2016

COMMUNITY HEALTH NEEDS ASSESSMENT









Clearwater Valley Hospital

Essentia Health

Here with you

COMMUNITY HEALTH NEEDS ASSESSMENT

2016

IDAHO

Overview

Clearwater Valley Hospital and Clinics, Inc.
301 Cedar St.
Orofino, ID 83544

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

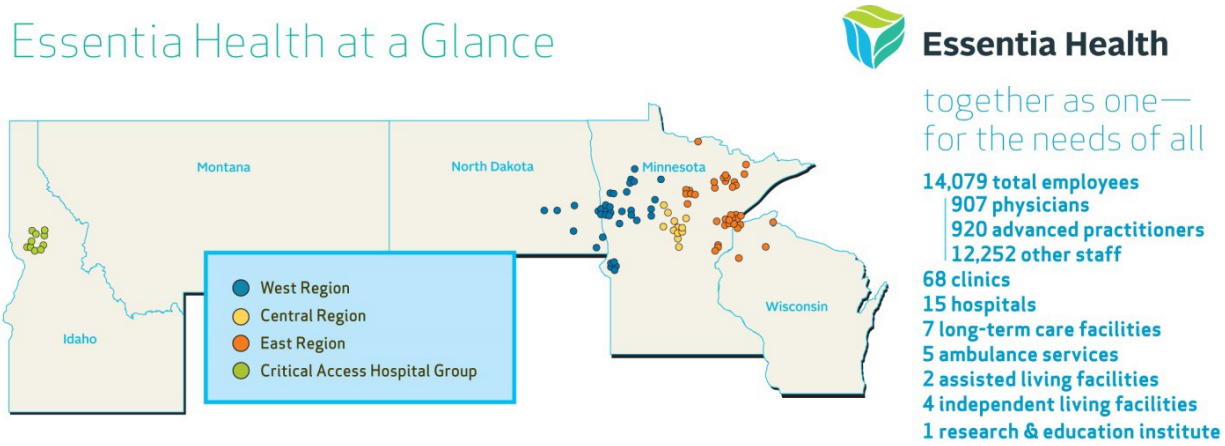
Clearwater Valley Hospital and Clinics (CVH) serves Clearwater County and surrounding areas with 23 hospital beds and primary care clinics in Orofino, Pierce and Kooskia. Doctors rotate between these clinics in two counties. Established in1957, the CVH system provided more than 20,000 outpatient visits last year. Doctors also round on hospital patients, deliver babies and cover the emergency department. The regional medical center is about an hour away, in Lewiston. Tertiary care is three hours away, in Spokane.

LEAD PARTIES ON THE ASSESSMENT

Pam McBride, Chief Grants Officer, Clearwater Valley and St. Mary's Hospitals and Clinics

Kayla Keigley, Community Health Program Manager, East Region

TABLE OF CONTENTS



Essentia Health: Here With You

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

Mission

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

Vision

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

Values

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

Belief Statements

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

Caring for our Community

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

Progress to Date on 2013 Community Health Needs Assessment

Priority Area	**Access to health care**
Target Population	Local population, all ages
Goal	Enhanced health care for the local population
Objective 1: Improve and increase access to health care, defined as providing enhanced health care for the local population.	
Accomplishments to Date: • Achieved certification as patient-centered medical home. • Expanded hours of access by changing provider schedules and opening Saturday urgent care. • Offering free and reduced care opportunities. • Recruited new providers. • Nurse case managers and community referral coordinators are working collaboratively to eliminate barriers to care. • Provide access to specialty services through visiting providers and telemedicine. • Participate in an active consortium of community members to discuss opportunities to improve access to health care.	

Clearwater Valley Hospital and Clinics has done tremendous work to improve access to health care in its service area. On top of the accomplishments noted above, the hospital has also updated its website to include a database of community health resources, freely available to the public and also linked to many of their community partners' websites. The hospital is also participating in statewide committees for Medicaid innovation, telemedicine, time-sensitive emergency care and community health workers. The hospital is conducting extensive outreach for ACA insurance enrollment, including partnering with private insurance brokers. The hospital is writing and administering grants focused on improving access to health care. The hospital continues to seek to improve access to health care and partner with its community partners and community members to meet the needs of its service area.

Priority Area	**Obesity, physical inactivity and poor nutrition as risk factors for chronic diseases such as Type 2 diabetes.**
Target Population	Adults, ages 18 and older, who are currently prediabetic or possess risk factors for developing Type 2 diabetes
Goal	Reduced body weight and increase physical activity in program participants, thereby reducing their risk for Type 2 Diabetes.

Performance Measures

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

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

Accomplishments to Date:

- In addition to the 10 participants who completed the program by April 2015, there were another 35 who completed by Dec. 31, 2015.
- Participants lost an average of 18.23 pounds, which is an average loss of 9% from starting body weight.
- Physical activity at the start of the program was an average of 116 minutes per person per week. On completion of the program, physical activity averaged 242 minutes per person per week for an increase of 126 minutes per person.
- In addition to the group that completed by December 31, 2015, another cohort of 45 individual completed three months of the program by December 31, 2015, they will be finished with their program later in 2016.
- By the end of the first three months, participants had lost an average of 12.80 pounds, which is an average loss of 6%.
- Physical activity at the start of the program was an average of 142 minutes per person per week. Three months into the program physical activity per person averaged 167.73 minutes, an increase of 26 minutes per person.

The information presented above only accounts for courses that have been completed as of December 31, 2015. Due to the length of the program, additional programs are ongoing. The course continues to see growth and expansion throughout the service area. The hospital continues to work collaboratively with community partners and resources to market NDPP course opportunities.

Reduction of Excessive/Binge Drinking

Clearwater Valley Hospital and Clinics providers have provided presentations on the dangers and effects of drinking to area high schools. The hospital is also participating in regional public health coalition focused on reducing alcohol consumption.

Immunizations

The hospital is participating in a state-wide IRIS registry system to update immunization records regardless of where the immunization was received. It is also focusing on raising awareness of the need for immunizations through newspaper articles, back- to-school events and public service announcements.

Preventative Care

The hospital currently conducts health screenings and health education at multiple community locations.

The hospital is very active in working to reduce childhood obesity. It has conducted BMI screenings for all elementary schoolchildren in Orofino.

Tobacco Use Primary Prevention/Cessation

Clearwater Valley Hospital and Clinics' providers have given presentations to area high schools on the dangers and implications of tobacco use. The hospital also provides tobacco cessation classes and referrals to statewide tobacco cessation aids. The hospital is participating in a regional public health coalition. Internally, the hospital has also focused on process improvement measures related to assessing smoking status of patients and providing care plans for tobacco cessation.

2016 Community Health Needs Assessment

Objectives

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

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

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

1. Assess the health needs, disparities, assets and forces of change in Clearwater Valley Hospital's service area.
2. Prioritize health needs based on community input and feedback.
3. Design an implementation strategy to reflect the optimal usage of resources in our community.
4. Engage our community partners and stakeholders in all aspects of the Community Health Needs Assessment process.

Description of Community Served by Clearwater Valley Hospital

Clearwater Valley Hospital and Clinics serves all or part of Clearwater, Lewis and Idaho counties in frontier north-central Idaho. The hospital is located in Orofino, Idaho. Primary care clinics are located in the towns of Orofino, Pierce and Kooskia.

Thanks to our mission and our Benedictine roots, Essentia addresses the health needs of the area's most underserved populations.

Residents of these counties are older and poorer than average, have high rates of suicide and stroke death, and are at increased risk for diabetes and other chronic conditions. The area has a high suicide rate for the state, and one of the highest suicide rates in the nation. Residents are also at greater than national risk for receiving preventive care services due to challenges of poverty and being in the state with the lowest rate of physicians per capita in the nation.

This tri-county region is home to approximately 28,000 residents, who are among the most medically isolated in the Pacific Northwest. These three counties span a service area the size of Maryland and Delaware combined. With an overall population density of just 2.5 people per sq. mile,[1] each target county in the region is designated not only as rural, but as "frontier."[2] Frontier

[1] Calculated from 2013 population and land mass data found at: http://quickfacts.census.gov/qfd/states/16000.html

[2] Confirmed by the National Center for Frontier Communities, http://frontierus.org/maps/

regions are defined as the most geographically remote, sparsely populated, and undeveloped terrain in the United States. This designation represents significant access barriers, limited wellness resources, and resultant health disparities for area residents.

The service area also contains large tracts of the Nez Perce Reservation. The Reservation is home to an estimated 3,300[3] members of the Nimiipuu tribe, descended from the Native Americans who first guided Lewis and Clark through this region in 1805. The Nimiipuu experience rurality-related health disparities, as well as additional disparities characteristic of Native American populations. These disparities include lower life expectancy and a disproportionate disease burden. According to Indian Health Services, diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian and Alaska Native deaths (2007-2009). American Indians and Alaska Natives born today have a life expectancy that is 4.4 years less than the U.S. all races population (73.7 years to 78.1 years, respectively). American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.[4]

[3] Montana BCC, at http://mbcc.mt.gov/Data/Montana-Reports/Statistical-Analysis-Center-Projects
[4] Disparities Fact Sheet by Indian Health Services, at https://www.ihs.gov/newsroom/factsheets/disparities/

Overall demographics description

	Clearwater County	Lewis County	Idaho County	Idaho State	US National
Population	8,562	3,838	16,215	1,634,464	308,745,538
Age 65 or older (%)	25	24	24	14	14
Median household income	$41,304	$41,858	$40,074	$47,572	$53,482
Income below 200% federal poverty level (%)	40	43	44	39	35
No high school diploma (%)	15	12	11	11	14
High school graduate (or GED) (%)	37	35	41	28	30
County Health Rankings Health Outcomes (1= high, 44 = lowest)	39	3	23	NA	NA
County Health Rankings Health Factors (1= high, 44 = lowest)	39	25	32	NA	NA

Profile source: http://www.indicatorsidaho.org

Healthy Lifestyles	**Clearwater, Lewis, and Idaho Counties**	**Idaho (ID)**	**U.S. Average**
Food Environment Index[5] (1 = no healthy foods – 10 = all healthy foods)	Clearwater: 6.6 Lewis: 6.2 Idaho: 6.1	Urban ID = 7.8 Statewide = 7.3	Not found for this measure
Residents reporting access to exercise opportunities[6]	Clearwater: 35% Lewis: 48% Idaho: 56%	Urban ID = 73% Statewide = 62%	Not found for this measure
Residents reporting physical inactivity[19ibdid]	Averaged: 23%	Urban ID = 15% Statewide = 20%	25%
Obesity rate, 2011[7]	Averaged: 30%	Urban ID = 24% State = 29.6%	34.9%
Diabetes[8]	**Clearwater, Lewis, and Idaho counties**	**Idaho (ID)**	**U.S. Average**
Diabetes rate, 2011	Averaged: 10.7	Urban ID = 7.6 Statewide = 7.7	8.3
Obesity rate, 2011[9]	Averaged: 30%	Urban ID = 24% State = 29.6%	34.9%

Diabetes[10]	**Clearwater, Lewis, and Idaho counties**	**Idaho (ID)**	**U.S. Average**
Diabetes rate, 2011	Averaged: 10.7	Urban ID = 7.6 Statewide = 7.7	8.3
Diabetes mortality rate	Clearwater: 34.7 Lewis: 47 Idaho: 17.2	Urban ID = 19.3 Statewide = 22.8	22.5

[5] County Health Rankings and www.webmd.com/food-recipes/news/20110426/cdc-kids-lack-access-to-healthy-food-choices.
[6] Both figures per County Health Rankings "Additional Measures," found at www.countyhealthrankings.org.
[7] Per www.cdc.gov/diabetes/atlas/countydata/atlas.html, http://stateofobesity.org/states/id/, and www.cdc.gov/obesity/data/adult.html.
[8] Per www.cdc.gov/diabetes/atlas/countydata/atlas.html, CDC Diabetes Report Card 2012, www.diabetes.org/diabetes-basics/statistics, and www.worldlifeexpectancy.com/usa/idaho-diabetes.
[9] Per www.cdc.gov/diabetes/atlas/countydata/atlas.html, http://stateofobesity.org/states/id/, and www.cdc.gov/obesity/data/adult.html.
[10] Per www.cdc.gov/diabetes/atlas/countydata/atlas.html, CDC Diabetes Report Card 2012, www.diabetes.org/diabetes-basics/statistics, and www.worldlifeexpectancy.com/usa/idaho-diabetes.

Heart Disease	Clearwater, Lewis, and Idaho ounties	Idaho (ID)	U.S. Average
Residents reporting high blood pressure[11]	Clearwater: 35.3% Lewis: no data Idaho: 28.9%	Urban = 21.6% State = 25.4%	31%
Heart disease death rate[12]	Clearwater: 184.74 Lewis: 195.89 Idaho: 176.90	Urban = 164.5 State = 167.9	196

Depression	Clearwater, Lewis, and Idaho counties	Idaho (ID)	U.S. Average
Poor mental health days[13]	Clearwater: 3.9 Lewis: 2.8 Idaho: 3.0	Urban ID = 3.2 Statewide = 3.4	3.3
Suicide rate [14]	Clearwater: 23.7 Lewis: 26.5 Idaho: 17.5	Urban ID = 15.4 Statewide = 18.8	12.6

County-level data is used for all three counties served by Clearwater Valley Hospital and Clinics: Clearwater, Lewis and Idaho counties. Because of the frontier nature of the service area, data for populations smaller than county level is frequently unavailable or of limited value.

North Central Idaho is one of the most remote and rugged regions in one of the nation's most rural states. Residents of these frontier counties experience profound medical isolation resulting from primary care provider shortages, great distances to care, high poverty and uninsurance rates, and numerous other contributing factors. As a result, they experience poor health indicators and outcomes related to chronic disease states, including diabetes prevalence and mortality, obesity rates, hypertension prevalence, depression and suicide rates, and colon cancer prevalence and mortality. These conditions serve as the focus of community benefit interventions.

[11] Summarized at county-health.findthebest.com; CDC policy brief at www.cdc.gov/dhdsp/docs/chw_brief.pdf.
[12] Per www.worldlifeexpectancy.com/usa/idaho-heart-disease.
[13] County Health Rankings; and www.ok.gov/health/pub/boh/state08/IndicatorReportCards/poor%20mental%20health%20days.pdf.
[14] Per Suicide Prevention Action Network at www.cdc.gov/violenceprevention/suicide/statistics/aag.html

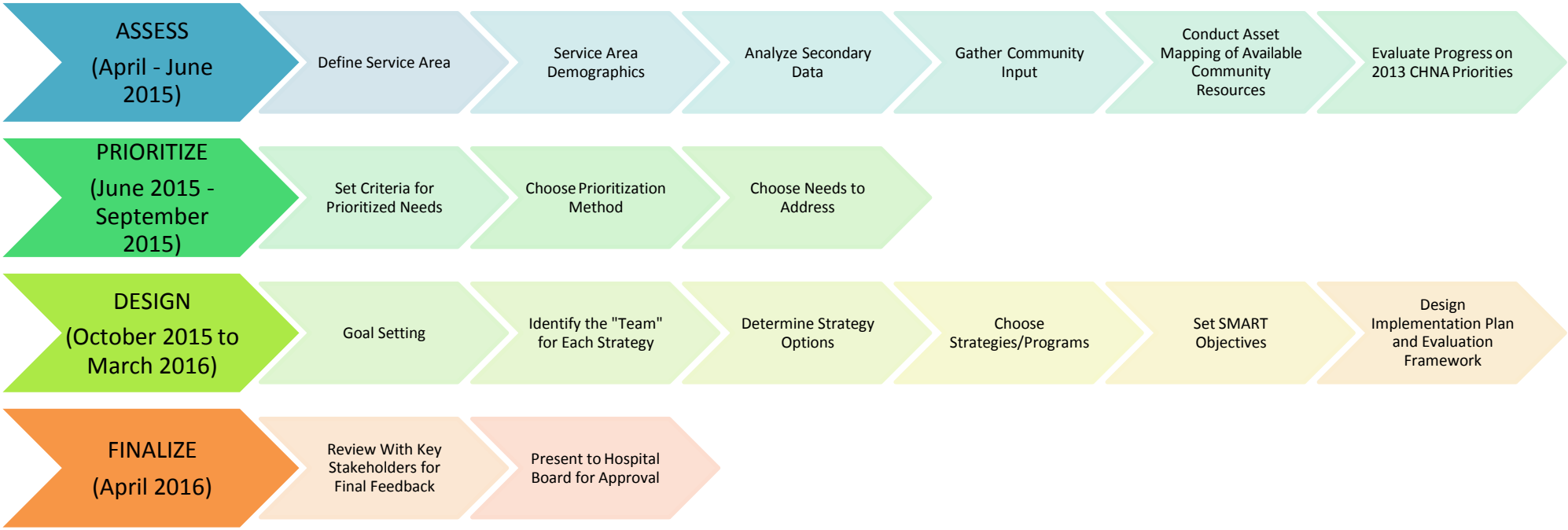
Process Overview

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

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

From there, each of Essentia's three regions was responsible for adapting and carrying out the plan within their communities and hospital service areas.

The Clearwater Valley Hospital assessment was conducted in four stages: assessment, prioritization, design and finalization. The process began in June 2015 and was completed in April 2016 with the final presentation of the Community Health Needs Assessment being presented to its leadership and the Board of Directors on April 26, 2016. The following describes the assessment steps and timeline.


ASSESS
(April - June 2015)
Define Service Area
Service Area Demographics
Analyze Secondary Data
Gather Community Input
Conduct Asset Mapping of Available Community Resources
Evaluate Progress on 2013 CHNA Priorities
PRIORITIZE
(June 2015 - September 2015)
Set Criteria for Prioritized Needs
Choose Prioritization Method
Choose Needs to Address
DESIGN
(October 2015 to March 2016)
Goal Setting
Identify the "Team" for Each Strategy
Determine Strategy Options
Choose Strategies/Programs
Set SMART Objectives
Design Implementation Plan and Evaluation Framework
FINALIZE
(April 2016)
Review With Key Stakeholders for Final Feedback
Present to Hospital Board for Approval

Assessment Process

Phase 1: Assessment

In 2011, Clearwater Valley Hospital convened a consortium with representatives from all hospitals, clinics, public health, tribal health and social service agencies in the tri-county service area. This consortium represents all existing healthcare facilities and resources within the community that are available to respond to the health needs of the community. Additional organizations would be added as necessary and able when additional needs arise. Organizations represented in this consortium include:

- Essentia Health – Clearwater Valley Hospital and Clinics
- Essentia Health – St. Mary's Hospital
- Syringa Hospital District
- Nimiipuu Health
- Public Health – Idaho North Central District
- Saint Alphonsus Regional Medical Center
- Human Needs Council (regional)
- Clearwater County Human Needs Council

The consortium began meeting in 2011 and has worked jointly on a project to implement nurse case managers and community referral coordinators. The 2016 CHNA activities build upon this foundation.

The majority of Clearwater, Idaho, and Lewis Counties are rural according to the 2012 UWPHI County Health Rankings data: 57.3% (Clearwater), 79.1% (Idaho), and 100% (Lewis). Given the known health disparities of rural populations, all attendees of the consortium meetings are representatives and/or members of medically-underserved and low income populations, as well as populations with chronic disease needs. Outside the borders of the Nez Perce Reservation, the service area population is 93.5% Caucasian.

The medically-underserved and low-income populations are represented by officers of county Human Needs Councils. These councils serve as umbrella networking entities for social service, schools and faith-based agencies throughout the region. In addition, surveys were obtained from a sample of pre-diabetic adults in 2015.

The CHNA consortium includes member Nimiipuu Tribal Health to address the needs of the area's Native Americans, on and off the reservation. Members of Nimiipuu Tribal Health, representing the Nez Perce Tribe, participated via emails on development of the action plan and attendance at earlier consortium meetings. Meeting participants were specifically instructed to consider themselves representatives of the community-at-large.

The Consortium determined the need, scope and target population for this CHNA based on a) progress on prior Community Health Needs Assessments and a Community Health Improvement Plan, b) data collected from prior collaborative grant-funded projects (including a Commonwealth Fund/Qualis Health medical home award, HRSA's Small Provider Rural Quality Grant, and the 2012 Rural Health Care Services Outreach Program *Medical Home Plus* project) and c) direct feedback from the local populace.

Consortium members meet regularly. The Human Needs Councils meet monthly, and the entire consortium meets every two to three months,

Project activities and strategic plans were developed from multiple discussions with key informants from all project partners, both government and nonprofit. The concept was further reinforced through a strategic planning process overseen by a HRSA technical support team that monitored progress on the Medical Home Plus award. No written comments were received from the prior CHNA.

Strengths

Primary community strengths include active community participation, expanded capacity and ease in collaboration.

Active Community Participation

All of the entities that participated in 2013 planning have continued to be active participants in meetings and the planning process. New members have recently joined meetings. These include a third hospital and the director of a free clinic in a neighboring urban area. Meeting discussions are focused on identifying leverage points for priority needs, while monitoring progress on specific project activities.

Expanded Capacity

Thanks to prior consortium-led grants, nurse case managers and referral coordinators have been hired at both St. Mary's Hospital and Clearwater Valley Hospital and Clinics. These new positions help patients track their chronic diseases, such as diabetes and hypertension, and assist patients with follow-up care, specialist visits, and community referrals. The new staff also attends monthly meetings of the Human Needs Councils. This has been identified as a large step forward in communication between agencies.

Counties to the north of the project service area have begun construction of a mental health crisis center and operation of a new Recovery Support Center. Regional collaboratives focused on specific disease conditions continue to meet, with representatives also attending the Health-Able Communities consortium meetings. St. Mary's Hospital and Clearwater Valley Hospital share a certified trainer for the CDC-recognized Diabetes Prevention Program, and several new classes started in 2015.

Weaknesses

Communication

Challenges were highlighted in communicating with clients, communities and between agencies. Clients may perceive cost as a barrier to seeking care. Some delay preventive screenings because of perceived cost barrier to treating anything that's found. A challenge is how to alleviate fears ahead of time by communicating costs covered by Medicare or other insurance benefits.

Diabetes Prevention program participants expressed challenges in knowing what health fairs, screenings and educational events were available.

Coordination with multiple staff/agencies

Communicating and coordinating health fairs, screenings and educational events was also a challenge noted between agencies. "We have lots of great things going on in our communities," noted one consortium member. "But sometimes those efforts feel fragmented, and it's hard to make sure the word gets out to everyone who needs to know." This was reinforced by Diabetes Prevention Program participants who were interested in but unaware of cooking classes, family exercise opportunities and other community events.

Opportunities

Consortium members have recently been awarded a grant to create a benefits counseling program. The counselor who has recently been hired has strong community ties and great knowledge of existing benefits programs. Consortium members readily identified opportunities to leverage the benefits counselor position for increased outreach, access and interagency coordination.

All project partners have commented on the value of learning about new regional resources during planning meetings. In addition, new opportunities for leveraging resources for community health and improving communication across agencies are identified at most meetings.

The over-arching needs of the community were identified as:

- Access to care
- Obesity and other contributors to chronic disease
- Mental health status
- Cancer

Phase 2: Prioritization

- Needs were prioritized based on the following criteria:
- *Alignment with facility's strengths/priorities/mission*
- *Magnitude – number of people impacted by problem*
- *Severity – the rate or risk of morbidity and mortality*

Opportunity for partnership

Consortium meetings from 2013 to present use the Policy-System-Environment framework for leading discussions toward strategic impact. Overall data trends are reviewed, including internal project data and external, county-wide health data. Regional resources and gaps are identified in each target area. We use appreciative inquiry to identify actions that are succeeding, and build from those to bridge gaps and identify new opportunities. In September and October of 2015, a technical assistant from Georgia Health Policy Center facilitated meetings aimed at on identifying focus areas for short-term implementation and longer-term sustainability strategies. Focus areas were identified through analysis of group discussion. In attendance were:

- Clearwater Valley Hospital and Clinics: Vicky Petersen, clinic manager; Shawna Altmiller, nurse case manager; Ashley Steinbruecker, community relations coordinator; Lessie Roughton, financial counselor supervisor; Shannon Hill, medical assistant supervisor; Colleen Hall, community referral coordinator; Heather Hodges, quality director; Becky Colwell, benefits counselor; Laura Hollingshead, diabetic educator
- St. Mary's Hospital: Shari Kuther, clinic manager; Pam McBride, Chief Grants Officer; Leah Kaschmitter, community health worker; Julie Church, nurse case manager; Ralyn Horton, community referral coordinator; Vicki Berg, diabetic educator; Curtis Fryer, Chief Information Officer
- Georgia Health Policy Center: John Butts, technical assistant
- Public Health: Kayla Springer, program manager, SHIP regional reform collaborative
- Snake River Free Clinic: Charlotte Ash, director
- Human Needs Council: Linda Bear, president
- Syringa General Hospital: Joanne Smith, community relations coordinator; Michelle Schaeffer, clinic manager
- St. Alphonsus Regional Medical Center: Kim Beauchesne, telemedicine program coordinator North Idaho Health Consortium: Caryl Johnston, director

While cancer care is an identified need, the facility lacks resources and expertise to completely address this need. We will seek to provide screenings and work with partners as appropriate to find affordable solutions to cancer care.

Phase 3: Design of Strategy and Implementation Plan

SUMMARY OF COMMUNITY-DEFINED PRIORITIES/STRATEGIES

PRIORITY AREA	GOALS
Access to Care	Improve access to care with increased community-based health contacts
Obesity and other contributors to chronic disease	Build community wellness resources
Mental health	Improve awareness, screening and access to care

The Consortium has prioritized aims with the most low-cost, high-impact and realistically achievable population health strategies in the near-term, given limited resources as well as frontier cultural norms. These aims are

expected to yield short-term results (within the three-year CHNA period), as newly empaneled patients within the general population improve their health indicators through effective chronic disease management. Outreach will also lay the foundation to realize the 10-year goal of building a local culture that embraces and invests in health prevention.

STRATEGIES FOR EACH PRIORITY

Priority: Access to Care	
Goal: Increase the number of residents who have at least one annual health contact that could result in a measurable impact on their health.	**Partners: CHNA consortium members**
Strategy #1: Implement a corps of community health workers to conduct screenings and outreach.	Actions: - Hire and train community health workers in multiple communities. - Screen residents for socioeconomic barriers to care. - Provide preventive screenings in community settings. - Provide navigation services to increase residents established with a primary care provider.
Expected Short-Term Outcomes	**Sources of Measuring Outcomes**
16% of area residents will experience at least one health contact per year; 48% will be reached by April 30, 2018. At least 20% of adult outreach event participants – 1 in 5 – will report not having had a medical office visit in the past 12 months.	Community health worker logs
350 residents will undergo a FIT test annually.	Electronic medical record
85% of screening participants requesting assistance will become established in a primary care medical home within two months of request.	Electronic medical record and community health workers logs
Expected Long-Term Outcomes	**Sources of Measuring Outcomes**
48% of area residents will experience at least one health contact by April 30, 2018.	Community health worker logs
660 new cases of high blood pressure, 400 cases of diabetes, 4,995 cases of pre-diabetes, and 4,050 cases of obesity will be identified by April 30, 2018.	Electronic medical record
Priority: Access to Care	
Goal: Improve the rate of residents who obtain, retain and use health insurance.	**Partners: Local insurance brokers State ACA Marketplace CHNA consortium members**
Strategy #1: Provide navigation services to existing resources.	Action: Implement a benefits counselor program
Expected Short-Term Outcomes	**Sources of Measuring Outcomes**
90% of adult outreach participants will be screened for	Community health worker logs

insurance status.	
Enroll or retain insurance for 500 individuals annually.	Benefits counselor logs
Expected Long-Term Outcomes	**Sources of Measuring Outcomes**
By 2018, identify 2,100 uninsured individuals and enroll or educate 1,500 individuals on using public or private health insurance.	Benefits counselor logs

Priority: Obesity and other contributors to chronic disease	
Goal: Build community wellness resources	**Partners: CHNA consortium members**
Strategy #1 Increase health literacy and use of health resources among residents.	Actions: – Improve residents knowledge of healthy eating, active living and other prevention measures. -Introduce and market wellness classes and other initiatives, including the Diabetes Prevention Program and community gardens to multiple communities.
Expected Short-Term Outcomes	**Sources of Measuring Outcomes**
Identify gaps in nutrition, fitness or health education resources in up to 10 communities.	Consortium minutes; community health workers logs
100% of outreach participants will receive prevention and self-care guidance corresponding with their personal risk level of risk and literacy level.	Community health worker logs
Expected Long-Term Outcomes	**Sources of Measuring Outcomes**
Established at least 10 small-scale/high-visibility projects by May, 2018. 100% of outreach participants will receive referrals to community-based wellness resources. Track types and quantity of community referrals in clinic setting.	Consortium minutes; community health workers logs Community health worker logs Electronic medical record
Priority: Mental Health	
Goal: Improve awareness, screening and access to care	**Partners: St. Alphonsus, University of Utah, CHNA consortium members**
Strategy #1 Conduct screenings and enhance access to care.	Actions: -Conduct screenings in clinics and at health fairs and outreach events. -Provide access to psychiatrists via telehealth.
Expected Short-Term Outcomes	**Sources of Measuring Outcomes**
500 telepsych visits annually	Electronic medical record
50% of outreach participants will be screened for mental health status.	Community health worker logs
Expected Long-Term Outcomes	**Sources of Measuring Outcomes**
1,500 telepsych visits by April 2018	Electronic medical record

Conclusion

As part of a nonprofit health system, Clearwater Valley Hospital and Clinics is called to make a healthy difference in people's lives. This needs assessment and implementation plan illustrate the importance of collaboration between our hospital and its community partners. By working collaboratively, we can have a positive impact on the identified health needs of our community during Fiscal Years 2017-2019. There are other ways in which CVHC will indirectly address local health needs, including the provision of charity care, the support of Medicare and Medicaid programs, discounts to the uninsured and others. Over the next three years, Clearwater Valley Hospital and Clinics will continue to work with the community to ensure that this implementation plan is relevant and effective while making modifications as needed.

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