2022 AdventHealth Durand Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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Letter From Leadership

At AdventHealth, our mission of Extending the Healing Ministry of Christ goes beyond our walls. We are committed to addressing the needs of the communities we serve with a wholistic focus – one that strives to heal and restore the body, mind and spirit.

Every three years, AdventHealth hospitals complete a Community Health Needs Assessment. We collaborate with community organizations, public health experts and people like you: those who understand our communities best. This in-depth look at the overall health of the community as well as barriers to care helps us better understand each area's unique needs, so we can address the issues that matter most.

AdventHealth is blessed to serve communities across the United States. In big cities and small towns, our promise of wholeness is constant. We believe all people deserve to feel whole, and we are committed to meeting them wherever they are on that journey and supporting them along the way.

Work of this magnitude is not possible without the incredible partnership of public health experts, community health organizations and countless community members. It is through open dialogue and constant collaboration with these key partners that AdventHealth will bring wholeness to all communities we serve.

In His Service,

Terry Shaw
President and CEO
AdventHealth

Executive Summary

Chippewa Valley Hospital and Oakview Care Center, Inc. d/b/a AdventHealth Durand will be referred to in this document as AdventHealth Durand or “the Hospital”. The Hospital conducted a community health needs assessment from August 2021 to June 2022. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations.
- Assess and understand the community’s health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use assessment findings to develop and implement a 2023-2025 Community Health Plan based on the needs prioritized in the assessment process.

Community Health Needs Assessment Committee

In order to ensure broad community input, AdventHealth Durand created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met three times in 2021 - 2022. They reviewed the primary and secondary data and helped to identify the top priority needs in the community.
See Priortization Process for a list of CHNAC members.

Hospital Health Needs Assessment Committee

AdventHealth Durand also convened a Hospital Health Needs Assessment Committee (HHNAC). The purpose of the HHNAC was to select the needs the Hospital would address as a result of the findings in the assessment. The HHNAC made this decision by reviewing the priority needs selected by the CHNAC and the internal Hospital resources available. With this information the HHNAC was able to determine where the Hospital could most effectively support the community.
See Prioritization Process for a list of HHNAC members.

Data

AdventHealth Durand in collaboration with the AdventHealth Corporate team collected both primary and secondary data. The primary data included community surveys and stakeholder interviews. Secondary data included internal Hospital utilization data (inpatient, outpatient and emergency department). This utilization data showed the top diagnoses for visits to the Hospital from 2019-2021. In addition, publicly available data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top 11 aggregate issues.
See Process and Methods for Primary and Secondary Data Sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the CHNAC and the HHNAC understand existing community efforts to address the 11 identified issues from aggregate primary and secondary data and to prevent duplication of efforts.
See Available Community Resources for more.

Selection Criteria

The CHNAC participated in a prioritization process after data review and discussion through which the needs were ranked based on established criteria.
See Priorities Selection for more.

The HHNAC reviewed and discussed the needs that had been identified by the CHNAC and the available resources to address them in the community. The HHNAC also considered the Hospital’s current resources and strategies which could most effectively address the needs having the biggest impact on the community. Through these discussions the Hospital selected the needs it is best positioned to impact.

The CHNAC and the HHNAC also considered four factors during prioritization:

A. Alignment: Does this issue align with our mission, strategy, public-health or community goals?

B. Impact on Community: What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now?

C. Resources: Are there existing, effective interventions and opportunities to partner with the community to address this issue?

D. Outcome Opportunities: Can an impact on this issue be made in a demonstrable way, and will interventions have an impact on other health and social issues in the community?

Priority Issues to be Addressed

The priority issues to be addressed are:

1. Nutrition and Healthy Eating
2. Physical Health
3. Diabetes

See Priorities Selection for more.

Approval

On October 26, 2022, the AdventHealth Durand Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2022 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2022.

Next Steps

AdventHealth Durand will work with the CHNAC to develop a measurable implementation strategy called the 2023-2025 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital's website prior to May 15, 2023.

About AdventHealth

AdventHealth Durand is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 80,000 skilled and compassionate caregivers serve 4.7 million patients annually. From physician practices, Hospital, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, wholistic care at nearly 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in research, new technologies and the people behind them to redefine medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are changing medicine and shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentations and paying a bill, to conducting a virtual urgent care visit with a provider, we are making health care easier by creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its workplace culture, having been recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" three years straight. This recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth.

AdventHealth Durand

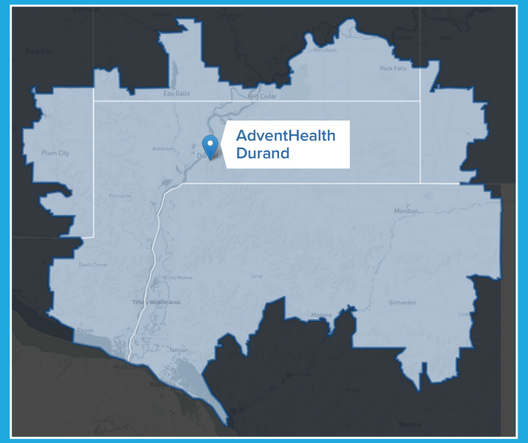
AdventHealth Durand is a 25-bed critical access hospital located in Pepin County, Wisconsin. The Hospital serves as a Critical Access Hospital (CAH). As a CAH, the Hospital fills a gap for needed medical care in a rural community, where there are no other hospitals within 35 miles and ensures that when moments matter access to care is available. AdventHealth Durand provides multiple services including: digestive care, heart and vascular care, imagining and lab services, sleep care, sports and rehab care, surgical care, emergency and urgent care, men's care and senior care.

COMMUNITY OVERVIEW

Community Description

AdventHealth Durand is located in Pepin County, Wisconsin. The Hospital defines its community as the Total Service Area (TSA), the area in which over 90% of its patient population lives. This includes seven zip codes across five counties: Pepin, Buffalo, Dunn, Pierce and Eau Claire. According to the 2020 Census, the population in the Hospital's Total Service Area has decreased 2.7% in the last ten years to 16,689 people.

Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention, unless indicated otherwise. Data are reported for the TSA unless listed differently. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.



Community Profile

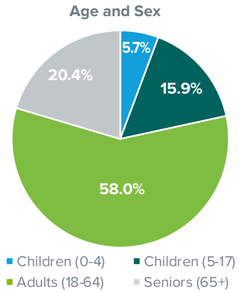
Age and Sex

The median age in the Hospital's community is 43.9, higher than that of state which is 39.6 and than the US, 38.2.

Males are the majority, representing 50.6% of the population. Middle-aged men, 40-64 are the largest demographic in the community at 17.9%.

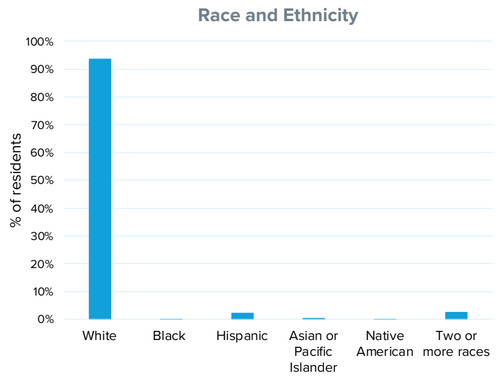
Children are 21.7% of the total population in the community. Infants, those zero to four, are 5.7% of that number. The community birth rate is 79.1 births per 1,000 women aged 15-50, this is higher than the US average of 51.9 and than that of the state, 52.6. In the Hospital's community, 17.8% of children aged 0-4 and 12.6% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 20.4% of the total population in the community. Females are 51.6% of the total senior population.



Race and Ethnicity

In the Hospital's community, 93.9% of the residents are non-Hispanic White, 0.3% are non-Hispanic Black and 2.3% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 0.4% of the total population, while .3% are Native American and 2.7% are two or more races.



Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health inequities in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so, when possible, the Hospital could align its work with national efforts when addressing social determinants of health. For the purposes of the CHNA the Hospital will follow this model for reporting any related data.

The Healthy People 2030 place-based framework outlines five areas of SDOH:

Economic Stability: This includes areas such as income, cost of living, food security and housing stability.

Education Access and Quality: This focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.

Health Care Access and Quality: This includes topics such as access to health care, access to primary care and health insurance coverage.

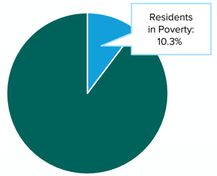
Neighborhood and Built Environment: This includes areas like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.

Social and Community Context: This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

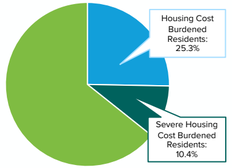
Income

The median household income in the Hospital's community is $60,296. This is below the median for both the state and the US. In the community, 10.3% of residents live in poverty, this is lower than the poverty rate of the state, 10.9% and US, 12.8%.



Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.[1] Feeding America estimates for 2020[2], showed the food insecurity rate in the Hospital's community as 11.8%.



Increased evidence is showing a connection between stable and affordable housing and health.[3] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%.

1 Food Insecurity - Healthy People 2030 | health.gov
2 Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)
3 Severe housing cost burden* | County Health Rankings & Roadmaps

Education Access and Quality

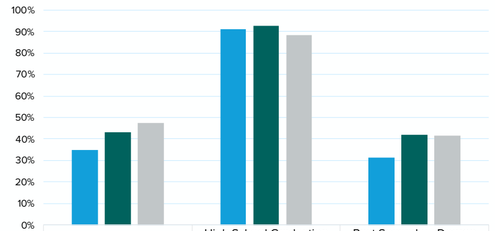
Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities.[4] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is a 90.6% high school graduation rate, which is lower than the state rate but higher than national rate. The rate of people with a post-secondary degree is 31.5%, which is lower than in both the state and nation.

Early childhood education is uniquely important and can improve the cognitive and social development of children. This helps provide the foundation for long term academic success, as well as improved health outcomes. Research on early childhood education programs show that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.[5]

In the Hospital's community, 34.9% of 3–4-year-olds were enrolled in preschool. This is lower than both the state (43.1%) and the national (47.3%) average, which leaves a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



	Preschool Enrollment Rate	High School Graduation Rate	Post Secondary Degree Rate
Hospital's Community	34.9%	90.9%	31.5%
WI	43.1%	92.6%	41.8%
US	47.3%	88.5%	41.6%

4 The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)
5 Early Childhood Education| Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC

Health Care Access and Quality

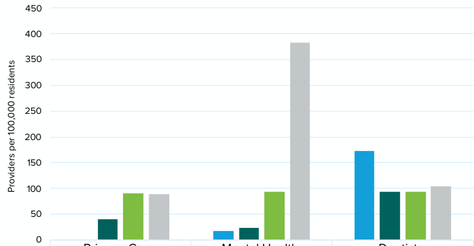
In 2020, 7.8% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.[6]

Accessing health care requires more than just insurance, there also needs to be available health care professionals to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. In Pepin County, there are less than half the number of primary care providers per 100,000 residents and fewer mental health providers compared to the state and nation.

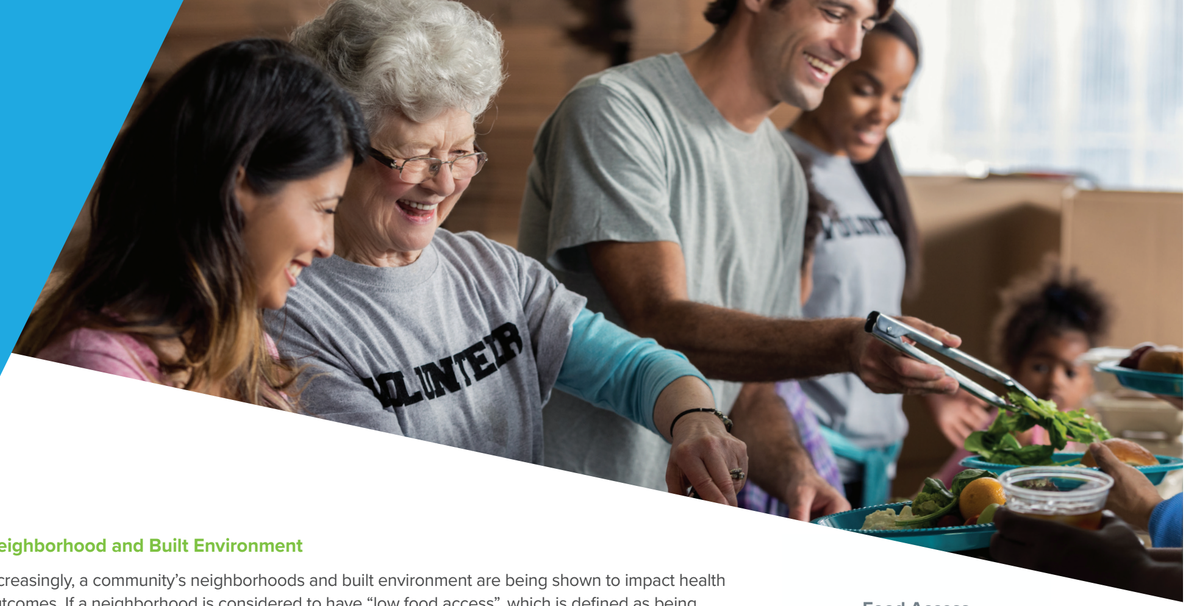
Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 75.9% of people report visiting their doctor for routine care.

6 Health Insurance and Access to Care (cdc.gov)

Providers Per Capita



	Primary Care	Mental Health	Dentists
Hospital's Community	N/A	17.9	172.9
Pepin County	40.7	24.2	94
WI	89.7	92.8	92.8
US	89.1	381.9	103.6

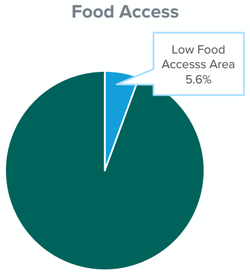


Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have "low food access", which is defined as being more than ½ mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than 1 mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.[7] In the Hospital's community, 5.6% of the community lives in a low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and maintaining employment. In the community, 5% of the households do not have an available vehicle.

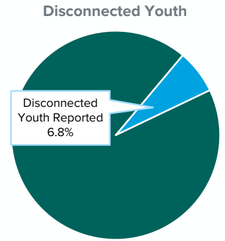


7 A Neighborhood's Built Environment May Have Numerous Effects on Its Residents' Health - RWJF

Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.[8] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers like language between groups.

In the community, 6.8% of youth aged 16-19 were reported as disconnected, which means they were neither enrolled in school nor working at the time. Also, in the community 25.2% of seniors (age 65 and older) report living alone. These factors can create barriers to feeling connected in the community.



8 Social and Community Context - Healthy People 2030 | health.gov

Process, Methods and Findings

Process and Methods

The Process

The health of people living in the same community can be very different, because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, the Hospital solicited input directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race/ethnicity, gender, profession, household income, education level and geographic location. The Hospital, aided by the AdventHealth Corporate team, also collected publicly available data and internal Hospital utilization data for review.

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form a Community Health Needs Assessment Committee (CHNAC) to guide the assessment process. During data review sessions, community members of the CHNAC provided insight on how health conditions and areas of need were impacting those they represented. The CHNAC used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2022 CHNA.

Community Input

The Hospital collected input directly from the community and from community stakeholders, individuals working in organizations addressing the needs and interests of the community. Input was collected through two different surveys: the community health survey and the stakeholder survey.

Community Health Survey

- Provided in both English and Spanish to anyone in the community and accessible through weblinks and QR codes.
- Links and QR codes shared through targeted social media posts and with community partners including public health organizations. Partners were provided links to the survey, with the request that it be sent to listservs, electronic mailing lists, they maintained and when possible shared on their own social media channels.

Stakeholder Survey

- Participants were asked to provide input on health and barriers to health that they were seeing in the community.
- Surveys were sent to individuals working at community organizations, including public health organizations, that work to improve the health and wellbeing of the community.
- A focus was on hearing from stakeholders who represent or serve communities that are underserved, underrepresented, lower income and/or who are more likely to be impacted by the social determinants of health.

Public and Community Health Experts Consulted

A total of eight stakeholders provided their expertise and knowledge regarding their community including:

Name	Organization	Services Provided	Populations Served
Katie Hartung, Registered Dietitian	AdventHealth Durand	Health care/public health	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Kathy Lee, Retired Nurse	Community Member and Volunteer (Lion's Club)	Diabetes and vision assistance	General public
Doug Peterson, CEO	AdventHealth Durand	Health care/public health	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Tali Schmitz, Administrative Director	AdventHealth Durand	Health care/public health; Mental/behavioral health care; Employment assistance; Financial support	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Marcia Bauer, Durand Area Food Pantry	Durand Area Food Pantry	Food assistance	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Angela Lindstrom, Nurse Practitioner	AdventHealth Durand	Health care/public health	Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public; Homeless
Cammi Catt-DeWyre, Manager of ADRC	Aging and Disability Resource Center	Government	Low income; Elderly; Women; Veterans; LGBTQIA+; General public; Anyone over the age of 60, adults with disabilities and their caregivers and families.
Erin Sterk, Public Health Specialist	Pepin County Health Department	Government; Public health	General public

Secondary Data

To inform the assessment process, the Hospital collected existing health related and demographic data about the community from publicly available sources and Metopio,[9] a web-based data platform. This included data on health conditions, social determinants of health and health behaviors.

The most current public data for the assessment was compiled and sourced from government and public health organizations including:

- US Census Bureau
- Centers for Disease Control and Prevention
- Feeding America
- County Health Rankings
- The State Health Department

Hospital utilization data for 2019-2021 was also used in the assessment. Data was for uninsured or self-pay patients who visited the Hospital for emergency department, inpatient or outpatient services. The top ten diagnosis codes were provided by the AdventHealth finance team for emergency room, inpatient and outpatient visits.

9 Metopio – Ridiculously easy data tools to understand places and populations.

The Findings

Throughout the assessment process there were several themes from community input that rose to the top, which were mentioned across numerous issues and health needs, including:

Access: A need for more affordable and accessible entry points of care in the community, including for primary, dental and mental health care.

Availability: A community need for more available social support services for everyone and recreational facilities for youth and seniors.

Seniors: A need for more services to support the senior population, from transportation to recreation centers.

Lifestyle: A need to increase understanding on the importance of lifestyle choices on health and health outcomes.

Economic Barriers: An increasing cost barrier to accessing care, products and services regardless of insurance and employment status.

Childcare: The rising cost of childcare and the impact on standard of living for families.

Mental Health: An awareness of increasing mental health needs in the community and the resources to support the growing need.

When reviewing the data for prioritization, the CHNAC considered the identified themes and their impact on the communities whose interests they represented.

The significant needs identified in the assessment process included:

Cancer: Cancer is a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body. Cancer can start almost anywhere in the human body, which is made up of trillions of cells. Normally, human cells grow and multiply (through a process called cell division) to form new cells as the body needs them. When cells grow old or become damaged, they die, and new cells take their place. Sometimes this orderly process breaks down, and abnormal or damaged cells grow and multiply when they shouldn't. These cells may form tumors, which are lumps of tissue. Tumors can be cancerous or not cancerous (benign).

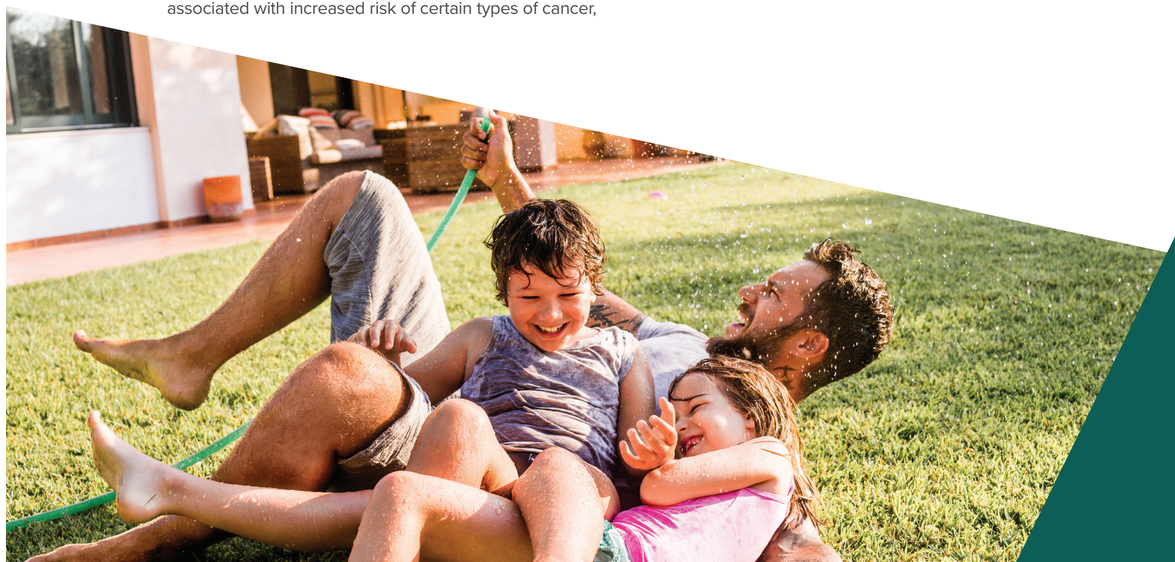
Cardiovascular Disease: Cardiovascular disease generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke. Other heart conditions, such as those that affect your heart's muscle, valves or rhythm, also are considered forms of heart disease. This includes heart disease, high cholesterol, hypertension.

Food Insecurity: Food insecurity exists when people do not have physical and economic access to sufficient safe and nutritious food that always meets their dietary needs and food preferences. Food insecurity has been linked to negative health outcomes in children and adults, as well as potentially causing trouble for children in schools.

Diabetes: Diabetes is a group of diseases characterized by high blood sugar. When a person has diabetes, the body either does not make enough insulin (type 1) or is unable to properly use insulin (type 2). When the body does not have enough insulin or cannot use it properly, blood sugar (glucose) builds up in the blood. Prediabetes is a condition in which blood sugar is higher than normal but not high enough to be classified as diabetes.

People with diabetes can develop high blood pressure, high cholesterol and high triglycerides (a type of fat in the blood). High blood sugar, particularly when combined with high blood pressure and high triglycerides, can lead to heart disease, stroke, blindness, kidney failure, amputations of the legs and feet and even early death. Diabetes is also associated with increased risk of certain types of cancer, such as liver, pancreas, uterine, colon, breast and bladder cancer. High blood sugar also increases a person's chance of developing dementia and Alzheimer's disease.

Substance Misuse – Drug: Substance use disorders can involve illicit drugs, prescription drugs or alcohol. Opioid use disorders, which stem from the improper use of prescription drugs, have become especially problematic in recent years. Substance use disorders are linked to many health problems and overdoses can lead to emergency department visits and deaths.



Nutrition & Healthy Eating: Nutrition is considered something that is taken into the body as food, influencing health, while healthy eating means eating a variety of foods that give you the nutrients you need to maintain your good health. Many people in the United States do not eat a healthy diet, which could be because some people do not have the information needed to choose healthy foods or do not have access to healthy foods or cannot afford to buy enough food. People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes and other health problems.

Preventative Care – Screenings: Prevention means intervening before health effects occur, through measures such as screenings, vaccinations, altering risky behaviors (poor eating habits, tobacco use) and banning substances known to be associated with a disease or health condition.

Obesity: Obesity is a medical condition in which excess body fat has accumulated to an extent that it may have a negative effect on health. Obesity is measured by an individual's body mass index (BMI). The prevalence of obesity continues to increase in the United States. Obesity is common, serious and costly. This epidemic is putting a strain on American families, affecting overall health, health care costs, productivity and military readiness. Moreover, obesity can have negative health outcomes since obesity can lead to type 2 diabetes, heart disease and some cancers.

Physical Health & Activity: Being physically active means movement of the body to get to and from places, for work or for leisure. Regular physical activity is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes and several cancers. It also helps prevent hypertension, maintain healthy body weight and can improve mental health, quality of life and well-being.

PRIORITIES SELECTION

Prioritization Process

The Community Health Needs Assessment Committee through data review and discussion, narrowed the health needs of the community to a list of 11. Community partners on the CHNAC represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community. During the Spring of 2022, the CHNAC met three times to review and discuss the collected data and select the top community needs.

Members of the CHNAC included:

Community Members

- Kathryn Lee, RN, Retired
- Cammi Catt-DeWyre, Director, Aging and Disability Resource Center of Buffalo and Pepin Counties, providing seniors a variety of services including counseling, transportation assistance, long term care support and a Meals on Wheels option for home bound seniors
- Marcia Bauer, Director, Durand Food Pantry, operating a food pantry for those that are homeless, low income or in need

AdventHealth Team Members

- Doug Peterson, President and CEO
- Angela Jacobson, Director of Nursing
- Angela Lindstrom, APNP
- Katie Hartung, Registered Dietitian
- Tali Schmitz, Administrative Director

Public Health Experts

- Heidi Stewart, Director, Pepin County Health Department, providing services to all community members with a focus on those that are underserved

To identify the top needs the CHNAC took part in a prioritization activity. During the activity, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community and the resources available to address it. CHNAC members then ranked the need based on the established criteria through an online survey.

The needs found in the assessment were evaluated and scored by the CHNAC and the HHNAC on a scale of 1 to 5 (1=lowest, 2=low, 3=moderate, 4=high, 5=highest) using the criteria below:

- **Alignment:** Does this issue align with our mission, strategy, public health or community goals? (15%)
- **Impact on Community:** What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now? (25%)
- **Resources:** Are there existing, effective interventions and opportunities to partner with the community to address this issue? (30%)
- **Outcome Opportunities:** Can an impact on this issue be made in a demonstrable way and will interventions have an impact on other health and social issues in the community? (30%)

The following needs rose to the top during the CHNAC's discussion and prioritization activity:

Topic Averages	Alignment (15%)	Impact on Community (25%)	Resources (30%)	Outcome Opportunities (30%)	Total Ranking
Nutrition and Healthy Eating	3.33	3.50	4.33	4.50	4.03
Physical Health	3.83	4.33	3.67	4.00	3.96
Obesity	3.83	4.33	4.00	3.50	3.91
Diabetes	3.33	3.67	4.33	3.83	3.87
Food Insecurity	3.17	3.50	4.33	3.83	3.80
Preventative Care – Screenings	3.83	3.17	4.50	3.33	3.72
Cardiovascular Disease: Heart Disease	3.50	3.00	4.33	3.50	3.63
Cardiovascular Disease: High Cholesterol	3.33	3.33	4.17	3.33	3.58
Cardiovascular Disease: Hypertension	3.33	3.17	3.83	3.67	3.54
Cancer	3.00	3.00	3.67	3.50	3.35
Drug Misuse	3.33	4.17	3.00	3.00	3.34

After a list of 11 of the top health needs of the community had been selected by the CHNAC, a Hospital Health Needs Assessment Committee (HHNAC) met to review the top needs that had been chosen. The HHNAC reviewed and discussed the needs that had been identified by the CHNAC and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies which could most effectively address the needs having the biggest short term and long-term impacts on the community. Through these discussions the Hospital selected the needs it is best positioned to impact.

Members of the HHNAC included:

- Doug Peterson, President and CEO
- Tali Schmitz, Administrative Director, Human Resources
- Angela Jacobson, Director, Nursing
- Katie Hartung, Dietitian and Diabetes Educator
- Angela Lindstrom, Nurse Practitioner
- Kathryn Lee, Community Member
- Heidi Stewart, Director, Pepin County Health Department

The HHNAC narrowed down the list to three priority needs:

- **Nutrition and Healthy Eating**
- **Physical Health**
- **Diabetes**

Available Community Resources

When evaluating the top issues in the community a review of the available organizations and resources addressing these issues was conducted to understand where the greatest impact could be made.

Top Issues	Current Community Programs
Nutrition and Healthy Eating	• Starting Out Strong, The Dad Thing and Family Living education programs offered by University of Wisconsin-Madison Pepin County Extension • Women, Infant and Children (WIC) in Ellsworth • AdventHealth Durand: Free Dietitian consultations for community members with provider referral
Physical Health	• Open Gym and Fitness Center at Durand High School open weekday morning for free to all community members.
Obesity	• TOPS and Weight Watchers group meetings held several times a month a various times and there is open access to the gym/fitness center at the Durand High School M-F mornings & evenings. There is also one fitness center in town that does weight loss challenges quarterly. • AdventHealth Durand: Free Dietitian consultations for community members with provider referral
Diabetes	• AdventHealth Durand: Free Dietitian consultations for community members with provider referral
Food Insecurity	• Durand Area Food Pantry • Mondovi Central Lutheran Church • Faith Lutheran Church in Durand • Aging and Disability Resource Center of Buffalo and Pepin Counties

Top Issues	Current Community Programs
Preventative Care – Screenings	• Pepin County Health Department • Planned Parenthood of Wisconsin in Madison • Wisconsin Well Woman Program offered by Wisconsin Department of Health Services
Cardiovascular Disease: Heart Disease	• Mayo Clinic Health System Eau Claire cardiology team has clinic in Durand at AH Durand weekly. • AdventHealth Durand: Free Dietitian consultations for community members with provider referral
Cardiovascular Disease: High Cholesterol	• Mayo Clinic Health System Eau Claire cardiology team has clinic in Durand at AH Durand weekly • AdventHealth Durand: Free Dietitian consultations for community members with provider referral
Cardiovascular Disease: Hypertension	• Mayo Clinic Health System Eau Claire cardiology team has clinic in Durand at AH Durand weekly • AdventHealth Durand: Free Dietitian consultations for community members with provider referral
Drug Misuse	• Western Region Recovery and Wellness Consortium • Arbor Place, Inc. • LE Phillips Libertas Treatment Center

Priorities Addressed

Nutrition and Healthy Eating

According to community survey respondents, 38.3% eat fruits and vegetables less than two days a week. Secondary data shows 5.6% of residents in the Hospital's community live in a low food access area and almost 12% are food insecure. Nutrition is known to be a critical influencer of health. Healthier eating improves maternal health and health at every stage of life. It builds stronger immune systems, lowers the risk of chronic diseases like diabetes and cardiovascular disease, while increasing longevity.

By addressing nutrition and healthy eating, the Hospital hopes to improve the overall health of the community. This will impact multiple health conditions identified in the assessment process, as well as food security challenges, by increasing the community's ability to access and incorporate a more balanced diet.

Physical Health and Activity

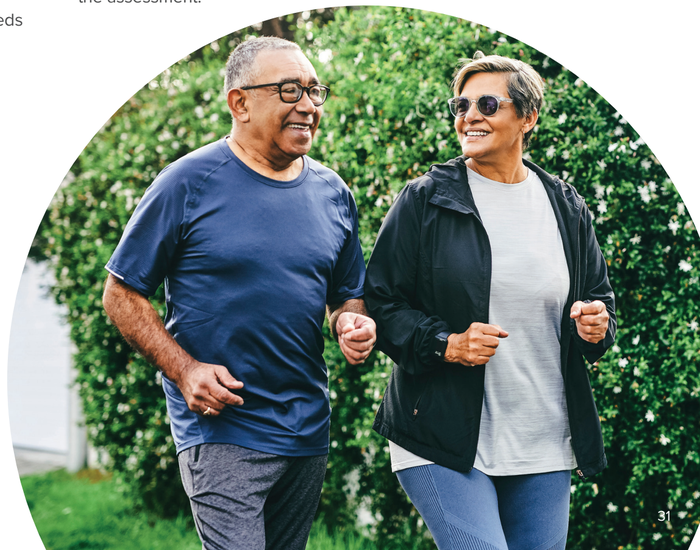
In the Hospital's community, 35.6% of residents report not engaging in physical activities outside of their jobs according to secondary data. The community also has a higher percentage, 12.7%, than both the state and the nation of residents who report 14 or more days in the last 30 during which their physical health was not good. Community members in the assessment cited a need for more low-cost fitness centers and accessible community spaces for recreation particularly in the winter months for families and seniors.

By addressing physical heath and activity, the Hospital hopes to improve the overall health of the community. Physical health and lifestyle choices can affect all aspects of an individual's life particularly those impacted by chronic diseases. Through this priority the Hospital hopes to indirectly impact several of the needs found in the assessment

Diabetes

Diabetes is shown to impact 9.5% of residents in the Hospital's community according to public data, while 9.2% of community survey respondents report having diabetes. Diabetes related conditions are also shown to be one of the top ten codes in Hospital visits by uninsured patients and diabetes is one of the top health priorities identified by community stakeholders.

The Hospital will align with national best practices, like the Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program, and local community organizations for a collaborative approach to address the priority. Through this priority the Hospital hopes to indirectly impact several of the needs found in the assessment.



Priorities Not Addressed

The priorities not addressed include:

Obesity

More than 51% of residents in the Hospital's community have been told they are obese according to public data. While one fifth of community stakeholders consider obesity a top health risk factor in the community, citing the health complications from obesity as a concern. The Hospital did not select obesity as a priority, as it is not positioned to directly address this in the community at large. The Hospital did choose nutrition and healthy eating and physical health and activity however and hopes to have an indirect impact on obesity through these efforts.

Food Insecurity

More than 11% of the residents in the Hospital's community are food insecure according to Feeding America and 5.7% live in a low food access area. According to community survey respondents, 11.8% received SNAP benefits last year, while secondary data shows 59% of households in poverty did not receive SNAP benefits in the last year. The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able. The Hospital hopes to informally address this need through the nutrition and healthy eating priority.

Preventative Care and Screenings

According to community survey respondents, 30.5% are not aware of what preventative screenings are needed. Among those that are aware, 28.3% report not getting regular screenings. Public data shows that 75.9% of community members are up to date on routine checkups. Preventative care has been shown to reduce the risk of disease, disabilities and death. Preventative care also improves health outcomes, quality of life and can decrease an individual's cost of care over time through early detection. The Hospital did not select preventative care and screenings as a priority due to a lack of resources. However, the Hospital did select diabetes as a priority and may use preventative care strategies in addressing it.

Cancer

In the Hospital's community 8.3% of the residents have had cancer according to secondary data, higher than both state and national rates. There is also a higher mortality rate per 100,000 than both state and the nation for breast cancer and lung, trachea and bronchus cancer in Pepin County. The Hospital did not choose cancer as a priority, instead focusing its efforts and resources on nutrition and healthy eating and physical health and activity, where there is an opportunity to indirectly impact several of the needs identified in the assessment, including cancer.

Drug Misuse

According to the Hospital's community survey, more than a third of respondents believe that people in the community are addicted to prescription or street drugs. Community feedback included a need for an expansion of substance abuse/rehabilitation programs, more drug education programs in schools and better communication and education on the dangers of prescription drugs. Although there is a lack of resources in the area for substance and drug misuse, the Hospital did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available to the community and the Hospital at this time.

Cardiovascular Diseases: Hypertension, Heart Disease, High Cholesterol

According to secondary data, individuals in Pepin County have similar or higher rates of coronary heart disease and of heart disease mortality per 100,00 than elsewhere in Wisconsin and the nation. More than 30% of community survey respondents report having hypertension, which can be a major contributing factor to heart disease and hypertension is shown to be one of the top ten codes in Hospital visits by uninsured patients. Also, 1/3 of individuals living in the community have been told they have high cholesterol which can be a contributing factor to heart disease as well.

The Hospital did not select cardiovascular diseases as a priority, as it is not positioned to directly address this in the community at large, outside of existing community education. The Hospital did choose nutrition and healthy eating however knowing that how an individual eats is an integral step in treating cardiovascular diseases and hopes to have an indirect impact through these efforts. The Hospital also selected physical health and activity which will provide opportunities for lifestyle changes, an important step in addressing all chronic conditions.

COMMUNITY HEALTH PLAN

Next Steps

The Hospital will work with the CHNAC and other community partners to develop a measurable Community Health Plan for 2023-2025 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly with an annual assessment of progress. A presentation of progress on the plan will also be presented to the hospital board annually.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2023.

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2020 Community Health Plan Review

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan. The full evaluation is available upon request.

Priority 1: Chronic Disease Management

The Hospital chose chronic disease management as a priority in the 2020 community health plan due to the chronic disease health indicators found. For example, more than one third of the residents in the Hospital's community were found to have high cholesterol (35.3%) and almost one third were found to have high blood pressure. Chronic diseases are the leading cause of death and disability in the US.

Since adopting the plan, the Hospital has focused its efforts on increasing education through the Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program. The program provides chronic disease education related to diabetes, hypertension, nutrition, etc. for members of the community. The Hospital began classes in June of 2022, after a delay due to the pandemic. To support the community and the needs identified in the assessment during the pandemic and still adhere to public health and safety guidance, the Hospital's registered dietitian and certified diabetes educator, provided 589 free one-on-one hourly sessions.

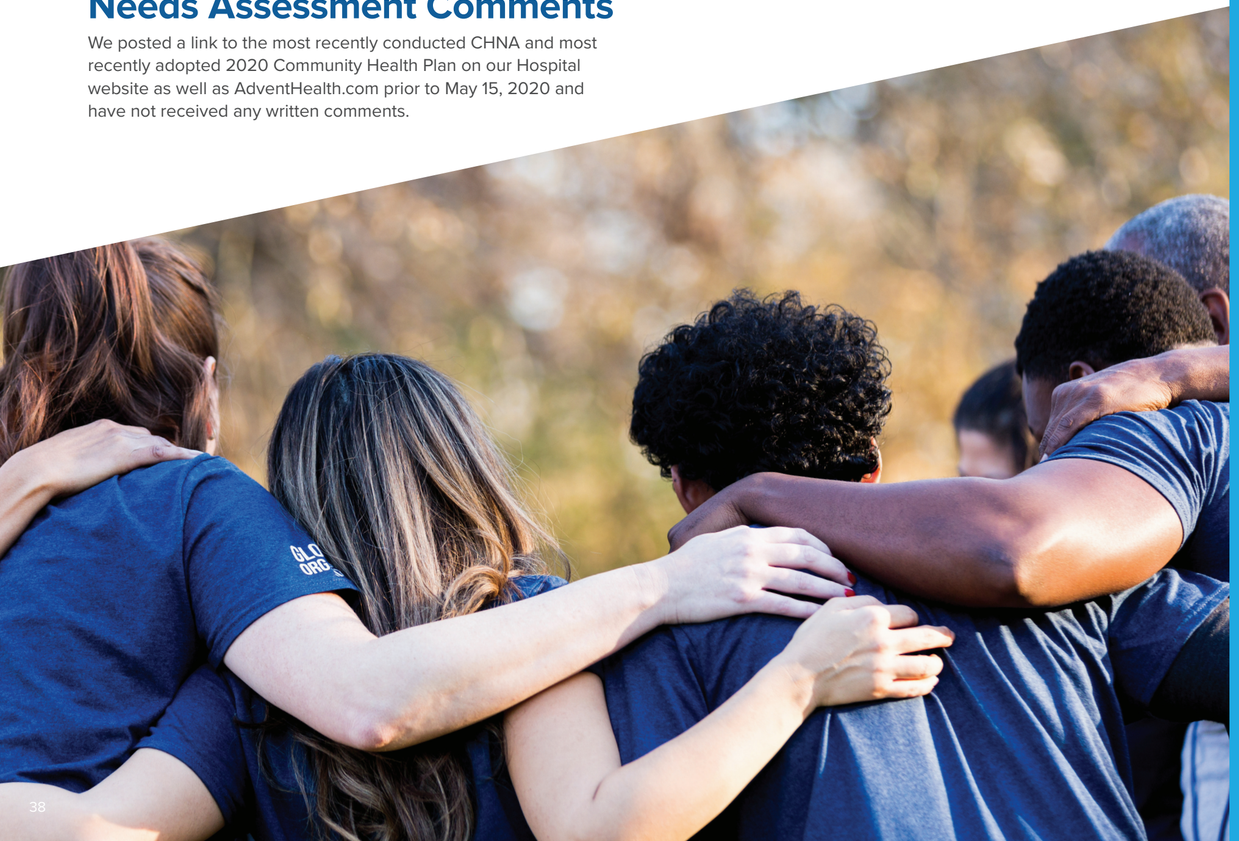
Priority 2: Healthy Growth, Development and Obesity

The Hospital addressed healthy growth, development and obesity as a priority in the 2020 community health plan. During the assessment, obesity was ranked as one of the top two risk factors by community stakeholders and in the state of Wisconsin there was a five percent increase in the rate of obesity in adults to 31% between 2008 and 2018. Secondary data also showed that 20% of adults in the hospital's community receive no leisure time physical activity.

As part of their efforts to address the need in the community, the Hospital has provided free events and education to promote activity, exercise and healthy lifestyle. This includes annual fun runs and run and bike events open to all community members. This has led to more than 150 community members participating with proceeds benefiting the Durand Municipal Ambulance Service and the Durand Food Pantry.

2019 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and most recently adopted 2020 Community Health Plan on our Hospital website as well as AdventHealth.com prior to May 15, 2020 and have not received any written comments.



AdventHealth

Chippewa Valley Hospital and Oakview Care Center, Inc. d/b/a AdventHealth Durand CHNA

Approved by the Hospital Board on: October 26, 2022

For questions or comments please contact:
CORP.CommunityBenefitSupport@AdventHealth.com

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