2016 COMMUNITY HEALTH NEEDS ASSESSMENT

Essentia Health-Virginia
Overview

Essentia Health-Virginia
901 Ninth Street North
Virginia, MN 55792

Essentia Health-Virginia is part of Essentia Health, a nonprofit, integrated health system caring for patients in Minnesota, Wisconsin, North Dakota and Idaho. Headquartered in Duluth, Minn., Essentia Health combines the strengths and talents of 14,000 employees, who serve our patients and communities through the mission of being called to make a healthy difference in people’s lives.

Essentia Health-Virginia is an 83-bed hospital serving Northeastern Minnesota, from International Falls to Cotton and from Ely to Hibbing. Established in 1936, the hospital’s medical campus includes two clinics, Essentia Health-Virginia Clinic and the Essentia Health-Virginia Medical Arts Clinic as well as a long-term care facility, the Virginia Care Center. The Iron Range Rehabilitation Center is also found on campus.

Essentia Health-Virginia offers emergency care 24 hours a day, seven days a week. It is a Level IV Trauma Center and a Stroke Ready Hospital. The hospital offers 24/7 surgical services, obstetrics and birthing services, intensive care and Urgent Care.

LEAD PARTIES ON THE ASSESSMENT

Heather Parenteau, Program Manager Chronic Disease Services: The Diabetes Center, Cardiac and Pulmonary Rehabilitation

Jean Rodvold, Community Health Intervention Specialist, East Region

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Essentia Health: Here With You
At Essentia, our mission and values guide us every day. Together, we deliver on our promise to be here with our patients and members of our communities from the beginning to the end of life, both in our facilities and where they live, work and play.

Mission
We are called to make a healthy difference in people's lives.

Vision
Essentia Health will be a national leader in providing high quality, cost effective, integrated health care services.

Values
- Quality
- Hospitality
- Respect
- Justice
- Stewardship
- Teamwork

Belief Statements
- Our highest priority is the people we serve.
- We believe that the highest quality health care requires a regard for both the soul and science of healing and a focus on continuous improvement.
- We believe in the synergy of sponsorship among faith-based and secular organizations.
- We believe in the value of integrated health care services.
- We believe in having a meaningful presence in the communities we serve.
Caring for our Community

Our commitment to community health and wellness goes well beyond the work of the Community Health Needs Assessment. Through donations of funds, along with employees’ time and talents, Essentia Health invests in a variety of programs and outreach efforts. Across the organization, we support community coalitions, housing, food shelves, mental health, congregational outreach, community infrastructure, public health, education, safety and other nonprofit organizations. These investments are designed to promote better health, help lessen inequities in our communities, improve access to health care and strengthen relationships with those we serve.

Progress to Date on 2013 Community Health Needs Assessment

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Obesity, physical inactivity and poor nutrition as risk factors for chronic diseases such as Type 2 diabetes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Population</td>
<td>Adults, ages 18 and over, who are currently prediabetic or possess risk factors for developing Type 2 diabetes</td>
</tr>
<tr>
<td>Goal</td>
<td>Reduce body weight and increase physical activity in program participants, thereby reducing their risk for Type 2 diabetes.</td>
</tr>
</tbody>
</table>

Performance Measures

- Participants will lose weight; program goal is 5-7% of body weight.
  - Baseline and post-course (1 year) weight will be tracked
- Participants will increase physical activity; program goal is 150 minutes/week.
  - Baseline* and post-course (1 year) progress for physical activity minutes will be tracked.

Objective 1: Implementation of a community-wide intervention, the National Diabetes Prevention Program, to address the hospital’s highest priority health need as identified by the 2013 Community Health Needs Assessment.

Evaluation of Impact:

- 48 participants, representing five (5) groups, have started the National Diabetes Prevention Program (NDPP) with four (4) groups completing the entire one-year program.
- Percentage of participants meeting the 7% weight goal at the end of the core sessions were Group 1, 20%; Group 2, 56%; Group 3, 38%; Group 4, 50%; and Group 5, 33%
- Participants meeting the 150 minutes physical activity goal at the end of the core sessions were Group 1, 100%; Group 2, 56%; Group 3, 75%; Group 4, 75%; and Group 5, 67%.
- Program participants’ total weight-loss was 418 pounds at the end of the core sessions.
  - Of note, physical activity is self-reported data compared to weight, which is measured onsite by the lifestyle coach at each session.

*Physical activity minutes are tracked beginning at week 7 of the NDPP.

Essentia Health-Virginia started five (5) NDPP groups and 78% of participants completed the core 16 sessions. Four (4) of the five groups have completed the year-long program with 37% of the original participants. Forty-two (42) women and four men have attended. Four women with a history of
gestational diabetes completed the program. Progress was made in 2015 with primary care physician referrals to the program.

The hospital has established a partnership with local public health in growing a diabetes prevention network throughout Northeastern Minnesota, and partnered in the training of seven lifestyle coaches for the northern half of St. Louis County. Opportunities to increase participation are being explored, including developing a partnership with the Mesabi YMCA to support the startup of NDPP groups at the YMCA.

The hospital/clinic continues to offer exercise programs geared towards diabetes prevention, reducing obesity and improving heart health, as well as weight management support groups.

Additional Achievements

Tobacco Use

Essentia Health-Virginia has a tobacco-cessation specialist available on weekdays and has a referral system to Minnesota’s Quit Plan Program. The tobacco-cessation specialist provides coaching, prescribes medication, and works with patients to assist with tobacco-cessation.

Immunizations

Essentia Health-Virginia offered flu vaccine clinics in fall 2015 and has utilized the Minnesota Immunization Information Connection (MIIC) to keep all patients up-to-date on vaccines. When a patient is overdue for a vaccine, Essentia Health-Virginia calls to schedule an appointment. There is also a focus at ancillary appointments for missed vaccinations and keeping all patients current on vaccines. The Virginia Clinic has two immunization champions that call parents of children under the age of 2 who are missing vaccinations.

Access to Health Care

Essentia Health-Virginia has expanded telehealth services to include Behavioral Health and Nephrology. The hospital has a care coordinator who works directly with patients with complex health conditions in order to provide them access to the correct and necessary healthcare options.

Essentia Health-Virginia continues to work with the Range Mental Health Task Force, a multi-disciplinary team that focuses on behavioral health issues. This task force is looking at available behavioral health services and transportation options to and from these services within the hospital’s service area.

Reduction of Excessive/Binge Drinking

The hospital continues to work with the Range Mental Health Task Force to look at issues related to chemical dependency in the hospital’s service area.

Preventative Care
Essentia Health-Virginia has begun a Baby Friendly initiative, which promotes skin-to-skin time, “the golden hour” of bonding and the importance of breastfeeding. A certified lactation consultant has been added in the clinic.

The hospital launched the STRIDE Study in June 2015. This three-year study focuses on reducing falls through fall assessments, protocols and follows-up with a registered nurse.

A staff physician from the hospital provides education to youth in schools around the service area on a variety of health topics, including sexual education.

The hospital offers support groups for individuals with chronic pain and weight management issues.
2016 Community Health Needs Assessment

Objectives

Essentia Health is called to make a healthy difference in people’s lives. To fulfill that mission, we seek opportunities to both enhance the care we provide and improve the health of our communities. In conducting the Community Health Needs Assessment, Essentia Health has collaborated with community partners to embrace these guiding principles:

• Seek to create and sustain a united approach to improving health and wellness in our community and surrounding area;
• Seek collaboration towards solutions with multiple stakeholders (e.g. schools, work sites, medical centers, public health) to improve engagement and commitment focused on improving community health; and
• Seek to prioritize evidence-based efforts around the greatest community good that can be achieved through our available resources.

The goals of the 2016 Community Health Needs Assessment were to:

1. Assess the health needs, disparities, assets and forces of change in Essentia Health-Virginia’s service area.
2. Prioritize health needs based on community input and feedback.
3. Design an implementation strategy to reflect the optimal usage of resources in our community.
4. Engage our community partners and stakeholders in all aspects of the Community Health Needs Assessment process.
**Description of Community Served by Essentia Health-Virginia**

Essentia Health-Virginia serves residents of northern St. Louis County, acting as a regional hub for those living on the Iron Range. For the purposes of this assessment, community is defined as the Essentia Health-Virginia Planning Area combined with the ZIP codes where 80% of inpatients resided in fiscal year 2015. This includes the ZIP codes of Angora (55703), Aurora (55705), Biwabik (55708), Britt (55710), Embarrass (55732), Eveleth (55734), Forbes (55738), Gilbert (55741), Hibbing (55746), Hoyt Lakes (55750), Iron (55751), McKinney (55761), Makinen (55763), Mountain Iron (55768), Parkville (55773), Virginia (55792 and 55777), Soudan (55782), Tower (55790), and Zim (55799).

The community was defined based on the hospital’s ability to have the greatest impact with the available resources. The hospital is committed to building and sustaining partnerships with area organizations in order to extend its reach to areas outside this region.

A number of other healthcare facilities are found within or near this region, including hospitals and associated clinics in Aurora, Hibbing, Cook and Ely. Project Care Free Clinic provides outpatient healthcare access to people who are uninsured and underinsured and has locations in Virginia, Hibbing and Grand Rapids. Pertinent to this needs assessment there are two behavioral health providers in the area, the Arrowhead Center and Range Mental Health Center.

Due to the region’s rural nature, data for populations smaller than county level is frequently unavailable or of limited value. Therefore, the following assessment data are presented at the county and state level to ensure stability of the estimates. When available, ZIP code or U.S. Census tract level data will supplement the county-level information to provide a deeper understanding of the health needs of the community.

**Table A: Overall demographics description**

<table>
<thead>
<tr>
<th></th>
<th>St. Louis County</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population¹</td>
<td>200,431</td>
<td>5,489,594</td>
</tr>
<tr>
<td>Population age 65 or over¹</td>
<td>17.2%</td>
<td>14.3%</td>
</tr>
<tr>
<td>White alone¹</td>
<td>92.6%</td>
<td>85.7%</td>
</tr>
<tr>
<td>American Indian or Alaska Native¹</td>
<td>2.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Black or African American¹</td>
<td>1.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Hispanic or Latino¹</td>
<td>1.5%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Median household income¹</td>
<td>$47,138</td>
<td>$60,828</td>
</tr>
<tr>
<td>People of all ages living in poverty¹</td>
<td>17.0%</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

When looking at the demographics of St. Louis County, it is necessary to look at the stark disparities that exist between ZIP codes. It has been said, as based on the social determinants of health, that one’s ZIP code is more important than one’s genetic code as a predictor of health and life expectancy and that rings true in St. Louis County.

This is clearly illustrated in findings from the 2015 St. Louis County Health Status Report. In northern St. Louis County, the cities of Virginia (55792) and Hibbing (55746) have the lowest life expectancies (see map below) in northern St. Louis County, and have the highest concentration of disparities. 4

- Projected life expectancy varies between the Virginia and Hibbing ZIP codes in St. Louis County by 8.65 and 7.5 years respectively; varying in northern St. Louis County by 5.76 and 4.63 years.
- ZIP codes with the lowest median household income ($30,782 in ZIP Code 55792) have the lowest projected life expectancy at 77.41 as compared to those with the highest median household income (over $50,000 in Zip Code 55803) who have the highest projected life expectancy at 81.43.
- The chronic stress experienced by people of color in St. Louis County has negatively impacted their projected life expectancy, lowering it by 2.31 years compared to the white population.
- Mining is one of the major industries in this area which has a number of well-known associated health risks, including shift work and lung disease that may negatively impact life expectancy.

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4 St. Louis County Health Status Report, January 2016
Poverty, education, age and race are all factors contributing to the inequitable health outcomes in St. Louis County. According to the Minnesota Department of Health’s White Paper on Income and Health, “Poverty in Minnesota is not evenly distributed across racial/ethnic groups, ages or educational levels. Poverty is concentrated among populations of color, children, people with less education, female-headed households and rural Minnesotans.”

People in Minnesota with lower incomes are more likely to:

- Have an infant die in the first year of life
- Report that their health is fair or poor
- Report having diabetes
- Report having seriously considered attempting suicide

St. Louis County also has a higher percentage of American Indian or Alaskan Native population. The Bois Forte Reservation is located within the community served. The reservation consists of three parts, with the Vermilion Reservation closest in proximity, located near the city of Tower on Lake Vermilion just 30 miles from Virginia. The Vermilion Reservation is home to the Vermilion Family Wellness Center and the Vermilion Community Center and Health/Dental Clinics. The health needs of the American Indian population are an important aspect of this assessment due to the existing inequities. As reported by the Indian Health Service, “The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

- Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian and Alaska Native deaths (2007-2009).
- American Indians and Alaska Natives born today have a life expectancy that is 4.4 years less than the all-races population (73.7 years to 78.1 years, respectively).
- American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.”

Older adults are among the fastest growing age groups in the nation. According to the 2010 U.S. Census, the number of Minnesotans age 65 and older increased 15% while the number of those over age 85

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7 U.S. Department of Health and Human Services, Indian Health Service, Indian Health Disparities
increased almost 25% since the 2000 Census. Older adults are at high risk for developing chronic illnesses and related disabilities, about 60% of those over age 65 will manage more than one chronic condition by 2030. These chronic conditions include diabetes mellitus, arthritis, congestive heart failure, and dementia. Chronic conditions impact older adults in a multitude of ways and are the leading cause of death. In addition, caregivers for older adults living at home are typically unpaid family members so caregiver stress can become an issue in the community.

Thanks to our mission and our Benedictine roots, Essentia addresses the health needs of the area’s most underserved populations; this dedication will be echoed in the implementation strategy for the Community Health Needs Assessment to ensure a special emphasis is placed on populations facing the highest disparities in health outcomes as described above.

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Process Overview
Essentia’s Community Health Committee developed a shared plan for the 15 hospitals within the system to conduct their 2016 Community Health Needs Assessments (CHNA). This plan was based on best practices from the Catholic Health Association and lessons learned from the completion of Essentia’s first CHNAs in 2013. This process was designed to:

- Incorporate community surveys and existing public data.
- Directly engage community stakeholders.
- Collaborate with local public health and other healthcare providers.

From there, each of Essentia’s three regions was responsible for adapting and carrying out the plan within their communities and hospital service areas. The Bridge to Health Survey, along with gathered secondary data from local, state and national sources, was paired with community conversations to paint a picture of the community’s health and help identify priority health needs. Focus groups were conducted in conjunction with a local social services agency and public health department to gather more information about the health needs of low-income, minority and underserved populations. The information was shared at a multi-sector community meeting, where the group identified and prioritized the significant health needs. A CHNA work group was convened within the hospital to guide the assessment process, review the data and make final recommendations on priorities.

Essentia Health-Virginia’s assessment was conducted in four stages: assessment, prioritization, design and finalization. The process began in October 2015 and the assessment portion was completed in May 2016 with the final presentation of the Community Health Needs Assessment for Essentia Health-Virginia being presented and approved by leadership and the Board of Directors on June 16, 2016. The East Region Board of Directors accepted and approved this report on June 8, 2016. The following describes the assessment steps and timeline.
ASSESS (April - October 2015)
- Define Service Area
- Service Area Demographics
- Analyze Secondary Data
- Gather Community Input
- Conduct Asset Mapping of Available Community Resources
- Evaluate Progress on 2013 CHNA Priorities

PRIORITIZE (December 2015 - March 2016)
- Set Criteria for Prioritized Needs
- Choose Prioritization Method
- Choose Needs to Address

DESIGN (March - April 2016)
- Goal Setting
- Identify the "team" for each strategy
- Determine strategy options
- Choose Strategies/Programs
- Set SMART Objectives
- Design Implementation Plan and Evaluation Framework

FINALIZE (May 2016)
- Review with key stakeholders for final feedback
- Present to Hospital Board for Approval
Assessment Process

Phase 1: Assessment
Essentia Health-Virginia did not directly collect primary health information, but instead collaborated with a group of health-related organizations for The Bridge to Health Survey, a multi-county mailed survey conducted in Northeastern Minnesota and Douglas County in Wisconsin. The Bridge to Health Survey was used as the primary data source for the CHNA. The full report, including survey methodology can be found online at www.bridgetohealthsurvey.org. Secondary data was gathered from county, state and national sources and were used to validate primary data as well as identify trends, make comparisons and track benchmarks. Geographic location, special sub-populations, health disparities and inequities were key considerations taken in reviewing the data. In order to understand the health of the community and facilitate the identification of community health needs, a set of indicators were identified. This list includes data on both health outcomes as well as the social, environmental, and behavioral drivers of health. A summary can be found under key findings section. See Appendix A for the full list of indicators and secondary data sources.

Community input was gathered through key informant interviews, focus groups, community meetings and online surveys. Focus groups were conducted in conjunction with the Arrowhead Economic Opportunity Agency and St. Louis County Public Health and Human Services to gather more information about the health needs of low-income, minority and underserved populations. Community input was collated and analyzed for key themes as described under the key findings section. Additionally, a multi-sector community meeting was held to identify and prioritize significant health needs. This group represented the broad interests of the community and included representatives with expertise in public health from St. Louis County Public Health and Human Services, as well as members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations. See Appendix B for a complete list of participants and who they represent.

A CHNA work group was convened within the hospital to guide the assessment process, review health data and make final recommendations on priorities. Representatives include leadership and those with expertise in behavioral health, nutrition, chronic disease management, pediatrics and family health, preventative and clinical care. After the recommendations were finalized, the results were shared with the community in order to validate them and begin conversations on strategies for the implementation plan.

Key Findings
A number of overarching themes arose from community input. A common thread throughout this process was the social and economic conditions of the Iron Range, with many citizens experiencing hardship and loss of income due to recent layoffs in local industry. The most prevalent issues brought up by the community were the abundant mental health issues and lack of mental health resources, illegal drugs, alcohol abuse, and lack of providers.

The natural environment and outdoor recreational resources were often cited as significant strengths in the community, including the local bike trails, hiking, lakes, and other outdoor amenities. While many stated there is a need for more local healthcare services, the services provided by the hospitals and clinics are effective in supporting a health in the community. Local agencies such as the YMCA, United Way, Salvation Army, Project Care Free Clinic and others who support the needs of the underserved in the community were always mentioned as a strength.
Community Input Themes

Mental health
- Lack of mental health providers, crisis care, and local treatment options.
- Stigma surrounding mental health was a definite theme from every source.
- A link between mental health problems and substance abuse was often made.

Illegal drugs and alcohol
- High use and abuse of illegal drugs in the community, which is causing increased violence and safety concerns for many, both young and old.
- The culture of drinking alcohol on the Iron Range was brought up in every focus group, interview and survey.
- Prescription pain medications and addiction were emphasized as an issue facing the community.
- Chemical health issues are creating long wait times for emergency care and overuse of the Emergency Department at the hospital.

Access to health care
- There is a lack of providers in the area, for primary care and specialty needs.
- Transportation to appointments, especially when being sent to Duluth for specialty services, is too costly or inaccessible.
- Cost of care is too high, even with insurance.
- Navigation of healthcare system, insurance and social services is difficult.
- It is physically difficult for seniors to go to the clinic, hospital, rehab, pharmacy, etc.
- It was often noted that there are helpful services available, but there is a lack of awareness of what exists.

Provider and patient relationships
- A lack of trust in providers and the healthcare system was expressed in all the conversations.
- Having a relationship with your provider was described as very important.
- Perceived over-prescribing of medications and lack of alternative treatments or options were raised.

Affordability
- Ability to access affordable and healthy foods was emphasized as a value.
- Gyms are too expensive; the YMCA is not affordable to most, even with its scholarships.
- Cost of medications, health care and transportation were all barriers to obtaining care.
- Those experiencing poverty and homelessness are food insecure and state that they “live on donations.”

Transportation
- Transportation was an issue found across cultures, income and age.
- The community infrastructure does not promote walking and biking as a safe form of transportation.
- Cost of transportation is high due to rural nature of the communities and distances to travel.
• Public transportation system is not a convenient option and sometimes unavailable for basic needs like food and health care.

Interest in healthy food

• People are seeking more information and access to healthy and fresh foods.
• There is an interest in more education on healthy food choices, procurement and preparation.
• Community gardens were desired by many participants.

In order to make optimal use of limited resources, the assessment process included analysis of community “assets” and activities currently taking place to improve the health of the community. This process of “asset mapping” identified opportunities for partnership and collaboration, as well as where significant efforts were already taking place, and was used to guide the selection of the 2016 CHNA priorities as community collaboration was a key criteria. Here is a short list of some of the more pertinent findings:

• Fairview Range Medical Center in Hibbing identified mental wellness and healthy lifestyles as its top priorities in its most recent CHNA. Both priorities include substance abuse prevention as sub-categories.
• Carlton-Cook-Lake-St. Louis Community Health Board’s 2012 Community Health Assessment (CHA) listed priorities that include: obesity; mental health; alcohol, tobacco and drug use; poverty; adolescent sexual activity; access to dental care; uninsured and underinsured; lack of preventive services; lack of physical activity; and food insecurity.
• The Arrowhead Economic Opportunity Agency and partners received grant money to work on food access in Virginia neighborhoods of greatest need.
• Community Wellness Grant efforts in the region focused on diabetes prevention, including the implementation of the National Diabetes Prevention Program and a Diabetes Prevention Network.
• New Statewide Health Improvement Program funds allocated to the Virginia community focus on healthy eating and active transportation.
• Regional prevention coordinators are available to support local communities in the prevention of alcohol, tobacco and other drug abuse.
• A number of coalitions exist, including the Virginia Chemical Action Advisory Board, Iron Range Mental Health Task Force and Youth Mental Health Task Force.
• Funding has recently been increased in the county for the mobile crisis unit that serves all of northern St. Louis County.

Essentia Health-Virginia is committed to developing partnerships with numerous sectors to do this work, including schools, area businesses, public health, law enforcement, religious groups, other healthcare organizations, tribal leaders, local government and other nonprofits.

No written comments were received from the 2013 CHNA. Any comments would have been taken into consideration in this report.

**Limitations**
In 2015, several methodological changes occurred with the Bridge to Health Survey that impact the 2015 survey results and the ability to trend the survey results over time. The survey changed from telephone to mail for budgetary reasons.
Additionally, a new process was used for the data weighting. There are also several sources of bias that can affect data collected via survey, including non-response and factors related to respondents.

Limitations in the assessment process included minimal representation of the American Indian population in community input. Further exploration of existing health data for this population is needed as well as continued conversations with Native people and the local reservation. In the implementation planning process and throughout the three-year CHNA cycle, the hospital plans to work on continuing these conversations with members of the Bois Forte Reservation and work towards culturally sensitive initiatives focused on improving health inequities among this population.

**Phase 2: Prioritization**

Needs were prioritized based on the following criteria as set by the CHNA committee:

- Importance of the problem to the community
- Feasibility of intervention
- Opportunity for partnership
- Ability of intervention to impact health and wellness

The multi-sector community meeting attendees participated in a dot voting activity to identify and prioritize health needs. Each member was asked to write down the top two health needs in the community based on presented assessment results. These were then categorized based on common themes into the areas of mental health, drugs/addiction, socio-economic, transportation, child care, health education, nutrition, obesity, education/schools, churches, adverse childhood experiences, prescription, diabetes, access to health care, and culture. Participants were given the opportunity to add any additional categories they felt might be missing from the list. Each member was then able to vote for the top two health needs based on the identified prioritization criteria listed above. After the vote, dots were tallied to rank the top five health needs. Results were:

1. Mental health
2. Drugs/addiction
3. Socio-economic
4. Access to health care
5. Adverse childhood experiences

The Essentia Health-Virginia CHNA work group identified two priorities to address through the 2016 CHNA:

1. Behavioral health
2. Social and economic barriers to health and wellness

The category of alcohol, tobacco and other drugs was combined with mental health under the umbrella term “behavioral health” for the first priority because it was decided that these two were interconnected issues in the community and implementation plans will address the spectrum of mental health and substance-related needs in the community. The second priority will address a range of issues identified through the assessment process where the underlying cause was a socio-economic barrier, including but not limited to access to health care and healthy foods.

Adverse childhood experiences (ACEs) were not chosen because strategies chosen to address the identified priorities will also impact ACEs in the community. The remaining identified issues were not chosen due to the amount of hospital resources available, and many areas (such as transportation, child care, education, culture) can be addressed through...
the second priority. While obesity remains a significant issue in the community, it was decided that the issues of highest importance to the community were the chosen priorities. Additionally, mental and physical health are closely connected, therefore mental health plays a major role in people’s ability to maintain good physical health. By addressing the chosen priorities, the strategies will indirectly impact physical health problems such as chronic diseases and obesity.

Lastly, there is significant momentum in the community surrounding the identified priorities, which will provide the hospital with the ability to have a greater impact through strategic collaboration and partnership.

**Phase 3: Design of Strategy and Implementation Plan**
Essentia Health-Virginia will work to design an implementation strategy with internal stakeholders as well as external partners and stakeholders who represent existing healthcare facilities and resources within the community that are available to respond to the health needs of the community as identified in this assessment. This implementation strategy will be reviewed and approved by the hospital board of directors prior to November 15, 2016.

Essentia Health has incorporated Community Health and Wellness into the FY 2016-2018 System Strategic Plan under “Building Healthy Communities.” The system has also outlined an allocation of resources available to each hospital as a percentage of net revenue less bad debt to address the priorities set forth in the Community Health Needs Assessments.

**Conclusion**
As part of a nonprofit health system, Essentia Health-Virginia is called to make a healthy difference in people’s lives. This needs assessment and implementation plan illustrates the importance of collaboration between our hospital and its community partners. By working collaboratively, we can have a positive impact on the identified health needs of our community during Fiscal Years 2017-2019. There are other ways in which Essentia Health-Virginia will indirectly address local health needs, including the provision of charity care, the support of Medicare and Medicaid programs, discounts to the uninsured and others. A detailed implementation plan to address the identified health needs will be finalized and available in the fall of 2016.
APPENDIX

Appendix A: Community Health Status Indicators for Essentia Health-Virginia

Appendix B: Community Input Participants
<table>
<thead>
<tr>
<th>Health Outcomes (76)</th>
<th>Quality of Life (78)</th>
<th>Health Factors (77)</th>
<th>Clinical Care (13)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length of Life (67)</strong></td>
<td>Premature death</td>
<td>Premature deaths (under 75 years) age adjusted (2013)$^3$</td>
<td>353.4</td>
</tr>
<tr>
<td></td>
<td>Cancer, age adjusted death rate (2009-2013)$^1$</td>
<td>184.8</td>
<td>161.3</td>
</tr>
<tr>
<td></td>
<td>Heart disease, age adjusted death rate (2009-2013)$^1$</td>
<td>153.6</td>
<td>118.9</td>
</tr>
<tr>
<td><strong>Health Outcomes (76)</strong></td>
<td>Low birth weight</td>
<td>Percent low birth weight (%) (2014)$^3$</td>
<td>4.9</td>
</tr>
<tr>
<td></td>
<td>Poor or fair health</td>
<td>Health status fair or poor (%) (2012)$^3$</td>
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</tr>
<tr>
<td></td>
<td>Poor mental health days</td>
<td>Poor mental health days$^4$</td>
<td>3.1</td>
</tr>
<tr>
<td><strong>Health Behaviors (78)</strong></td>
<td>Tobacco Use</td>
<td>Adult smoking (%) (2012)$^3$</td>
<td>18.3</td>
</tr>
<tr>
<td></td>
<td>Mothers who smoked during pregnancy (%) (2009-2013)$^1$</td>
<td>20.3</td>
<td>10.8</td>
</tr>
<tr>
<td></td>
<td>Diet and exercise</td>
<td>Physical inactivity/no exercise (%) (2012)$^3$</td>
<td>17.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to exercise opportunities (%)$^4$</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percent adults who consumed 5 or more servings of fruits and vegetables yesterday$^7$</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult obesity (%) (2012)$^3$</td>
<td>25.5</td>
</tr>
<tr>
<td><strong>Health Factors (77)</strong></td>
<td>Alcohol and drug use</td>
<td>Binge drinking (%)$^4$</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol-related motor vehicle fatalities (%) (2012)$^3$</td>
<td>27.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drug overdose deaths$^4$</td>
<td>13</td>
</tr>
<tr>
<td><strong>Health activity</strong></td>
<td>Teen birth rate, 18-19 years (2012-2014)$^3$</td>
<td>22</td>
<td>30.7</td>
</tr>
<tr>
<td></td>
<td>Rate per 100,000 of chlamydia (2015)$^5$</td>
<td>370</td>
<td>400</td>
</tr>
<tr>
<td><strong>Clinical Care (13)</strong></td>
<td>Access to care</td>
<td>Adults without health insurance, under age 65 (%) (2013)$^2$</td>
<td>10.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary care physicians$^4$</td>
<td>800:1</td>
</tr>
<tr>
<td></td>
<td>Mental health providers&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Licensed and practicing dentists (per capita) (2013)&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Quality care</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------</td>
<td>----------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>510:1</td>
<td>490:1</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>490:1</td>
<td>55.6</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

|                      | Education | Four-year graduation rate per 100 (2012-2013)<sup>1</sup> | Employment | Unemployed (annual average) (%) (2013)<sup>3</sup> | Family and social support | Children in single-parent households (%) (2010-2014)<sup>3</sup> | Income | Median household income (2010-2014)<sup>2</sup> ($) | Children in poverty (%) (2010-2014)<sup>2</sup> | People of all ages living at or below 200% of poverty (%) (2010-2014)<sup>3</sup> | Children eligible for free/reduced price lunch (%) (2013-2014)<sup>1</sup> | Community safety | Unintentional injury, age-adjusted premature death rate (2009-2013)<sup>3</sup> | Assaults ED visits (age adjusted rate per 100,000) (2008-2012)<sup>3</sup> | Physical Environment | Air and water quality | Private well with > 2 micrograms/L* (%) (2008-2013)<sup>2</sup> | Fine particles, average annual concentration (2011)<sup>2</sup> | Housing and transit | Severe housing problems (%)<sup>4</sup> | Long commute - driving alone (%)<sup>4</sup> |
|----------------------|-----------|---------------------------------------------------------|-------------|--------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------|-------------------|----------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------|-----------------------------------|-----------------------------------|
|                      | 78.2      | 78.4                                                    | 6.3         | 5.1                                                                | 2.7                                                                      | NA                               | 47,138                        | 41.4                                                 | 29.2                                                   | 34.7                                                                     | 27.1                                                                 | 28.4                               | 44                                | 38.6                             | 433                                                 | 40.7                                   | 8.7                                    | 15                                 | 19                                 |
|                      | 78.4      | NA                                                      | 5.1         | 2.7                                                                | 2.7                                                                      | NA                               | 61,481                        | 14.9                                                 | 27.1                                                   | 28.4                                                                     | NA                                                                 | NA                                | 38.6                             | 36.4                             | 264.9                                             | 46                                     | 12**                                   | 14                                 | 30                                 |
|                      | NA        | NA                                                      | 2.7         | NA                                                                | NA                                                                      | NA                               | NA                             | NA                                                 | NA                                                    | NA                                                                      | NA                                                                 | NA                                | NA                               | NA                                | NA                                                 | NA                                     | NA                                    | NA                                 | NA                                 |
|                      | NA        | 71.1                                                    | NA          | NA                                                                | NA                                                                      | NA                               | NA                             | NA                                                 | NA                                                    | NA                                                                      | NA                                                                 | NA                                | NA                               | NA                                | NA                                                 | NA                                     | NA                                    | NA                                 | NA                                 |

Sources and notes:

Minnesota Department of Health, Minnesota State, County, and Community Health Board Vital
2 Minnesota Department of Health, Minnesota Public Health Data Access.
Minnesota Department of Health, Minnesota County Health Tables.


4 Healthy People 2020, https://www.healthypeople.gov/2020/topics-objectives

Bride to Health Survey 2015, Rural St. Louis County data,
7 http://www.bridgetohealthsurvey.org/index.php/reports

`HP 2020 target to increase abstinence from cigarette smoking among pregnant women to 98.6%

*micrograms per cubic meter

**standard
# APPENDIX B: Community Input Participants

<table>
<thead>
<tr>
<th>CHNA Community Meeting Attendees</th>
<th>Who they represent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrowhead Agency on Aging</td>
<td>Low-income, underserved, minority</td>
</tr>
<tr>
<td>Lake County Ambulance Service</td>
<td>Health care</td>
</tr>
<tr>
<td>Arrowhead Center</td>
<td>Health care</td>
</tr>
<tr>
<td>Essentia Health-Virginia Regional Foundation Board</td>
<td>Health care</td>
</tr>
<tr>
<td>Community member</td>
<td>Community</td>
</tr>
<tr>
<td>Essentia Health-Virginia</td>
<td>Health care</td>
</tr>
<tr>
<td>NAMI Iron Range</td>
<td>Underserved</td>
</tr>
<tr>
<td>United Way of Northeastern Minnesota</td>
<td>Low-income, underserved, minority</td>
</tr>
<tr>
<td>Range Mental Health Center</td>
<td>Health care</td>
</tr>
<tr>
<td>Arrowhead Economic Opportunity Agency, Inc.</td>
<td>Low-income, underserved, minority</td>
</tr>
<tr>
<td>Iron Range Partnership for Sustainability</td>
<td>Non-profit</td>
</tr>
<tr>
<td>Mesabi Family YMCA</td>
<td>Community</td>
</tr>
<tr>
<td>Hometown Focus</td>
<td>Media</td>
</tr>
<tr>
<td>Northeast Higher Education District</td>
<td>Education, youth</td>
</tr>
<tr>
<td>Eveleth Schools</td>
<td>Education, youth</td>
</tr>
<tr>
<td>Essentia Health-Virginia Board</td>
<td>Health care</td>
</tr>
<tr>
<td>Bois Forte</td>
<td>Minority</td>
</tr>
<tr>
<td>St. Louis County Public Health and Human Services</td>
<td>Public health</td>
</tr>
<tr>
<td>Wellbeing Development and Behavioral Health Network</td>
<td>Health care</td>
</tr>
<tr>
<td>Healthy Northland</td>
<td>Public health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Input Participants*</th>
<th>Who they represent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Northland</td>
<td>Public Health</td>
</tr>
<tr>
<td>Mesabi Range College</td>
<td>Education</td>
</tr>
<tr>
<td>United Way of Northeastern Minnesota</td>
<td>Low income, underserved, minority</td>
</tr>
<tr>
<td>Arrowhead Economic Opportunity Agency, Inc.</td>
<td>Low income, underserved, minority</td>
</tr>
<tr>
<td>Mesabi Family YMCA</td>
<td>Community</td>
</tr>
</tbody>
</table>
Virginia Rotary Club | Community
---|---
Essentia Health-Virginia Diabetes Center group | Community
Essentia Health-Virginia Patient and Family Advisory Group | Community
Essentia Health-Virginia staff | Community
Essentia Health-Virginia volunteers | Community
Bill’s House residents | Low-income, underserved, minority
Youth Foyer residents | Low-income, underserved, minority
Arrowhead Economic Opportunity Agency, Inc. Senior Meals Participants | Underserved (seniors)
Our Savior’s Lutheran Church Council | Community

*names available upon request