HealthPartners®

Westfields Hospital & Clinic

Community Health Needs Assessment

November 2018

Prepared by:

The Improve Group

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About HealthPartners

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

Mission, Vision and Values

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

Mission

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

Vision

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

Values

Excellence, compassion, partnership, integrity

Executive Summary

Westfields Hospital & Clinic is part of HealthPartners, the largest consumer-governed, non-profit health care organization in the nation with a mission to improve health and well-being in partnership with members, patients and the community. Westfields Hospital & Clinic serves western Wisconsin with primary, acute, emergency and outpatient health care services. This report describes the current Community Health Needs Assessment (CHNA) process and results for Westfields Hospital & Clinic.

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

This assessment meets all the federal requirements of the Patient Protection and Affordable Care Act (ACA) and the Internal Revenue Service final regulations. It was approved by Westfields Hospital & Clinic Board on November 15, 2018. In accordance with federal requirements, this report is made widely available to the public on our website at www.westfieldshospital.com/health-wellness-programs/programs/healthier-together/.

Community Served

Westfields Hospital & Clinic is located in the city of New Richmond in St. Croix County, Wisconsin. In total, our community has approximately 87,000 residents. With a population of about 14,000, Hudson is the largest city in the county. While we serve patients from everywhere, 80 percent of the people we serve live in St. Croix County. In 2017, Westfields Hospital & Clinic reported 939 inpatient admissions from patients living in St. Croix County.

Methodology

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

Prioritized Needs

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

HealthPartners collectively prioritized community health needs using a process informed by the Hanlon method and other commonly used prioritization methods. Each hospital shared its 4-5 priority topic areas and rationale for each topic area based on: *size, seriousness, equity, value and change*. HealthPartners hospitals worked in a thorough, facilitated large and small group process to reach consensus on top priorities using both

the criteria described above and community input data. The five priorities are of equal importance and are presented in alphabetical order. The five priority areas and priority area definitions are:

Access to care

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

Access to health

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

Mental health and well-being

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

Nutrition and physical activity

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

Substance abuse

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

Next Steps

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

About the Community Health Needs Assessment (CHNA) process

Background and goals

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

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

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

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

Methodology

HealthPartners collaborated across these six hospitals for the CHNA:

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

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

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

Core health data indicators

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

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

Additional data sources include:

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

This report also includes additional data sources provided by HealthPartners, including:

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

Community input data

As part of the CHNA process, HealthPartners and Westfields Hospital & Clinic partnered to conduct community input activities to understand top health priorities.

The community input for in this report includes:

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

Healthier Together Pierce & St. Croix Counties Community Health Survey: In 2015 and 2018, Healthier Together sought community input from a residential survey and community dialogues. The survey measured perceptions residents have of community strengths, leading health concerns and access to resources. In 2015,

1,363 participants responded to the survey (548 from Pierce County and 815 from St. Croix County). In 2018, 1,072 participants responded to the survey (368 from Pierce County and 704 from St. Croix County).

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

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

HealthPartners approach to equity

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

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

CHNA prioritization process

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

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

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

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

Access to care

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

Access to health

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

Mental health and well-being

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

Nutrition and physical activity

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

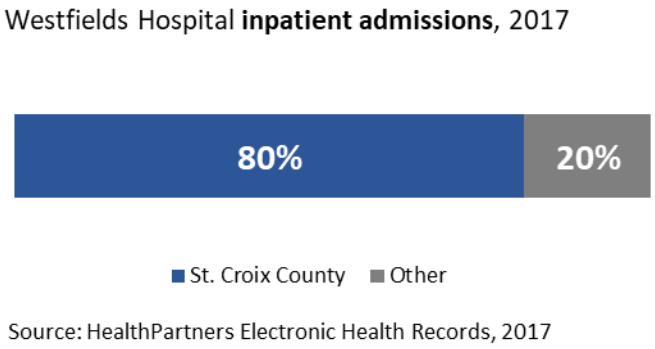
Substance abuse

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

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

About the community we serve

People served

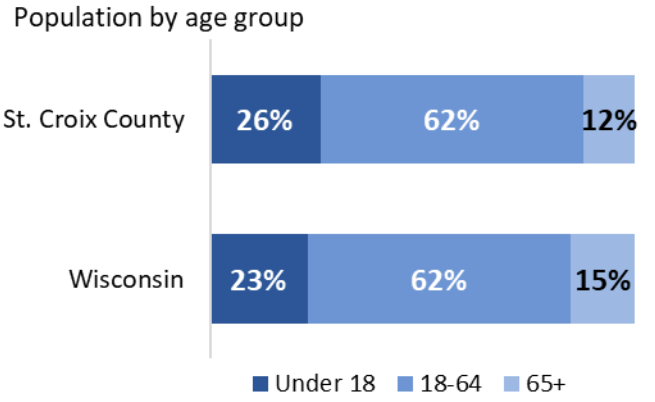


Source: HealthPartners Electronic Health Records, 2017

While we serve patients from everywhere, 80 percent of the people we serve live in St. Croix County. Throughout this report, we refer to St. Croix County as "our community" and primarily use data from this county.

In total, our community has approximately 87,000 residents. In 2017, Westfields Hospital reported 939 inpatient admissions from patients living in St. Croix County.

Population age



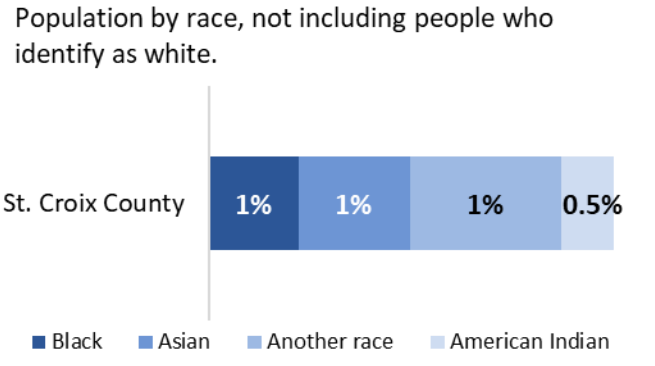
Source: US Census Bureau, American Community Survey, 2012-16

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

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

However, St. Croix County is an aging community, with the number of adults over age 65 expected to increase significantly over the next decade. Our implementation plan will address this demographic change.

Race and ethnicity



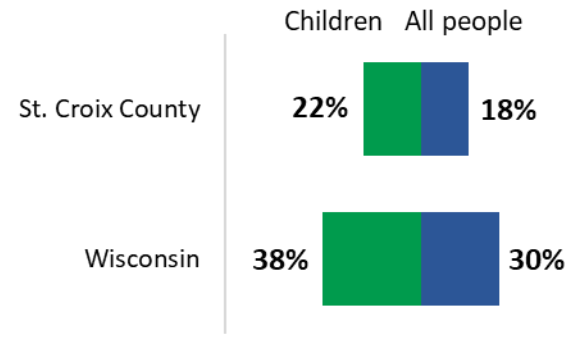
Source: US Census Bureau, American Community Survey, 2012-16

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

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

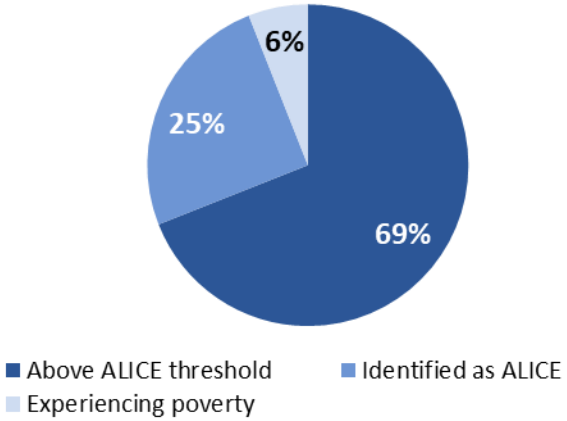
Poverty and economic constraints

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



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

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



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

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

One in 5 people in St. Croix County is currently living in a low income household. Poverty rates for children are similar to those of the general population.

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

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

Education status

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

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

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

In our community, more than 9 in 10 students graduate from high school in four years. About 4 percent of adults over 25 do not have a high school diploma and 33 percent of St. Croix County adults have a bachelor's degree or higher.

Priorities and definitions

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

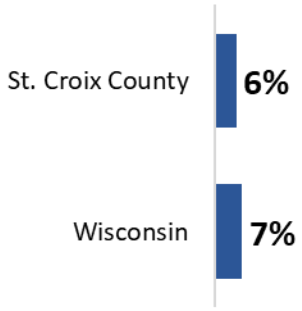
Priority: Access to care

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

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

Health insurance access and cost

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



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

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

– Community survey respondent

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

– Provider survey respondent

When people cannot afford to pay for insurance or other health care costs, they are less likely to get the care they need.

According to the American Community Survey, 6 percent of St. Croix County residents do not have health insurance.

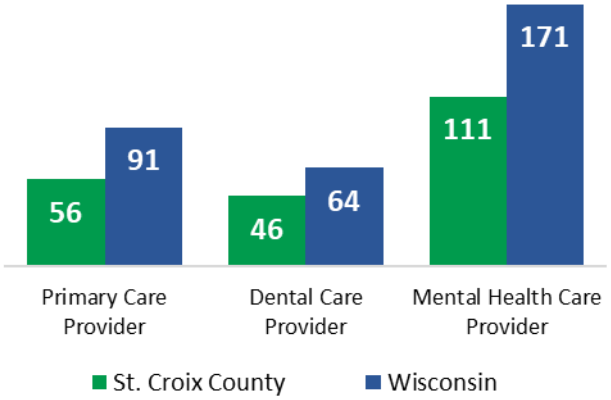
Health insurance coverage shows racial and economic disparities. According to the Wisconsin Department of Health's Family Health Survey, low income families are 3 times more likely to be uninsured than wealthier households. Latino and American Indian families are 3 to 4 times more likely to be uninsured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

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

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

Availability of care

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



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

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

– Community survey respondent

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

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

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

Patients may also face barriers when scheduling appointments and communicating with providers. These barriers are especially significant for community members who do not speak English as a primary language. Approximately 4 percent of people in our community over age 5 speak a language other than English.

Transportation barriers

"[In our area], getting to appointments [is difficult]. There are so many who do not drive or do and shouldn't. This isolates them, precipitates worse health … etc."

– Provider survey respondent

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

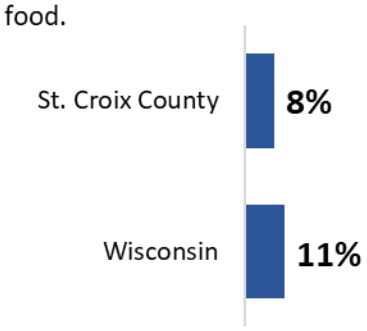
Priority: Access to health

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

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

Food insecurity

Percentage of adults reporting **food insecurity,** or a lack of consistent access to healthy and adequate food.



Source: Feeding America, 2016

"Better distribution of access to healthy foods for all people in the county [is needed]."

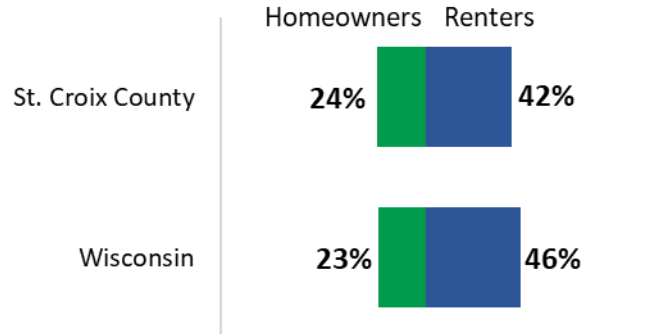
- Community survey respondent

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

Eight percent of community members said they are food insecure, and 15 percent of community survey respondents said ability to get healthy foods was one of the three most important health concerns in their county.

Housing cost burden

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



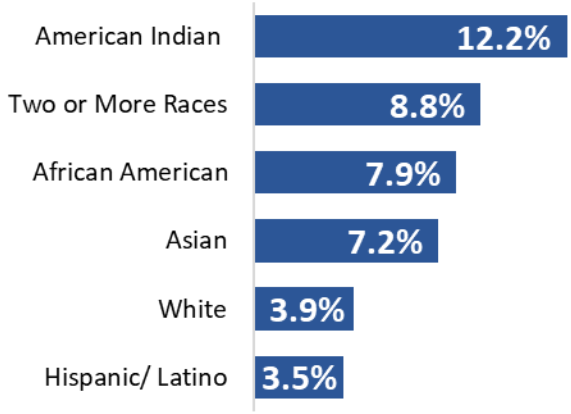
Source: US Census Bureau, American Community Survey, 2012-16

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

According to the American Community Survey, 24 percent of homeowners and 42 percent of renters in our community are housing cost burdened. These numbers are both similar to state averages.

Unemployment

Unemployment rates by race for St. Croix County, estimated.



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

The unemployment rate in our community is approximately 4 percent, which is on par with the average rate in Wisconsin in 2018. However, significant unemployment disparities exist by race.

While current county-level unemployment rates by race are not available, data from the American Community Survey is useful for identifying employment disparities. According to this data, unemployment rates among American Indians in our community is more than 3 times higher than among the community overall. People who identify as two or more races, as black, or as Asian are unemployed at approximately twice the rate as people who identify as white.

Priority: Mental health and well-being

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

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

Adult mental health

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

Source: Behavioral Risk Factor Surveillance System, 2016

Residents in St. Croix County report feeling down, depressed or hopeless 3.2 days over the past 30 days, more than 10 percent of the time.

HealthPartners health care providers routinely screen patients for depression. According to 2017 EHR data, 5 percent of patients from our community were experiencing mental health symptoms consistent with depression.

Death by suicide is significant concern for our community. According to the Wisconsin Department of Health Services, 10 St. Croix County adults died by suicide in 2016. According to the CDC, death by suicide has increased 25 percent in Wisconsin since 1999. Although suicide can affect all people, men who are white and age 45 to 54 are one of the most affected groups in the state of Wisconsin.

While many residents identified community

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

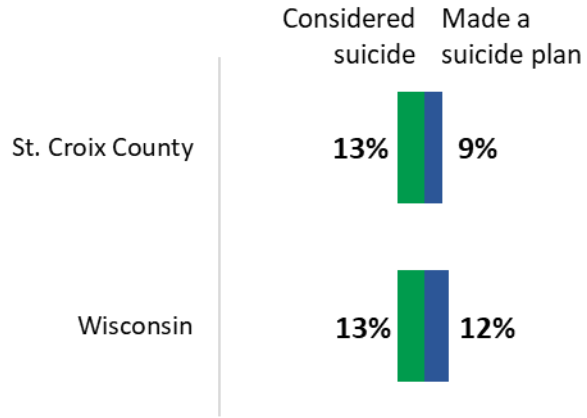
- Community survey respondent

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

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

Youth mental health

Percentage of youth **experiencing suicidal thoughts** over the past year.



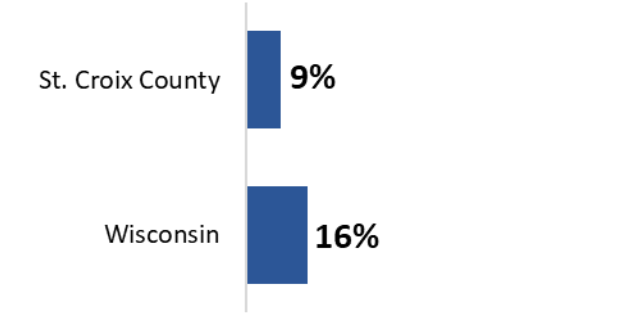
Source: Youth Risk Behavior Survey, 2013

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

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

Contributors to poor mental health: social isolation

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



Source: Behavioral Risk Factor Surveillance System, 2006-2012

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

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

Contributors to poor mental health: stigma

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

- Community survey respondent

The stigma associated with having a mental illness can also negatively affect mental health. Reducing stigma related to mental health was a leading theme that emerged from the community. According to the IMPACT Survey, only 65 percent of adults in St. Croix County are comfortable talking with others about their mental illness.

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

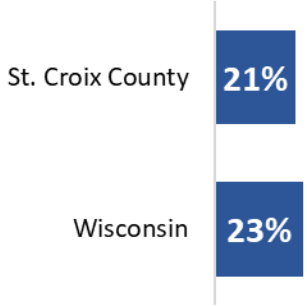
Priority: Nutrition and physical activity

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

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

Fruit and vegetable consumption

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



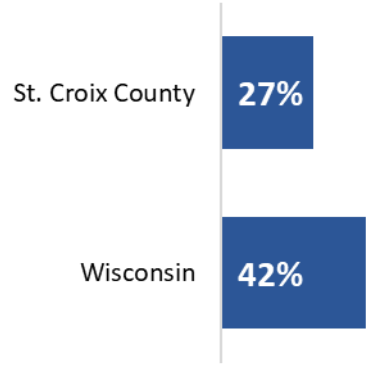
Source: Behavioral Risk Factor Surveillance System, 2005-09

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

In St. Croix County, only 1 in 5 adults eats the recommended 5 servings of fruits and vegetables per day. According to the 2017 Youth Risk Behavior Survey, only 30 percent of Wisconsin youth report eating 2 or more servings of fruit per day, and only 14 percent report eating vegetables 3 or more times per day.

Access to healthy food

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



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

"There is no place in Hammond to buy the healthy food and Baldwin is just expensive."

- Community survey respondent

Several community survey respondents indicated accessing affordable, healthy food was an important issue in St. Croix County.

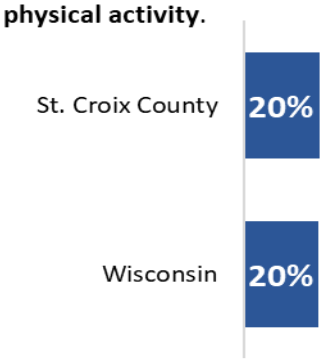
According to the U.S. Department of Agriculture (USDA), 27 percent of residents live in neighborhoods considered food deserts. A neighborhood is considered a food desert if 33 percent of the population lives more than one mile from a supermarket or large grocery store (10 miles for rural communities).

Even when healthy food is available locally, it may not be affordable. Six percent of residents receive SNAP benefits, and only 51 retailers accept SNAP in the county.

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

Adult physical activity

Percentage of adults reporting **no leisure time physical activity**.

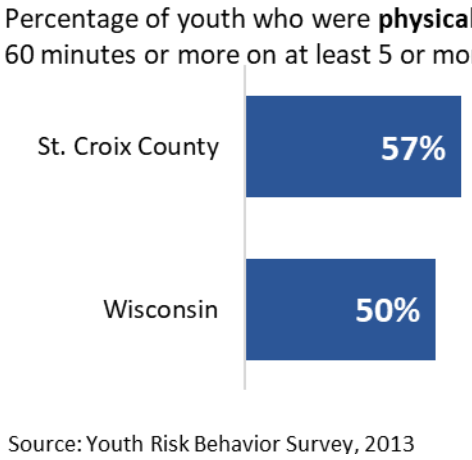


Source: Centers for Disease Control and Prevention, 2013

Physical activity is defined as exercise and other activities that involve bodily movement. Physical activity includes playing, working, active transportation, household chores and recreational activities.

The current recommendation for adults is 150 minutes of moderate activity a week. While many Wisconsin residents are getting at least some physical activity, almost 1 in 5 St. Croix County residents report getting no leisure time physical activity, which is consistent with the state average.

Youth physical activity



Source: Youth Risk Behavior Survey, 2013

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

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

Access to activity opportunities

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

- Community survey respondent

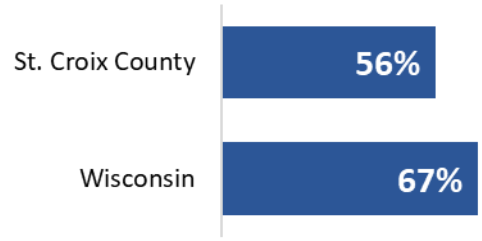
St. Croix County has a higher number of recreation or fitness facilities per resident than the state average, with 16 recreation and fitness facilities in the area. However, community members still do not feel there are adequate opportunities to be physically active in their community.

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

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

Unhealthy weight

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



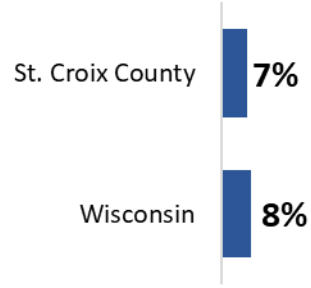
Source: Behavioral Risk Factor Surveillance System, 2011-12

Being overweight or obese puts people at higher risk for heart disease, diabetes and other chronic conditions. According to self-reported height and weight, over half of adults in our community are overweight or obese. HealthPartners patient data shows similar rates.

While St. Croix County has lower rates than the state average, both community survey respondents and providers identified obesity as a top concern for the community.

Chronic disease

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



Source: Behavioral Risk Factor Surveillance System, 2006-12

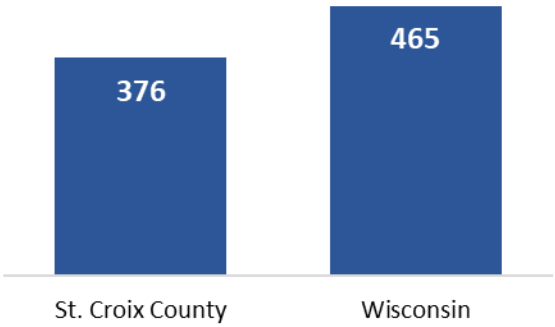
Several chronic diseases are associated with poor nutrition and lack of physical activity.

Almost 7 percent of adults over age 20 have been told by a health care provider that they have diabetes.

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

Cancer rates

Cancer rates per 100,000 people, all cancers combined.



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

According to the Wisconsin Department of Health Services, from 2009 to 2013, more than 11,286 Wisconsin residents died of cancer. The incidence of all cancers in our community are lower than the Wisconsin rate overall. In St. Croix County it is estimated that 376 people out of every 100,000 will have a cancer diagnosis of any kind.

Breast and prostate cancers have the highest incidence of any cancer type among women and men. The breast cancer rate in St. Croix County is 104 cases per 100,000 people. The prostate cancer rate in St. Croix County is 84 cases per 100,000 people. The rates for both types of cancer are lower than statewide incidence rates.

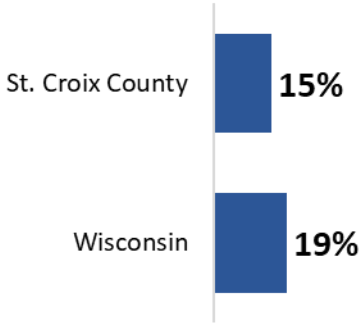
Priority: Substance abuse

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

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

Tobacco use

Percentage of adults who **currently smoke cigarettes**.



Source: Behavioral Risk Factor Surveillance System, 2006-12

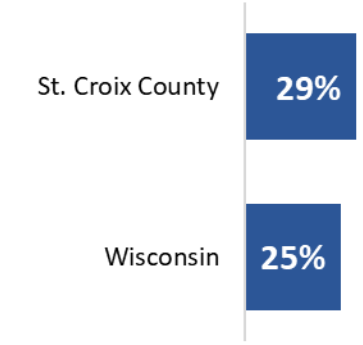
Tobacco use is associated with many chronic diseases and health conditions including respiratory disease, heart disease and cancer.

The adult smoking rate in St. Croix County is lower than in Wisconsin overall: 15 percent compared to 19 percent.

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

Adult alcohol use

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



Source: Behavioral Risk Factor Surveillance System, 2006-12

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

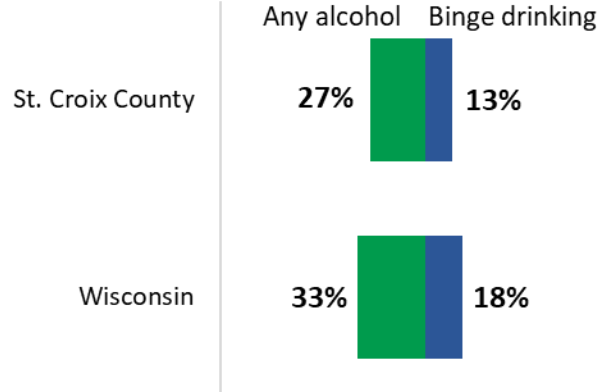
- Community survey respondent

Excessive drinking is defined as two or more drinks per day for men and one or more drinks per day for women. In St. Croix County, 29 percent of adults report drinking excessively in a month compared to 25 percent across Wisconsin.

Alcohol abuse and excessive drinking was identified by community members as a top health concern during the Healthier Together community dialogues and on the Community Health Survey.

Youth alcohol use

Percentage of youth **using alcohol** in the last 30 days.



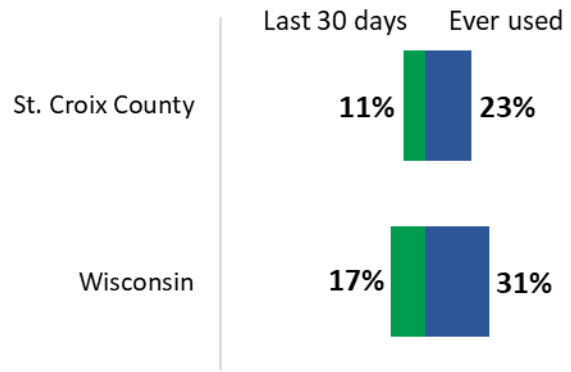
Source: Youth Risk Behavior Survey, 2013

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

In St. Croix County, 27 percent of youth reported any alcohol use and 13 percent reported binge drinking in the last month. These rates are lower than the state average.

Illicit drug use including prescription drug use

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



Source: Youth Risk Behavior Survey, 2013

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

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

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

Evaluation of Impact, 2016-2018 CHNA Implementation Strategy

This section was added to the CHNA report on December 19, 2019.

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

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

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

Priority 1: MENTAL AND BEHAVIORAL HEALTH

Goal	Strategies and Activities	Progress and Key Results		
		2016	2017	2018
Reduce stigma surrounding mental illnesses	Implement Make It OK anti-stigma campaign	More than 500 people have been trained Make it OK Ambassadors in the St. Croix Valley. Ambassadors have reached 5,483 in St. Croix Valley through presentations, events and community outreach.		
	Integrate Make It OK into employee wellness programs for hospital and clinic	Make It OK campaign was included in employee communications, and Ambassador trainings and Make It OK presentations were offered for staff throughout the care system and in the community on an ongoing basis.		
	Support efforts to raise stigma awareness including participating in annual NAMI walk	Participation in the annual NAMI walk continues, with approximately 300 HealthPartners employees participating in 2018.		
Improve access to mental health services	Update and distribute the Mental Health Guide Pierce & St. Croix Counties	The mental health guide continues to be updated for Pierce and St. Croix Counties. The guide was last updated in June of 2019, and includes over 30 resources for mental health services.		
	Develop strategies to improve patient and community connection to mental and behavioral health care including seeking funding for a navigation model	In 2016, the development of Emergency Department behavioral health services began. As of 2016, a primary integrated therapist is based at Stillwater Medical Group, and a 2nd therapist was added in 2018. In 2016, program development role starts, which turned into an overview of a		

		service line by 2018. In 2018, a new valley level leadership position was created for behavioral health. Progress results for program development in 2016 and 2017 include expanding Programs for Change (2016) to Westfields (all WI Hospitals).
	Develop partnerships and models to embed behavioral health in primary care	Evaluation continues in partnership with Amery Regional Medical Center and Regions.
	Evaluate and develop inpatient treatment capacity for behavioral health care in the St. Croix Valley area	The evaluation and discussion on inpatient treatment capacity is ongoing throughout the St. Croix Valley Area.
	Improve processes for behavioral health patients in emergency department and outpatient clinics.	A Mental Health Therapist is embedded in clinics to improve patient access. Televideo Crisis Stabilization process has been developed. Emergency Department staff received additional training on mental health crisis situations. Upgrades to Emergency Department patient rooms to create a safe environment for individuals experiencing a mental health crisis.
	Represents one of six hospitals that comprise the Valley Co-op Behavioral Health Team	Hudson Hospital continues to have representation on the Valley Co-op Behavioral Health Team.
Increase education around mental and behavioral health	Offer and promote ongoing community education classes including classes on stigma, depression and various other mental health issues	Make It OK ambassador trainings continue to be offered. Mental Health First Aid is also being offered at various locations throughout western Wisconsin. About 261 adults have been trained in Mental Health First Aid, along with over 500 Make It OK Ambassadors trained in the St. Croix Valley. Through the Make It Ok campaign, thousands have been reached via the ambassador team, community outreach and events.
	Support and offer staff education on mental and behavioral health issues including mental health crisis training for Hospital and Emergency Department staff	Staff education includes, but is not limited to, restraint and de-escalation training (Work Place Violence). Trainings for mental health crises occur when a need arises.
	Offer "Beating the Blues" online program for both patients and employees to learn ways to better manage mood, stress and anxiety	Westfields Hospital continues to promote and offer the free "Beating the Blues" online program for members, patients and employees.
	Participate in Success by 6 Coalition	Internal resources are aligned with Success by 6 coalition work. Westfields adopted the Reach Out and Read program and has a healthy beginnings counselor meet with at risk, expectant moms.
Reduce risky and unhealthy alcohol and drug use	Participate in Pierce - St. Croix CARES Coalition to create a responsive and effective system for promoting and protecting our children's wellbeing	CARES continues to provide resources for the Healthier Together Mental Health task force as needed. CARES continues to work with the Healthier Together mental health task force in schools.

	Participate in Substance Abuse, Withdrawal and Detox Training	Reduced the number of opioid pills through changes in prescribing practices over the course of three years. There has also been a reduction in chronic prescribing of opioids.
	Actively participate in ongoing discussions and exploration of changing alcohol abuse through public policy	The Alcohol Abuse action team through Healthier Together continues exploring policy and ordinances in the community, and recently assessed Hudson's readiness for change. 12 key community stakeholders interviewed by Healthier Together's alcohol action team, to determine the Hudson Community's readiness for change regarding youth alcohol consumption. Next steps will involve implementation planning.
	Train staff on prescription drug abuse, diversion and chemical health.	Changes in prescribing practices reduce the number of opioid pills with reductions being achieved over time. All Valley hospital sites now have prescription medication collection stations.
Reduce the use and exposure of tobacco among youth and adults	Offer tobacco cessation education to patients and the community Tobacco cessation classes are promoted across the Valley for patients and the community. Tobacco cessation resources are offered at all Valley hospitals	
	Participate in the Tobacco Free Living Coalition	The Tobacco Free Living Coalition continues working on tobacco free activities for the western region and 6 counties. They conduct compliance checks (WINS) in the region along with leading quarterly coalition meetings
Enhance suicide prevention efforts	Participate in Suicide Prevention Coalition	St. Croix County Public Health continues to operate. Many of its initial goals have been met.

Priority #2: ACCESS AND AFFORDABILITY

Goal	Strategies/Activities	Progress and Key Results		
		2016	2017	2018
Improve connection health care and community resources	Compile local community resources and share with staff, partners and patients via multiple methods including web and staff training	A complete resource guide was not recommended by the community advisor and was duplicative to work being done by public health partners. Staff training and resources are provided on a topic-specific basis and through employee communications.		
	Continue to support employee wellness through Be Well in the Valley collaboration	Employee wellness programs are aligned with key health priorities identified by employee health assessments and claims data. Employee communications have engaged more employees in health activities. Employee health champions have been identified, trained and mobilized. This includes two annual trainings for wellness champions. Leadership has committed to wellness moments during meetings and healthier food offerings at the hospital.		
Increase access and affordability of primary and preventative healthcare	Continue Wal-Mart Health Station	Westfields Hospital continues to operate the Wal-Mart health station, which accepts all major insurance plans for persons 18 months and older.		
	Continue Total Cost of Care Task Force efforts to reduce the total cost of care for patients served by the hospital	This task force continues to meet to try and reduce the total cost of care		
	Provide van service transportation for patients	Westfields Hospital continues to offer van transportation services by appointment. $1 for transport within 10 miles, and $3 outside of a 10 mile radius.		
	Continue Scholarship Program to help increase the number of qualified providers in the community. Two scholarship awards are offered to graduating high school seniors	The scholarship program continues to be offered, granting two scholarships each year to individuals entering a healthcare program.		

	Assist patients with accessing affordable medication and medication monitoring by operating the Retail Pharmacy and continuing the Community Care Program (resource assistance)	Pharmacy services include online refills using Quick Refill, or through the myHP app for IOS and Android, transfer of existing prescriptions, RxCheckup, a one-on-one visit with a pharmacist in the primary care clinic to manage medications, and Medicare DME accreditation.
	Continue financial counseling program (1.0 FTE) to help secure a payment source for un-insured and under-insured patients. Specifically, the Patient Financial Services Representative will help patients with financial assistance applications, setting up payment plans, enrolling in government programs, finding other sources of payment, or accessing services beyond medical care.	Financial services offered at Westfields include patient account representatives, which will file Medicare and Medicaid health insurance coverage on the patient's behalf, along with having financial assistance opportunities available for patients who are unable to pay for their health care services, in full, within the required 30 days of billing. Payment plans with no interest are available to all patients with an outstanding account balance. Discounts will be based on certain qualifications such as income, size of family and others.
	Plan and implement the Methodist Hospital Family Medicine Residency Program Rural Training Track that is expected to add an additional physician to a northwestern Wisconsin region every year	HealthPartners continues to offer the Methodist Hospital Family Medicine Residency Program Rural Training at Westfields, Amery, and Methodist Hospitals.
Increase access and affordability of primary and preventative healthcare	Utilize the electronic medical record system, which reduces the opportunity for error, expedites the patient transfer process, and allows for easier scheduling of appointments	The hospital continues to utilize electronic medical records (EMR)
Improve quality of care	Collaborate around quality improvement to identify and improve quality gaps including training in quality improvement for leaders	Westfields Hospital engages in ongoing performance and quality improvement projects focused on improving the patient experience. All leaders are trained in key performance improvement methods.

Priority #3: CHRONIC DISEASE AND ILLNESS PREVENTION

Goal	Strategies/Activities	Progress and Key Results		
		2016	2017	2018
Make better eating and physical activity easy, fun and popular for children and families through PowerUp Initiative	Deliver PowerUp School Challenge and School Change Toolkit in all interested schools in the Hudson School District	The PowerUp School Challenge program continues being delivered each spring in all Hudson schools, both public and private. School Challenge has been delivered to over 25,000 children to date throughout the St. Croix Valley.		
	Engage the community and develop PowerUp partnership through website resources, social media, ongoing newsletters and communications, community outreach and opportunities to advise and participate in priority program development	PowerUp continues to partner through social media, web resources, and other ongoing communications. PowerUp also has a steering committee, which provides opportunities to advise and participate in program development.		
	Consult with community partners and provide resources to create a healthier food and physical activity environment through open gyms, farmer's markets, school policy and practice changes, improving foods at community and school events and concessions	Westfields Hospital continues to support open gym sponsorships in New Richmond. 150 Open Gyms were held in partnership with school districts in 2016. 143 Open Gyms or Open Skates were held in partnership with school districts and other community organizations 2017.		
	Focus community attention on healthier communities for children through PowerUp for Kids Week and ongoing community outreach	Westfields Hospital continues to partner with local organizations each May to celebrate PowerUp week, through offering opportunities to eat better and move more. These organizations have included the Centre, WESTconsin Credit Union, Art Doyle's Spokes and Pedals, Willow River State Park, Table 65 and Friday Memorial Library.		
	Provide ongoing educational opportunities for kids and families including cooking classes and educational resources	DIRO Outdoors partnered with the community health team to provide educational classes for families to be active outside in all months of the year, including winter.		

Improve the health of children in early childhood through Children's Health Initiative	Develop and implement Children's Health Initiative strategies including: Read, Talk Sing resources; Social Emotional Development identification; Promote drug and alcohol free pregnancies; Breast-Feeding Promotion; Standard Workflows; OB-Pediatric coordinated care; Postpartum Depression; Decrease Teen Pregnancy; Supporting High-Risk Families; Early Childhood Experience screening	All children 6 months to 5 years old receive a book at every well-child visit through the Reach Out and Read program. Books are also provided to expecting mothers at OB visits. All children from 2 months to 5 years are screened at regular intervals during well-child visits for social and emotional developmental delays. Westfields continues to support 'Healthy Beginnings', which promotes drug, alcohol and tobacco free pregnancies by universally screening all pregnant women and offering non-judgmental support. Family centered care continues to screen for postpartum depression, as well as encouraging using only human milk for feedings during the first 6 months by offering resources and support services.
Improve oral health	Participate in Healthier Together Oral Health Task Force	Community health assisted in the beginning stages of this task force, but dental health did not remain a top health priority for the Healthier Together coalition beyond 2015. Supplies were provided by monetary donations from each local hospital to cover the school districts in the hospital's area. Candy Trade in collections are done every year at valley hospitals and dental clinics.
	Contribute and participate in the creation of the oral health backpack program. Students from each school district across the county receive a backpack with food supplies as well as a toothbrush, fluoride toothpaste, floss, a timer and oral health education/resources.	Supplies were provided by monetary donations from each local hospital to cover the school districts in the hospital's area. Candy Trade in collections were done every year at valley hospitals and dental clinics. The program reached 350 – 400 students in St Croix County each year. In 2018, over 300 pounds of candy were collected and sent overseas.
	Contribute in local community meetings to promote the safety and health benefits of community water fluoridation	Initially, Westfields Hospital had representation at the community meetings for water fluoridation. The meetings consisted of people from the state of Wisconsin and the DNR. A state and regional fluoridation educator spoke at a recent Oral Health Care meeting and spoke on behalf of community water fluoridation.

Increase access to physical activity	Participate in Healthier Together Physical Activity Task Force	Obesity and physical activity are prioritized, and Westfields Hospital's community health representative actively participates in this task force. Westfields Hospital will continue to have active involvement in this task force. Over 1700 students across St. Croix and Pierce County participated in the National Walk to School Day in the fall of 2018.
	Obtain and assist in the implementation of the Community Opportunity Grant and Active Schools Core 4+	Pedometer data was obtained, and determined that most students don't get enough steps. A Core 4+ presentation was developed and attempts are being made to implement in school activities and wellness policy improvements.
	Support and promote community efforts to encourage physical activity including providing materials for National Walk to School Day for all school districts in St. Croix County	The hospital continues to support schools in the National Walk to School Day efforts in partnership with Healthier Together, through providing assistance, resources and materials. Over 1700 students across St. Croix and Pierce County participated in the National Walk to School Day in the fall of 2018.
	Partner with local, state and national park, recreation clubs, YMCA, youth sports, schools and others to increase opportunities for youth, families and general community to be physically activity	PowerUp in the Parks Passport was created in partnership with the Minnesota DNR to promote youth and family physical activity in local, regional and state parks. A Parks Rx was handed out at clinics to facilitate the conversation about physical activity. A total of 165 people attended a special program at Willow River State Park in Hudson in 2017.
	Participate on Bike and Pedestrian Advisory Committee and support complete streets, increased pathways and safe routes to school	Participation on this committee resulted in the creation of a new St. Croix County Bicycle and Pedestrian plan, which was approved in May 2018.
Increase access to fruits, vegetables and health food and decrease access to high calories, highly processed, low nutrient beverages and foods	Coordinate a Community Farmers Market on campus	Westfields continues to offer its Farmers Market on Tuesdays throughout the growing season.
	Offer Community Supported Agriculture (CSA) and other sources of local produce at the hospital	Salad greens are provided by Urban Organics, which has converted from an old brewery in St. Paul into one of the first USDA-certified organic aquaponics farms in the country. Urban Organics delivers organic salad greens to each of the four participating HealthPartners hospitals or clinics.

	Continue to increase healthier, less processed food options in hospital café and meetings	Westfields Hospital continues offering healthier options in the cafeteria.
	Sustain the Healthier Together community garden on campus	The community garden continues to operate on Westfields Hospital's campus.
	Lead and participate in Healthier Together Healthy Foods Task Force	Healthier Together is addressing food insecurity through food pantry initiatives and education for volunteers.
	Participate in the New Richmond School District Wellness Committee	At this time, the Westfields Hospital does not have representation on the district wellness committee.
	Reduce Sugar Sweetened Beverages in hospital and clinic campuses to no more than 20% of total beverages and foods offered.	Westfields Hospital continues to strive to reduce sugar-sweetened beverages in the hospital and clinic to no more than 20 percent.
	Provide fruit and veggie community giveaway	Westfields Hospital continues to support fruit and veggie community giveaways.
	Consult with and support partners to reduce high sugar/low nutrient food and sugar sweetened beverage offerings at community events	PowerUp continues to partner with the community through events and education, including consulting on healthier food and beverage offerings.
Reduce chronic disease and prevent illnesses	Support Public Health in communicable disease prevention efforts as circumstances warrant (i.e. immunizations for Whooping Cough, H1N1, etc.)	Support includes disease surveillance, childhood immunizations, mass immunization clinic for flu in schools, immunizations given for uninsured adults, community education and social media posts, vector control, and providing up to date information on communicable diseases.
	Collaborate to provide high quality Diabetes education to patients and families include standardized processes and educational materials	Westfields continues to offer Diabetes education and services, including "Stomp Out Diabetes", "Life Steps to Preventing Diabetes", and a Diabetes support group. Lakeview Hospital also held the Diabetes Expo in 2017.
Provide health education and support to patients and community members	Provide a variety of childbirth education and family classes (Baby & Me, Expectant Parents, Breastfeeding, Babysitter Training, CPR, Sibling Preparation)	*Baby and Me* classes continue to be provided by Westfields, the Family Resource Center and the United Way Success by Six Coalition. *Baby and Me* topics include sleep, reading baby's cues, taking care of mom, baby signs, massage, nutrition, separation anxiety, music and family traditions. Westfields continues to offer classes for expectant parents, including an introductory course on breastfeeding. Babysitter Training is offered through the American Red Cross

		at Hudson Hospital and Clinic. CPR classes are offered through the American Red Cross at Lakeview Hospital.
	Provide a wide variety of community education classes including cardiac rehab, tai chi for arthritis, advance planning, cancer prevention, etc. Continue to review opportunities in relation to programming and service line development	Classes are offered quarterly to patients and the community. Topics include cardiac rehab, tai chi for arthritis, among others.
	Provide diabetes, caregiver, cancer survivor and weight control education and support groups. Continue to review opportunities in relation to programming and service line development.	Westfields continues to offer education and support groups for each of these topic areas.
Provide health education and support to patients and community members	Provide Lactation Support; encouraging breastfeeding and providing access to certified lactation consultants and breastfeeding education	Westfields is in the third phase of becoming a Baby-Friendly hospital, and will enter the fourth and final phase before the end of 2018.
	Employ hospital dietitians to promote nutrition awareness and education to patients, their families, and the community	Registered dietitians provide personalized nutritional counseling as well as education programs to help the community learn new ways to eat healthy. Nutrition Services provides weight loss and diabetic education and community programs, including healthy cooking demonstrations.
Improve health awareness, knowledge and literacy in the community	Healthier Together: Engage the community and develop partnership through website resources, social media and communications, community outreach and opportunities to advise and participate in priority and program development	Healthier Together continues to engage the community through an online and social media presence, with periodic updates of its community resource guides.
	Host a community health fair and events to share health information and resources with the community	Westfields Hospital hosted a health fair in 2015 and 2016. Free health screenings were offered, as well as visiting with physicians and care teams. Screens included blood pressure screening, skin cancer screening, hearing assessment, and a mammography. Children's activities included a bike safety rodeo, car seat safety checks, PowerUp activities, a bounce house and a hand washing station.

		Cooking demos were also put on for families.
	Host health outreach events to specific populations to share health information and resources with the community (Hops for Health; Women's Event; Diabetes event etc.)	Ladies Night Out, Diabetes Expo, and Hope for Health were held at all Valley hospitals in 2016. The Diabetes Expo was held at Hudson Hospital in 2017.

Priority #4: EQUITABLE CARE

Goal	Strategies/Activities	Progress and Key Results		
		2016	2017	2018
Improve capacity to deliver equitable care	Train leaders and staff in diversity, health literacy and cultural humility	HealthPartners Diversity and Inclusion Team has been guiding the process for all employees through MyLearning to increase cultural humility. All leaders were trained with tools addressing diversity, inclusion and bias to bring back to their teams. Diversity, inclusion and bias are embedded into our approach to care.		
	Explore, develop and promote policies to address health equity	The hospital continues to address health equity. Health equity work to date includes, but isn't limited to, transportation services to and from the hospital, documents offered in Spanish, along with working with individuals to develop payment plans based on ability to pay.		
	Explore issue of equitable care and adept changes and measures	Leadership continues to address and provide online resources pertaining to equitable care.		
	Provide financial counseling to help secure a payment source for un-insured and under-insured patients (see also Access and Affordability)	Financial services offered at Westfields include patient account representatives, which will file Medicare and Medicaid health insurance coverage on the patient's behalf, along with having financial assistance opportunities available for patients who are unable to pay for their health care services, in full, within the required 30 days of billing. Payment plans with no interest are available to all patients with an outstanding account balance. Discounts will be based on certain qualifications such as income, size of family and other sources of payment provided on		

		the Financial Assistance application.
Facilitate improved access to services and resources for low income and diverse populations	Participate in Healthy Wisconsin Leadership Institute's Community Teams Program to improve health food access and health equity.	Healthier Together is currently working on two objectives related to food shelves: 1. By December 2016, two food pantries in each county will undergo improvements to increase fruit and vegetable access among clients by 25%. 2. By December 2016, one food pantry in each county will establish a nutrition policy
Facilitate improved access to services and resources for low income and diverse populations	Increase number of hospital materials available in other languages (Spanish)	Westfields Hospital continues to provide offerings of materials in other languages, such as financial assistance documents, policies and applications. These are offered in Spanish.
	Financially support the New Richmond School District backpack program for low income students	Westfields Hospital continues to financially support the backpack program in the New Richmond school district.
	Improve and connect health service systems to community member (see also Access and Affordability)	Westfields Hospital has improved the connection to health service systems through offering transportation services to and from appointments and offering documents in Spanish pertaining to financial assistance documents, policies and applications.
	Increase availability of free and low cost physical activity options for children and families	PowerUp continues to sponsor open gyms to help provide inexpensive gym access during the school year. 150 Open Gyms were held in partnership with school districts in 2016. 143 Open Gyms or Open Skates were held in partnership with school districts and other community orgs. in 2017.
	Expand access to healthy food through transforming 5 Loaves Food Pantry, in partnership with 5 Loaves Food Pantry.	The 5 Loaves Food Pantry was transformed in 2016 in partnership with PowerUp, Healthier Together and Valley Outreach Food Shelf. The food shelf was modified through changes in shopping lists, layout, promotions, education and inventory. These changes make healthier food more accessible at the food pantry.

Next steps

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

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

Contact Information

For more information or questions about this report, please contact Westfields Hospital & Clinic via email at WFCommunications@HealthPartners.Com.

Sources

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

Data retrieved from Community Commons includes the following:

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2012.

Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2012.

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US Department of Health Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2014.

US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2006-10.

US Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File. 2015.

Additional health and demographic data was retrieved from the following sources:

Centers for Disease Control and Prevention, Youth Risk Behavior Survey. 2017. Retrieved 11/9/18 from: https://dpi.wi.gov/sspw/yrbs

US Census Bureau, American Community Survey. 2012-16. Retrieved from: https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml?

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Wisconsin Department of Health Services, Wisconsin Public Health Profiles, 2017. Retrieved November 2018 from: https://www.dhs.wisconsin.gov/stats/pubhealth-profiles.htm

Wisconsin Department of Health Services, Wisconsin Suicide Prevention. Retrieved 11/9/18 from: https://www.dhs.wisconsin.gov/injury-prevention/suicideprevention.htm

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Appendix

Community Committee Participation

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

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Center for Community Health (CCH) Steering Committee	The Center for Community Health (CCH) is a collaborative between public health agencies, non-profit health plans, and not-for-profit hospital/health systems in the seven-county metropolitan area in Minnesota. The mission is to advance community health, well-being, and equity through collective understanding of needs and innovative approaches to foster community strengths.		Nancy Hoyt-Taff Marna Canterbury
Dakota County Healthy Communities Collaborative	The mission of the DCHCC is to bring together healthcare providers, county staff, school representatives, faith communities, nonprofit staff and other organizations to support the health and well-being of Dakota County citizens. The goal of the DCHCC is to identify needs, connect community resources, and create solutions	Monthly	DeDee Varner Libby Lincoln
Hmong Community Stroke Education and Awareness Initiative	Originally initiated from Regions Hospital Stroke Center as an awareness of high rates of Stroke in Hmong Community, through St. Paul School partnerships, has turned into a Hmong Stroke Translation project with funding from the Regions Foundation to translate 8 selected American Heart Association Stroke documents into Hmong and to make it ethnically appropriate.	Monthly	Pakou Xiong
Mental Health and Wellness Action Team (MHWAT)	Part of the Saint Paul - Ramsey County Public Health (SPRCPH) Community Health Improvement Plan (CHIP), SPRCPH formed an authentic community engaged Mental Health and Wellness Action Team that informs the work of our department in responding to the integrated health care needs of Saint Paul - Ramsey County residents and greater communities. Ramsey County Mental Health and Wellness Action Team (MHWAT) is one of 5 SPRCPH Community Health Improvement Goals.	Monthly	Pakou Xiong

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
MHWAT Wellness Group	This is 1 or 4 subgroups of the MHWAT. The MHWAT Wellness Group's purpose is to increase mental well-being for students, families and school staff in Ramsey County by focusing on components of mental well-being for adolescent students.	Monthly	Pakou Xiong
Minnesota Department of Health Healthy Minnesota Partnership	The Healthy Minnesota Partnership brings community partners and the Minnesota Department of Health together to improve the health and quality of life for individuals, families, and communities in Minnesota. The Healthy Minnesota Partnership has been charged with developing a statewide health improvement plan around strategic initiatives that ensure the opportunity for healthy living for all Minnesotans, and that engages multiple sectors and communities across the state to implement the plan.	5x/year	Donna Zimmerman (representing Itasca Project) DeDee Varner
Minnesota Department of Health Mental Well-Being & Resilience Learning Community	The purpose is to expand understanding about a public health approach to mental health by profiling current community initiatives across a continuum of public health aligned strategies	Monthly	DeDee Varner
St. Paul Ramsey County Community Health Services Advisory Committee	The board advises, consults with or makes recommendations to the Saint Paul City Council and the Ramsey County Board of Health on matters relating to policy development, legislation, maintenance, funding, and evaluation of community health services	Monthly	Dr. Kottke

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
St. Paul Ramsey County Public Health Statewide Health Improvement Program Community Leadership Team Meetings	The Minnesota Department of Health provides funding to Saint Paul – Ramsey County Public Health through the Statewide Health Improvement Partnership (SHIP) to work with a variety of partners to improve the health of our community. Saint Paul - Ramsey County Public Health is in its fourth cycle of SHIP funding. Three goals: Increasing physical activity; improving access to healthy foods; reducing the use of and exposure to tobacco.	4x/year	DeDee Varner
Forces of Change Affecting Community Health	The Center for Community Health hosted a dialogue for community leaders. This event aimed to increase collaboration and richness of conversation about health, broadly defined, across the Minneapolis Saint Paul Metro Region. Sixty participants contributed to insights and exchanged ideas.	10/25/2017	DeDee Varner Marna Canterbury Nancy Hoyt Taft Pakou Xiong Libby Lincoln
East Metro CHNA/CHA Pilot Workgroup	Dakota County Public Health, Washington County Public Health, St. Paul Ramsey County Public Health along with HealthEast, Regions Hospital, Lakeview Hospital are meeting to align respective community needs assessments which are all due in 2018.	Monthly	DeDee Varner Sidney Van Dyke Heather Walters Libby Lincoln Amy Homstad Marna Canterbury Andrea Weiler
Community Health Action Team (CHAT)	CHAT meets monthly to discuss and address unmet community health needs in the area through action, networking and educational opportunities. Attendees are from Stillwater Area School District and Washington County partners.	Monthly	Andrea Weiler

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
East Metro Mental Health Roundtable	The East Metro Mental Health Roundtable and the associated Mental Health Alliance and Measurement Committees are focused on examining and improving the mental health system for adults in the East Metro. This study looks at a variety of metrics for the adult mental health system in the east metro to identify patterns, needs, and opportunities for improvement.		Megan Remark Wendy Waddell
Central Corridor Anchor Partnership	The Central Corridor Anchor Partnership is a group of colleges, universities, hospitals, and health care organizations located near the Green Line in Minneapolis – St. Paul. We have invested greatly in our physical infrastructure to serve our patients, students, and employees, and are anchored to the health, vitality, and growth of the neighborhoods around us.	Quarterly	Megan Remark Ruth Bremer
Catholic Charities Higher Ground Steering Committee	The Catholic Charities Higher Ground Steering Committee meets to support the work of Higher Ground, a shelter for adults with 171 shelter spaces and 80 Pay-For-Stay beds.	Every other month	Chris Boese John Clark Mona Olson Wendy Waddell Rachelle Brambach Katie Paulson
REASN	The Racial Equity Action Support Network (REASN) brings together racial equity champions and advocates from community, nonprofit, and government organizations across Minnesota, providing them a space for support in doing the challenging work of creating racial equity and to strategically advance new thinking and action in their work.	Quarterly	Sidney Van Dyke

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Healthcare for the Homeless	The Healthcare for the Homeless group is part of Westside Community Health Services. They provide primary care to homeless patients that discharge from Regions and those who utilize the Higher Ground Homeless shelter. This group meets to discuss how Regions Care Management and Healthcare for the Homeless can work better together and communicate effectively to best provide care for our shared patients.	Quarterly	Rachelle Brombach
East Metro Coordination of Care	The East Metro Community is part of the Lake Superior Quality Innovation Network (LSQIN) Coordination of Care initiative, which is a community-based collaborative designed to improve coordination of care, care transitions, and reduce readmissions for Medicare beneficiaries and all patients in Minnesota. In addition to the monthly informational meetings there are several work groups that work on various topics related to reducing re-admissions.	Monthly	Rachelle Brombach Mona Olson
West Metro CHNA Collaborative	North Memorial & Maple Grove Hospital, Allina, Park Nicollet Health Services, Hennepin Health are meeting to align respective community needs assessments which are due in 2018 and beyond.	Ad hoc	Libby Lincoln Amy Homstad
Scott County Health System Collaborative	The Health System Collaborative brings together representatives of area health systems, schools and community organizations to identify and address the health needs of the community.		Libby Lincoln
SHIP Community Leadership Team	The SHIP Community Leadership Team oversees the work being done in Scott County under the state SHIP grant.		Libby Lincoln

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Brooklyn Center Health Resource Center Advisory Committee	The BCHRC Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the Health Resource Center.	Monthly	Libby Lincoln
Richfield Health Resource Center Advisory Committee	The RHRC Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the Health Resource Center.	Monthly	Libby Lincoln
Northwest Hennepin Healthy Community Partnership	The Partnership is a collaboration of healthcare, school, county and community organizations that come together to address the needs of the Northwest Hennepin community.	Monthly	Libby Lincoln
Central Clinic Advisory Committee	The Central Clinic Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the clinic.	Quarterly	Libby Lincoln
Dakota County School Mental Health Practice Group	The Mental Health Practice Group is a collaboration of providers of mental health services in the Dakota County schools. They meet to share best practices and coordinate services.	Monthly	Libby Lincoln
Diamondhead Clinic Advisory Committee	The Diamondhead Advisory Committee is a broad school, provider and community member group that develops and implements policies and procedures for the clinic. It meets 3 - 4 times/year.	Quarterly	Libby Lincoln
Health and Wellbeing Advisory Committee (HWA)	The Health and Wellbeing Advisory Committee serves as the eyes and ears for Lakeview Hospital and provides resources and services to meet the health and wellbeing needs of the community.	Quarterly	Marna Canterbury Andrea Weiler

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Healthier Together Pierce & St. Croix Counties	Healthier Together is a community coalition comprised of local health systems, public health agencies, local businesses, media, education, government and community members. Healthier Together provides strategic and collaborative framework for health improvement activities throughout the two-county region of Pierce & St. Croix Counties, Wisconsin.	Monthly	Jacob Hunt
Hudson School District Wellness Committee	The Hudson School District Wellness Committee is a group that meets three times throughout the school year to develop planning on student wellness. Areas that are addressed include mental health and well-being and physical activity/nutrition.	Triannually	Jacob Hunt
Physical Activity Action Team-Healthier Together	The goal of the physical activity action team is to decrease the percentage of the population in Pierce and St. Croix Counties that is overweight or obese. In order to achieve this goal, the action team is trying to increase physical activity and decrease food insecurity/improve nutrition through changes to policy, systems, environment and community support.	Monthly	Jacob Hunt
Alcohol Action Team-Healthier Together	The goal of the alcohol action team is to decrease alcohol abuse in Pierce and St. Croix Counties. In order to achieve this goal, the action team is trying to decrease adult and youth alcohol use through changes to policy, systems, environment and community support.	Every other month	Jacob Hunt
Thrive Barron County	Thrive Barron County is a coalition of the Barron County Health Department, community partners, and healthcare partners that work together to conduct periodic community health assessments, evaluate the findings and develop strategies to address top health priorities in Barron County, Wisconsin.	Monthly	Katy Ellefson

Committee Name or Community Meeting Name	Purpose	Frequency of Meeting	HealthPartners Attendee
Polk United	Polk United is a coalition of the Polk County Health Department, medical centers, and community partners that work together to evaluate community health needs, develop, and implement activities in Polk County, Wisconsin.	Monthly	Katy Ellefson
Polk County Nutrition & Physical Activity Workgroup	This subcommittee of Polk United works specifically on the priority area of nutrition and physical activity by developing and implementing plans and activities to address obesity and chronic disease. It is comprised of key stakeholders in Polk County.	Monthly	Katy Ellefson
Mental Health Taskforce of Polk County	The Mental Health Task Force of Polk County is a non-profit organization committed to addressing community mental health needs cooperatively. The task force is comprised of mental health care providers, government and law enforcement representatives, human service agencies, school personnel, and community members.	Monthly	Heather Erickson, Kesha Marson
Polk County Substance Abuse Workgroup	This subcommittee of Polk United works specifically on the priority area of substance abuse by developing and implementing plans and activities to substance abuse issues. It is comprised of key stakeholders in Polk County.	Monthly	Brian Francis

535 Hospital Road
New Richmond, WI 54017
(715) 243-2600
www.westfieldshospital.com