A total of 165 people attended a special program at Willow River State Park in Hudson in 2017.
	Participate on Bike and Pedestrian Advisory Committee and support complete streets, increased pathways and safe routes to school	Participation on this committee resulted in the creation of a new St. Croix County Bicycle and Pedestrian plan, which was approved in May 2018.

	Participate in the Hudson School District Wellness Committee	Hudson Hospital continues its participation on the Hudson School District's Wellness Committee.
Increase access to fruits, vegetables and health food and decrease access to high calories, highly processed, low nutrient beverages and foods	Offer Community Supported Agriculture (CSA) and other sources of local produce at the hospital	Salad greens are provided by Urban Organics, which has converted from an old brewery in St. Paul into one of the first USDA-certified organic aquaponics farms in the country. Urban Organics delivers organic salad greens to each of the four participating HealthPartners hospitals or clinics.
	Continue to increase healthier, less processed food options in hospital café and meetings	Hudson continues offering healthier options in the cafeteria and for its meetings.
	Sustain the Healthier Together community garden on campus	The community garden continues to operate on Hudson Hospital's campus.
	Lead and participate in Healthier Together Healthy Foods Task Force	Healthier Together is addressing food insecurity through food pantry initiatives and education for volunteers.
	Participate in the Hudson School District Wellness Committee	Hudson Hospital continues its participation on the Hudson School District's Wellness Committee
	Continue serving zero sugar sweetened beverages in the hospital	Hudson Hospital offers both sugar-sweetened beverages and healthier alternative beverages without sugar.
	Provide fruit and veggie community giveaway	Hudson Hospital continues to support fruit and veggie community giveaways.
	Consult with and support partners to reduce high sugar/low nutrient food and sugar sweetened beverage offerings at community events	PowerUp continues to partner with the community through events and education, including consulting on healthier food and beverage offerings.
Reduce chronic disease and prevent illnesses	Support Public Health in communicable disease prevention efforts as circumstances warrant (i.e. immunizations for Whooping Cough, H1N1, etc.)	Support includes disease surveillance, childhood immunizations, mass immunization clinic for flu in schools, immunizations given for uninsured adults, community education and social media posts, vector control, and providing up to date information on communicable diseases.
	Collaborate to provide high quality Diabetes education to patients and families include standardized processes and educational materials	Hudson Hospital continues to offer Diabetes education and services, including a support group. Lakeview Hospital also held the Diabetes Expo in 2017.

Provide health education and support to patients and community members	Provide a variety of childbirth education and family classes	In the Birth Center, education for feeding from birth to one year and toddlers to age 5 is provided, along with education for breast feeding.
	Provide a wide variety of community education classes including cardiac rehab, tai chi for arthritis, advance planning, cancer prevention, etc. Continue to review opportunities in relation to programming and service line development	Classes are offered quarterly to patients and the community. Topics include cardiac rehab, tai chi for arthritis, among others.
	Provide a cardiovascular disease, diabetes, new parent, Parkinson's disease, and grief/loss education and support groups. Continue to review opportunities in relation to programming and service line development	Support groups are offered to patients and the community, and promoted across the Valley.
Provide health education and support to patients and community members	Provide Lactation Support; encouraging breastfeeding and providing access to certified lactation consultants and breastfeeding education	Lactation outpatient clinic is Mon-Fri, and has 3 International Board Certified Lactation Consultants on staff, and 4 Certified Lactation Counselors on staff. The hospital holds monthly breastfeeding class for patients, and each patient receives a complimentary visit from an IBCLC, as well as a follow-up call.
	Employ hospital dietitians to promote nutrition awareness and education to patients, their families, and the community. In addition, dietitians see all chemotherapy patients to ensure adequate and appropriate nutrition at no charge	Dietician consults can be ordered by physicians at any time. Screens are conducted to determine those who are at nutrition risk or food insecure patients/families. These patients are prioritized, along with providing assessment and education.
Improve health awareness, knowledge and literacy in the community	Healthier Together: Engage the community and develop partnership through website resources, social media and communications, community outreach and opportunities to advise and participate in priority and program development	Healthier Together continues to engage the community through an online and social media presence, with periodic updates of its community resource guides.
	Participate in and support community health fairs and events to share health information and resources with the community	Healthier Together continues to participate in community events and fairs to share health and wellness information with the community

	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.)	Ladies Night Out, Diabetes Expo, and Hope for Health were held at all Valley hospitals in 2016. The Diabetes Expo was held at Hudson Hospital in 2017.

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.		
	Explore, develop and promote policies to address health equity	The hospital continues to address health equity. Health equity work to date includes, but isn't limited to, transportation services to and from the hospital, documents offered in Spanish, Hmong and Somali, along with working with individuals to develop payment plans based on ability to pay.		
	Explore issue of equitable care and adept changes and measures	Leadership continues to address and provide online resources pertaining to equitable care.		
	Provide financial counseling to help secure a payment source for un-insured and under-insured patients (see also Access and Affordability)	Hudson continues to refer patients to other enrollment assistance resources, primarily through the county.		
Facilitate improved access to services and resources for low income and diverse populations	Participate in Healthy Wisconsin Leadership Institute's Community Teams Program to improve health food access and health equity.	Healthier Together is currently working on two objectives related to food shelves: 1. By December 2016, two food pantries in each county will undergo improvements to increase fruit and vegetable access among clients by 25%. 2. By December 2016, one food pantry in each county will establish a nutrition policy		

Facilitate improved access to services and resources for low income and diverse populations	Increase number of hospital materials available in other languages (Spanish)	Hudson Hospital continues to provide offerings of materials in other languages, such as financial assistance, plain language, financial assistance applications, and provider and payment information. These are offered in Spanish, Hmong and Somali.		
	Financially support the Hudson School District backpack program for low income students	The Hudson School District's backpack program continues to be supported. A grant was given to the program in 2016.		
	Improve and connect health service systems to community member (see also Access and Affordability)	Financial assistance policies have improved access to the health services system through working with individuals seeking care based on ability to pay. Financial assistance documents are also offered in Spanish, Hmong and Somali. Transportation barriers have been improved through the hospital van transportation service to and from the hospital, which operates within an 8 mile radius.		
	Increase availability of free and low cost physical activity options for children and families	150 open gyms	143 open gyms or skates	135 open gyms

Next steps

Hudson 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 Hudson 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

For more information or questions about this report, please contact Hudson Hospital & Clinic via email at info@hudsonhospital.org.

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 to develop and implement 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, tasked to carry 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 seven-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	The mission of the DCHCC is to bring together healthcare 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 as an awareness of high rates of Stroke in Hmong Community, through St. Paul School partnerships, 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 it 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 that informs the work of our department in responding to the integrated health care needs of Saint Paul - Ramsey County residents and greater communities. Ramsey County Mental Health and Wellness Action Team (MHWAT) is one of 5 SPRCPH Community Health Improvement Goals.	Monthly	Pakou Xiong
MHWAT Wellness Group	This is 1 or 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 ensure 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	The 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	The 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. Three goals: Increasing physical activity; improving access to healthy foods; reducing the use of and exposure to tobacco.	4x/year	DeDee Varner
Forces of Change Affecting Community Health	The Center for Community Health hosted a dialogue for community leaders. This event aimed to increase collaboration and richness of conversation about health, broadly defined, across the Minneapolis Saint Paul Metro Region. Sixty participants contributed to 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, St. Paul Ramsey County Public Health along with HealthEast, Regions Hospital, 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 – 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 that 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, 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 readmissions.	Monthly	Rachelle Brombach Mona Olson
West Metro CHNA Collaborative	North Memorial & Maple Grove Hospital, Allina, Park Nicollet Health Services, 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	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	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 healthcare, 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 - 4 times/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 wellbeing 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 & 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.	Tri-annually	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 healthcare partners that work 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 work together to evaluate community health needs, 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 Taskforce 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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