Community Health Needs Assessment Implementation Strategy

Fiscal Year 2014 Progress Report and Fiscal Year 2015 Update

Essentia Health Virginia, Virginia, MN

Essentia Health

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Executive summary

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

In full embrace of the Triple Aim[2] of improving the experience of care, improving population health, and reducing the cost of healthcare, Essentia Health is now expanding its community health efforts and will proceed with different plans in subsequent fiscal years. This document provides a progress report on the first intervention, which will continue in FY 2015, as well as an updated implementation strategy for FY 2015. At the end of FY 2015, the implementation strategy will be updated once again for FY 2016. The Essentia Health Virginia Board of Directors and the Essentia Health East Region Board of Directors accepted the progress report and adopted (approved) the FY 2015 plans on June 19, 2014 and June 9, 2014, respectively.

Fiscal Year 2014 implementation strategy progress report

1. BACKGROUND

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

2. PROCEDURES, RESOURCES COMMITTED, AND COLLABORATIONS

In FY 2014 along with 13 other Essentia Health hospital facilities, Essentia Health Virginia began offering a diabetes prevention intervention based on the National Diabetes Prevention Program (NDPP) as intervention 1 to address the hospital facility's highest priority health need. The Centers for Disease Control and Prevention-led NDPP is an evidence-based lifestyle change program for type 2 diabetes prevention.[3] The program is based on the Diabetes Prevention Program research study, which showed that modest behavior changes can help participants lose 5–7% of their body weight and reduce the risk of developing type 2 diabetes by 58% in people with prediabetes. NDPP participants work with a lifestyle coach in a group setting to receive a 1-year lifestyle change program that includes 16 core sessions (usually 1 per week) and 6-8 post-core sessions (1 per month). See Appendix A for further detail.

The anticipated impact of this program is reduced body weight and increased physical activity in participants, which prior research suggests will reduce their type 2 diabetes risk. This impact is anticipated across the Essentia Health system where the program is offered. The primary plan to evaluate such impact is system-wide pre- (baseline) and post- (1 year) intervention comparison of body weight and physical activity in participants.

The hospital facility committed staff member time to serve as the Lifestyle Coach, as well as space in the facility at the Diabetes Center to hold the sessions. The hospital facility collaborated with several organizations. Program brochures and prediabetes screening forms were distributed to Project Care, Arrowhead Economic Opportunity Agency (AEOA), the YMCA, the Essentia Health Virginia Clinic, the Laurentian Clinic, local health fairs, and the Essentia Health Virginia Ob/Gyn Clinic. A Natural Harvest

Food Cooperative representative spoke to the program participants on October 20, 2013. A YMCA representative spoke to the group on October 27, 2013, and the YMCA offered passes to participants who toured the facility with staff on January 22, 2014. The Hometown Focus newspaper published an article on the participants on April 25, 2014. The article was a follow-up to an article about the CHNA published in August 2013.

The Essentia Health system committed resources to the implementation, evaluation, and reporting of the program. Three staff members at the Essentia Institute of Rural Health (EIRH) assist with system-wide coordination. Each has been trained as Lifestyle Coaches, and two attended NDPP logistics training. One of the staff members serves as the Lifestyle Coach for Essentia Health Duluth and Essentia Health St. Mary's Medical Center in Duluth, MN. That individual was trained as an NDPP Master Trainer in March 2014 and intends to train other Lifestyle Coaches system-wide as needed as soon as is feasible.

3. PROGRESS AND RESULTS TO DATE

There are two concurrent sessions of the NDPP-based program at the hospital facility. The first session began on September 11, 2013 and has data reported to April 2, 2014. Following CDC standards and protocol, data are reported on participants with 4 or more Core sessions, and data are only reported for the Core sessions (16 weeks). There are 10 participants, all female, with average age of 66 years. The participants had an average attendance in Core sessions of 63%. For participants who attended at least 4 sessions, the average weight at baseline was 191.6 pounds. When data on exercise began being collected and among those who recorded their activity, the median was 165 minutes of brisk weekly activity. Change in average weight at the participants' last recorded session was a weight loss of 0.9 pounds, a 0.6% reduction. Median physical activity at participants' last recorded session was 90 minutes/week, a 75% decrease. The session will continue through August 2014. Participants will continue to be encouraged to attain and maintain at least 150 minutes/week of physical activity and 5-7% body weight loss. Evidence suggests these lifestyle changes, if maintained, can reduce the risk of developing type 2 diabetes by 58%.

June 23, 2014 addendum: The second session began on January 5, 2014 and has data reported to April 30, 2014. There are 10 participants, 8 females and 2 males, with average age of 67 years. Participants had an average attendance of 92%. For participants who attended at least 4 sessions, the average weight at baseline was 197.7 pounds. When data on exercise began being collected and among those

who recorded their activity, the median was 175 minutes of brisk weekly activity. Change in average weight among participants at their last recorded session was a weight loss of 15.2 pounds, a 7.5% reduction. Median physical activity at participants' last recorded session was 120 minutes/week, a 55% decrease from their first recorded physical activity. The session will continue through December 2014.

June 23, 2014 addendum: For both the first and second sessions, all 20 participants had an average attendance in core sessions of 77%. For all participants who attended at least four sessions, the average weight at baseline was 194.5 pounds. When data on physical activity began being collected and among those who recorded their physical activity, the median for all participants was 170 minutes/week of brisk activity. Change in average weight for all participants at their last recorded session was a weight loss of 7.7 pounds, a 3.8% reduction. Median physical activity at all participants' last recorded session was 105 minutes/week, a 65% decrease. Along with continued encouragement to reach and maintain at least 150 minutes/week of brisk physical activity, participants will continue to be encouraged to reach and maintain a 5-7% body weight loss. A third session is planned to begin on September 3, 2014.

Qualitatively, the program in its initial stages is successfully benefitting the communities Essentia Health serves. Participants are acquiring knowledge, skills and support systems necessary for sustained weight loss and increasing physical activity as the program progresses. Most are enthusiastic to continue these lifestyle changes. Participants in Essentia Health's communities have expressed appreciation for having the high-quality, well-organized program available to them. They also appreciate the fun of a group, as well as the support and sense of community the group provides.

Family members and others who constitute a participant's support system are also included in some activities. Through this mechanism, as well as through participants serving as exemplars of a healthier way of living, we hope the benefits of the program extend beyond the program participants themselves. For example, in one of Essentia Health's communities, a participant's spouse has made lifestyle changes along with the participant. They are both seeing positive results and have made healthful changes in how they prepare and purchase food.

4. OTHER EDUCATIONAL ACTIVITIES

In addition to the diabetes prevention intervention, an educational event on Metabolic Syndrome was offered by an Essentia Health physician on May 8, 2014 at the Iron Range Rehab Center.

Fiscal year 2015 implementation strategy update

1. INTRODUCTION

The Triple Aim for health care is simultaneous pursuit of three goals: "improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations."[2] Essentia Health aims to become a recognized leader in supporting population health. While Essentia Health has several ongoing initiatives directed toward population health, including the intervention described in this document, the system must undertake considerable work to achieve this goal. Consequently, Essentia Health's hospital facilities will participate in building organizational capacity for population health improvement during fiscal year (FY) 2015. The following sections include detail on this capacity building, as well as this plan's implications for intervention 1 and other identified health needs.

2. HOW THE HOSPITAL FACILITY PLANS TO ADDRESS HEALTH NEEDS

2.1. System population health improvement capacity building

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

2.2. Continuation and optimization of intervention 1

The hospital facility will continue offering the diabetes prevention intervention in FY 2015. The current sessions began on September 11, 2013 and January 15, 2014 and will each continue for one year. Essentia Health Virginia plans to sustain this program by keeping an ongoing "Waiting List" of interested participants. As people learn about the program throughout the year they will be able to sign up for the next available session. There will be a session offered every fall beginning the first Wednesday in September and the first Wednesday in January that is not New Year's Day. The Essentia Health Virginia Diabetes Center will continue to develop avenues for interested community members to learn about the program. These avenues will grow as we continue to engage participants in sustainable lifestyle change. At present, future participants may be referred by past participants, their primary care provider, AEOA staff, YMCA and other local fitness center, community health fairs, local newspapers etc. The next session is planned to begin on September 3, 2014.

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

3. HEALTH NEEDS NOT BEING DIRECTLY ADDRESSED AND REASONS WHY

3.1. Second and third priority health needs

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

3.2. Other health needs

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

Appendix A: National Diabetes Prevention Program

BACKGROUND

All Essentia Health hospitals conducted Community Health Needs Assessments in the 2013 fiscal year. Most of the hospitals are offering the National Diabetes Prevention Program (NDPP)[3] in order to address health needs including obesity, physical inactivity, and poor nutrition as risk factors for chronic diseases such as type 2 diabetes; access to healthcare; and access to patient-centered health education (disease prevention and wellness). This intervention has been simplified from its original form described in implementation strategies adopted in fiscal year 2013. The procedures described below update and replace those original descriptions and form the basis of the program offered by Essentia Health Virginia.

THE NATIONAL DIABETES PREVENTION PROGRAM[4]

In the NDPP, lifestyle change classes led by trained coaches meet for 16 core sessions as participants focus on losing 7% of their body weight and increasing physical activity to 150 minutes each week. After the initial 16 sessions, classes meet monthly for 6-8 months.

Who: Participants are enrolled according to the Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program Standards and Operating Procedures eligibility requirements:[5]

1. 18 years of age or older and body mass index (BMI) ≥24 kg/m2 (≥22 kg/m2, if Asian)
2. ≥ 50% of a program's participants must have had a recent (within the past year), documented, blood-based diagnostic test indicating they have prediabetes, or a self-reported history of clinically-diagnosed gestational diabetes mellitus (GDM)
3. ≤ 50% of a program's participants may be considered eligible if they screen positive for prediabetes based on the CDC Prediabetes Screening Test (see Form A)

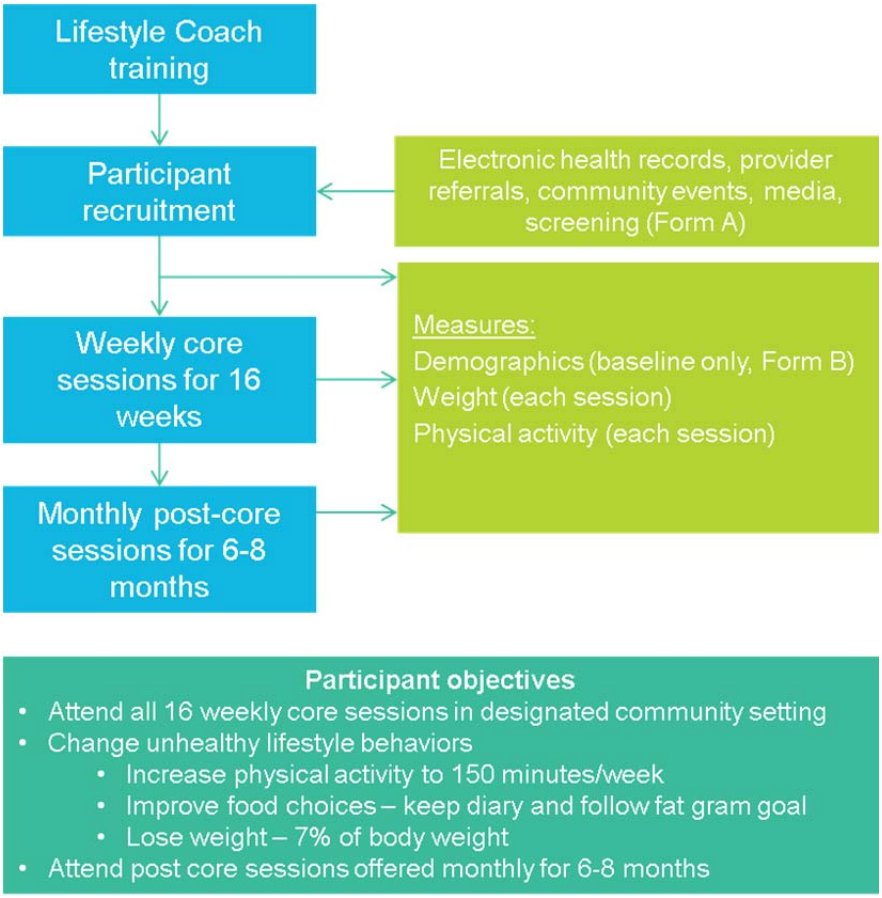
What: The NDPP is designed to bring to communities evidence-based lifestyle change programs for preventing type 2 diabetes. It is based on the Diabetes Prevention Program research study led by the National Institutes of Health and supported by the CDC. Family members and others who constitute a participant's support system may be included in some activities. Activities such as fitness classes, cooking classes, and grocery store tours will be incorporated when possible. Measurements, as shown in

the flowchart below, are taken periodically for evaluation purposes.

Why: The lifestyle program shows that making modest behavior changes, such as improving food choices and increasing physical activity to at least 150 minutes per week, results in participants losing 7% of their body weight. These lifestyle changes reduce the risk of developing type 2 diabetes by 58% in people at high risk for diabetes.

When: Participants work with a lifestyle coach in a group setting to receive a 1-year lifestyle change program that includes 16 core sessions (1 per week) and 6-8 post-core sessions (1 per month).

INTERVENTION FLOW CHART



FORM A – CDC PREDIABETES SCREENING TEST[5]

A score of nine or higher on this screening test indicates that the tested person is at high risk for having prediabetes. In a national sample of U.S. adults aged 18 years and older (2007–08 National Health and Nutrition Examination Survey), this screening test correctly identified 27%–50% of those with a score of 9 or higher as true cases of prediabetes based on the HbA1c, fasting blood glucose, or two-hour oral glucose tolerance confirmatory diagnostic tests (Division of Diabetes Translation, Centers for Disease Control and Prevention, 2010).

An online widget of the screening test can be downloaded at http://www.cdc.gov/widgets. The screening test can be given on paper using the document below.

Prediabetes – You Could Be at Risk

Prediabetes means your blood glucose (sugar) is higher than normal, but not yet diabetes. Diabetes is a serious disease, which can cause heart attack, stroke, blindness, kidney failure, or loss of toes, feet or legs. Type 2 diabetes can be delayed or prevented in people with prediabetes, however, through effective lifestyle programs. Take the first step. Find out your risk for prediabetes.[6]

Take the Test — Know Your Score!

Answer these seven simple questions. For each “Yes” answer, add the number of points listed. All “No” answers are 0 points.

Question	Yes	No
Are you a woman who has had a baby weighing more than 9 pounds at birth?	1	0
Do you have a sister or brother with diabetes?	1	0
Do you have a parent with diabetes?	1	0
Find your height on the chart. Do you weigh as much as or more than the weight listed for your height? (See chart below)	5	0
Are you younger than 65 years of age and get little or no exercise in a typical day?	5	0
Are you between 45 and 64 years of age?	5	0
Are you 65 years of age or older?	9	0
Total points for all “yes” responses:		

Know Your Score

9 or more points: High risk for having prediabetes now. Please bring this form to your health care provider soon.

3 to 8 points: Probably not at high risk for having prediabetes now. To keep your risk level below high risk:

- If you're overweight, lose weight
- Be active most days
- Don't use tobacco
- Eat low-fat meals including fruits, vegetables, and whole-grain foods
- If you have high cholesterol or high blood pressure, talk to your health care provider about your risk for type 2 diabetes

At-Risk Weight Chart

Height	Weight (in pounds)
4'10"	129
4'11"	133
5'0"	138
5'1"	143
5'2"	147
5'3"	152
5'4"	157
5'5"	162
5'6"	167
5'7"	172
5'8"	177
5'9"	182
5'10"	188
5'11"	193
6'0"	199
6'1"	204
6'2"	210
6'3"	216
6'4"	221

FORM B – DEMOGRAPHICS QUESTIONS

1.) What is your age in years? ____ _____

2.) What is your sex? ____ _____

3.) What is your race (circle all that apply)?

- o American Indian or Alaska Native
- o Asian
- o Black or African American
- o Native Hawaiian or Other Pacific Islander
- o White
- o I prefer not to respond

4.) What is your ethnicity?

- o Hispanic or Latino
- o Not Hispanic or Latino
- o I prefer not to respond

5.) How tall are you? _____

Appendix B: Fiscal Year 2015 Implementation Strategy

ACTION: CONTINUATION AND OPTIMIZATION OF INTERVENTION 1				
Specific actions the hospital facility, or hospital organization on behalf of the hospital facility, plans to take	Anticipated impact of actions	Plan to evaluate such impact	Programs and resources the hospital facility, or hospital organization on behalf of the hospital facility, plans to commit	Planned collaboration with other organizations
Hospital facility: Continue diabetes prevention intervention based on the National Diabetes Prevention Program (NDPP)	Hospital facility: Participants will acquire knowledge, skills and support systems for sustained weight loss and physical activity participation	Hospital facility: Primary analysis is system-wide pre (baseline)/post (1 year) t-test for weight and physical activity; descriptive statistics by hospital will also be calculated	Hospital facility: • Three Diabetes Center Staff (Certified Diabetes Educator, Exercise Physiologists, Registered Nurse) trained as Lifestyle Coaches • Office management staff, scheduling and materials • Sessions are held at the hospital facility's Diabetes Center • Printed brochures and risk assessment • Medical Direction Dr. Michelle Oman and Dr. Steve Park	Hospital facility: • Walking trail around local lake received $5000 from Essentia Health Virginia to promote health and wellness

Essentia Health (hospital organization): 1. A trained NDPP Master Trainer will train other Lifestyle Coaches 2. Through a diabetes intervention workgroup, address outstanding and future implementation challenges	Essentia Health: 1. Other individuals will become trained Lifestyle Coaches 2. Challenges will be addressed	Essentia Health: 1. Number of newly trained Lifestyle Coaches will be tracked 2. Record meeting minutes of workgroup	• Staff continuing education and travel • Weight Scale Essentia Health: • Certified Diabetes Educator, Registered Nurse at the Essentia Institute of Rural Health serves as system coordinator and Master Trainer • Staff members will be part of diabetes intervention workgroup	Essentia Health: • Certified Diabetes Educator/Registered Nurse at the Essentia Institute of Rural Health will pursue partnership with the Minnesota Department of Health to offer Lifestyle Coach training.
ACTION: BUILD SYSTEM POPULATION HEALTH IMPROVEMENT CAPACITY				
Specific actions the hospital organization plans to take on behalf of the hospital facility	Anticipated impact of actions	Plan to evaluate such impact	Programs and resources the hospital organization plans to commit on behalf of the hospital facility	Planned collaboration with other organizations
1. Review methods used by other health systems to improve population health and wellness. Report findings to	• Become the market leader for health and wellness in all Essentia Health hospital markets.	• Progress to plan and % completed o Develop spread plan for system o Identify and	System-wide: • Staff time • Travel expenses	As appropriate: • Other hospital organizations • Public health • Other local

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

engagement methods. 5. Develop a community approach to identifying, tracking, and communicating health and wellness assets in relevant communities; developing partnerships; and building on existing resources. 6. While factoring in variation across the health system, identify resource needs to build community and system infrastructure, including organizational structure, role definitions, and Performance Management System. 7. Hold retreat with relevant stakeholders to gain consensus around new plan in first quarter and begin role out. 8. Form workgroups to improve CHNA and implementation strategy tactics across the system. Workgroups will plan process for 1) conducting FY16 CHNA				

and 2) developing FY17-FY19 implementation strategies; planned process to be commenced no later than July 2015.				
ACTION: DEVELOP CONNECTIONS BETWEEN COMMUNITY HEALTH AND WELLNESS RESOURCES AND NDPP-BASED DIABETES PREVENTION INTERVENTION PARTICIPANTS				
Specific actions the hospital facility plans to take	Anticipated impact of actions	Plan to evaluate such impact	Programs and resources the hospital facility plans to commit	Planned collaboration with other organizations
• Former & current participants will be invited to "Breathe Easy" quarterly educational support meetings and other health and wellness community events through email, mail, advertisement, etc.	• Sustained or continued weight loss and physical activity participation, prevention of diabetes diagnosis and continued utilization of community resources by participants	• Yearly self-reported survey of key measures: weight, physical activity minutes per week, and diabetes diagnosis for all participants	• Management of program delivery will continue to facilitate connections with community partners and events	• Continued connections with YMCA, AEOA, Natural Harvest, grocery stores, fitness centers, City of Virginia walking trail, etc.

References

1. Essentia Health Virginia. "Community Health Needs Assessment." 18 June 2013. <http://essentiahealth.org/Uploads/Public/Documents/Community%20Assessments/Virginia%20CHNA%20Final%20Report.pdf>.

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

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6. Based on Herman WH, Smith PJ, Thomason TJ, Engelgau MM, Aubert RE. A new and simple questionnaire to identify people at risk for undiagnosed diabetes. Diabetes Care. 1995;18(3):382-7.