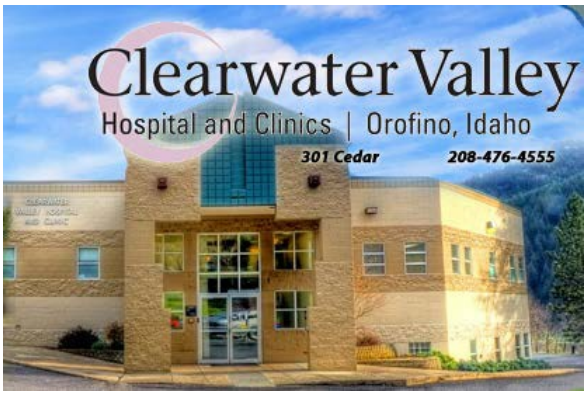
Community Health Needs Assessment

Clearwater Valley Hospital and Clinics, Inc., Orofino, Idaho
June 17, 2013



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Executive Summary

Clearwater Valley Hospital and Clinics, Inc. is required to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy to meet the community health needs identified through the CHNA at least once every three years. The following document and past and future activities described therein serve to meet that requirement. The implementation strategy included in Appendix A was approved by the Clearwater Valley Hospital and Clinics, Inc. Board on May 7, 2013.

The majority of the hospital facility's CHNA process occurred in 2012 and early 2013, and several steps occurred in collaboration with St. Mary's Hospital, Inc. of Cottonwood, ID. The CHNA process for these two hospital facilities was coordinated with the CHNA processes of thirteen other Essentia Health hospital facilities and was facilitated by the Essentia Institute of Rural Health, a center for research and education. For all hospital facilities, community health profile data were compiled and presented to Community/Patient Focus Groups that were asked to identify and prioritize their community's health needs based on the data. The three highest-priority health needs for the community served by Clearwater Valley Hospital and Clinics, Inc. and St. Mary's Hospital, Inc. are 1) access to healthcare, defined as enhanced healthcare for the local population, 2) obesity, physical activity, and nutrition as risk factors for chronic diseases, such as type 2 diabetes, and 3) tobacco use primary prevention/cessation. Each of these health needs will be addressed by a three year intervention, the first of which will begin in 2013 with the others beginning in subsequent years. The first intervention will be enhanced type 2 diabetes self-management education. Town Hall Meetings to select interventions for the other two health needs will be held in the future in tandem with St. Mary's Hospital, Inc. Intervention Planning Meetings will be held after each Town Hall Meeting in tandem with St. Mary's Hospital, Inc. in order to make concrete plans for implementing the selected interventions and to identify individuals who are accountable for the implementation. The first Intervention Planning Meeting for Clearwater Valley Hospital and Clinics, Inc. and St. Mary's Hospital, Inc. will occur on July 11, 2013. All interventions will be monitored over time to determine whether the community health needs are being met and to add to the evidence on intervention effectiveness.

We truly believe this CHNA and associated implementation strategy will benefit community health, thus supporting Essentia Health's mission to make a healthy difference in people's lives.

1. Introduction

This Community Health Needs Assessment (CHNA) was conducted in response to the enactment through The Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)), of section 501(r) of the Internal Revenue Code.[1] According to REG-106499-12, "Section 501(r)(3) requires a hospital organization to conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA."[1]

In addition to the CHNA being a legal requirement, the CHNA and associated implementation strategy support population health-related goals of Essentia Health. First and foremost, Essentia Health's mission is to make a healthy difference in people's lives. As the CHNA is ultimately designed to provide community benefit by improving community/population health, meeting CHNA requirements helps Essentia Health pursue that mission. Second, Essentia Health is one of the first accredited Accountable Care Organizations (ACOs) in the nation.[2] This accreditation is part of Essentia Health's pursuit of the Triple Aim of "improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations."[3] Finally, Essentia Health is working on a Patient Centered Medical Home (PCMH) primary care delivery model project. As described by the Agency for Healthcare Research and Quality, PCMHs coordinate care among different parts of the healthcare system, such as hospitals and community services and supports, and assure quality through activities such as population health management.[4] Community/population health consequently links several of Essentia Health's goals (Figure 1).

Figure 1. Population Health Links ACOs, PCMHs, and Community Benefit (CHNA)

To meet the CHNA requirement, fifteen Essentia Health hospital facilities participated in a coordinated process that was facilitated by the Essentia Institute of Rural Health (EIRH), a center for research and education. In addition to furthering the goals listed above, a coordinated CHNA process presents research opportunities to EIRH through methodical

evaluation of processes for and outcomes of health interventions developed in response to each community's health needs. EIRH researchers will contribute to the evidence on intervention effectiveness, as well as quantify provision of community benefit for the IRS.

A substantial portion of the CHNA process was completed prior to the April 5, 2013 release of additional CHNA guidance via REG-106499-12.[1] Consequently, the following CHNA report and accompanying implementation strategy conform to requirements outlined in Notice 2011-52[5] with one exception and one addition resulting from guidance provided in REG-106499-12. The exception taken to Notice 2011-52 relates to the following excerpt from REG-106499-12: "…these proposed regulations do not specifically require the CHNA report to contain the names or titles of any individuals contacted within an organization. In addition, the proposed regulations specify that a CHNA report does not need to name or otherwise individually identify any individuals participating in community forums, focus groups, survey samples, or similar groups." Consequently, names and titles of individuals providing input in the hospital facility's CHNA are suppressed. In order to conform to Notice 2011-52, names and titles will be made available upon request. The addition made to this CHNA based on guidance provided in REG-106499-12 is the opportunity for public comment on the CHNA and implementation strategy. REG-106499-12 requires a hospital facility to take into account input from "written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy." Thus, comments on this CHNA and accompanying implementation strategy can be emailed to Essentia Health in order to meet this regulation for the next CHNA.

The following report is divided into sections and subsections as prescribed by Notice 2011-52. Additional sections and subsections were included by the authors as needed. The conceptual model guiding the CHNA process is the Institute of Medicine's Community Health Improvement Process[6] (Figure 2). The "Problem Identification and Prioritization Cycle" culminated in identification and prioritization by participants at a Community/Patient Focus group of three health needs for the community served by the hospital facility. These health needs, described in Section 6, will each be addressed by a 3-year intervention, the first of which will begin in 2013 with the other two beginning in subsequent years (Figure 3). The "Analysis and Implementation Cycle" is currently underway. An inventory of resources is provided in Appendix C. Development of a health improvement strategy has already occurred for the highest priority health need through conduct of a Town Hall Meeting (see Section 5 and Appendix A for greater detail). At the meeting, intervention options for meeting the community's highest priority health need were presented, and individuals representing the broad interests of the community served by Clearwater Valley Hospital and Clinics, Inc. and St. Mary's Hospital, Inc. were asked to select one for implementation. Town Hall Meetings for the second and third priority health needs will occur in late 2013/early 2014 and late 2014/early 2015, respectively. The remaining steps in the "Analysis and Implementation Cycle" will occur

in the future. Intervention Planning Meetings will be held in order to make concrete plans for implementing the interventions and to identify individuals who are accountable for the implementation. Once the interventions are underway, their effectiveness will be monitored over time in order to determine whether the community health needs are being met and for researchers at EIRH to contribute to scientific evidence on intervention effectiveness.

Figure 2. Institute of Medicine Community Health Improvement Process

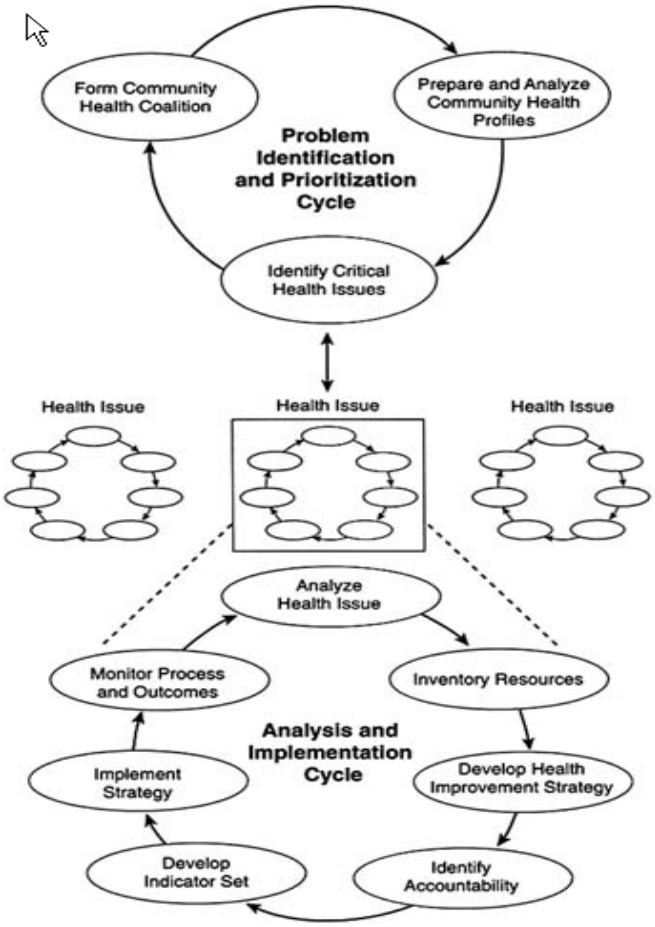
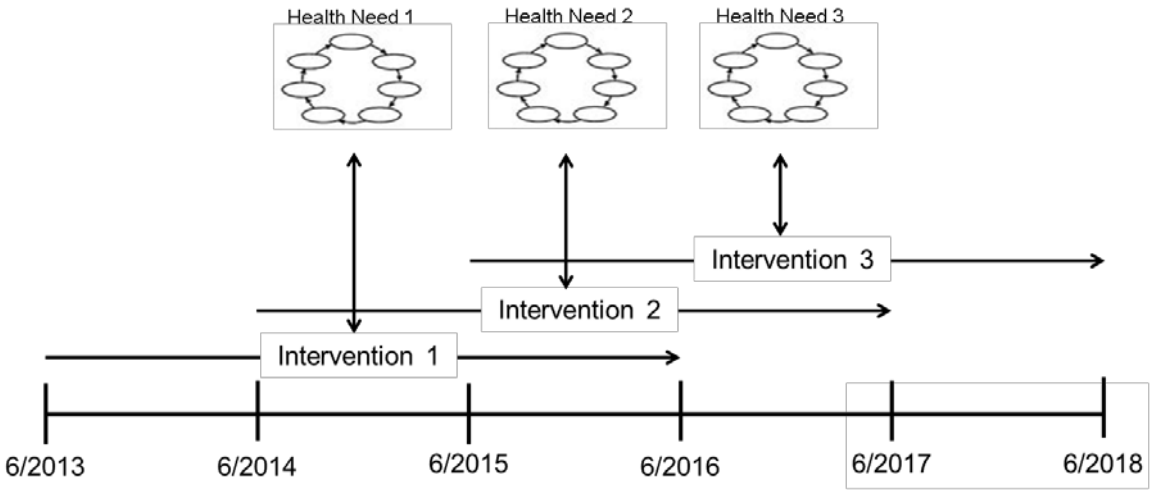


Figure 3. Intervention Timeline



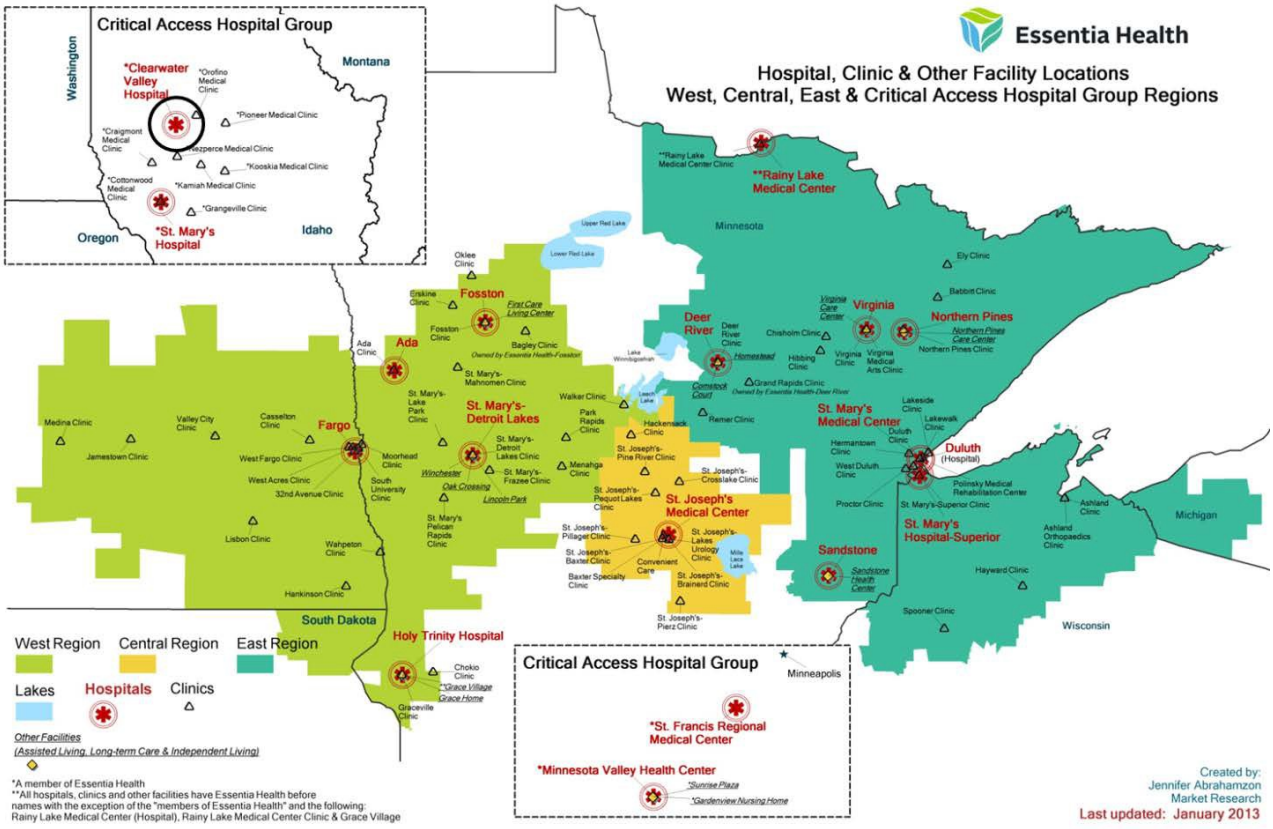
2. Community Served by the Hospital Facility

2.1. Description/Definition and Determination

As stated in previously filed IRS-990 forms, Clearwater Valley Hospital and Clinics, Inc. and St. Mary's Hospital, Inc. serve Clearwater, Idaho, and Lewis Counties. All counties are federally qualified health professional shortage areas in the state with the lowest rate of physicians per capita in the nation. The hospitals and their clinics serve all patients in the service area, regardless of ability to pay. No caps are placed on the number of uninsured, Medicare, or Medicaid patients seen.

Clearwater Valley Hospital and Clinics, Inc. is located in Orofino, ID. It is the only hospital in Clearwater County. Clearwater Valley Hospital and Clinics, Inc. is part of the larger Essentia Health system, which is defined in IRS form 990 Part VI, Line 6. Clearwater Valley Hospital and Clinics, Inc. operates one hospital and three clinics that serve the communities of Clearwater, Idaho, and Lewis Counties covering 2,400 square miles. The overall community is classified as rural. In the following report, data are presented at the county and state level to ensure stability of the estimates.

Figure 4. Hospital Location



2.2. Demographics

Population demographics for the four states in which Essentia Health has a presence are displayed below. See Subsection for 3.1 for detail on methods. As shown in Table 1, compared to the other states, Idaho has the highest percentage of individuals with annual household income < $35,000 and less than high school education. These differences translate into Idaho having the highest proportion of individuals with low socioeconomic status (SES). Idaho also has the highest percentage of individuals with at least one health service deficit (HSD), defined as lacking health insurance, lacking a healthcare provider, deferring medical care because of cost, or failing to obtain a routine medical exam, all within the last twelve months.

Table 1. Population Demographics for States Where Essentia Health Has a Presence.

Measure		2009 BRFSS* Data (%)			
		Idaho	Minnesota	North Dakota	Wisconsin
Sex	Male	50.0	49.4	49.9	49.3
	Female	50.0	50.6	50.1	50.7
Age Ranges	18-34 Years	32.8	30.1	32.9	29.5
	35-64 Years	50.8	53.3	47.8	52.8
	>=65 Years	16.5	16.6	19.2	17.7
Annual Household Income	<$35,000	40.7	26.0	33.3	37.9
	>=$35,000	59.3	74.0	66.7	62.1
Educational Attainment	<High School	9.8	4.1	8.4	6.1
	Completed High School	60.4	54.5	59.9	63.8
	College Graduate	29.8	41.4	31.7	30.1
Socioeconomic Status**	Low SES	37.1	22.1	29.1	35.5
	Middle SES	49.5	52.3	55.6	49.3
	High SES	13.4	25.6	15.3	15.3
Marital Status	Married Or Living With Partner	70.1	68.2	66.8	66.2
	Unmarried And Not Living With A Partner	29.9	31.8	33.2	33.8
Race/Ethnicity	Caucasian	88.4	91.5	89.8	89.0
	African American	0.2	2.5	0.6	3.0
	Hispanic	6.7	1.9	2.0	3.1
	Other/Multiracial	4.7	4.1	7.6	4.9
At Least 1 Child In Household		45.9	43.1	39.7	39.6
At Least 1 Health Service Deficit***		56.8	42.8	50.4	44.2
Population In State Rural		36.3	29.2	61.0	30.6

* Behavioral Risk Factor Surveillance System

** SES is a composite or computed variable comprised of two categorical variables: education and income.

*** Defined as lacking health insurance, lacking a healthcare provider, deferring medical care because of cost, or failing to obtain a routine medical exam, all within the last twelve months.

As displayed in Table 2, all four states have a higher percentage of individuals ≥ 65 years of age in rural versus non-rural areas, as well as a higher percentage of individuals with less than high school education in rural versus non-rural areas. A higher percentage of individuals in rural versus non-rural areas in all states have an annual household income < $35,000. Rural Idaho is largely Caucasian (87.6%), but the percentage of Hispanics is higher in rural versus non-rural Idaho.

Table 2. Population Demographics for States Where Essentia Health Has a Presence Stratified by Geographic Locale (Rural/Non-Rural)

Measure		% Idaho		% Minnesota		% North Dakota		% Wisconsin	
		Non-Rural	Rural	Non-Rural	Rural	Non-Rural	Rural	Non-Rural	Rural
Sex	Male	49.7	50.5	50.0	47.8	50.2	49.8	49.2	49.4
	Female	50.3	49.5	50.0	52.2	49.8	50.2	50.8	50.6
>=65 Years		15.8	17.7	14.5	21.7	17.9	20.0	16.7	20.2
Household Income <$35,000		36.9	47.4	22.7	34.4	27.7	37.0	35.3	43.8
Education	<High School	8.5	12.2	3.6	5.3	5.9	10.1	5.9	6.6
	High School or GED	58.5	63.8	50.2	65.0	55.9	62.4	59.5	73.3
	College Graduate	33.1	24.0	46.2	29.7	38.2	27.5	34.5	20.1
Unmarried and Not Living With A Partner		30.4	29.0	32.4	30.4	33.9	32.7	33.9	33.5
Race/Ethnicity	Caucasian	88.9	87.6	89.6	96.1	93.8	87.2	86.8	94.2
	African American	0.2	0.1	3.5	0.2	1.1	0.3	4.4	0.0
	Hispanic	5.8	8.3	2.2	1.2	0.9	2.8	3.9	1.2
	Other/Multiracial	5.1	4.0	4.8	2.6	4.2	9.8	4.9	4.7
At Least 1 Child In Household		47.2	43.5	44.8	39.2	41.1	38.9	40.3	37.9

Stratification by race/ethnicity, as shown in Table 3, highlights other demographic factors in the four states. The sex ratio is more skewed among non-Caucasians in Idaho versus non-Caucasians in the other states with a higher percentage of non-Caucasians in Idaho being male. In all states, a higher percentage of non-Caucasians earn <$35,000 annually and have less than a high school education. The difference across race/ethnicity in having less than a high school education is particularly large in Idaho compared to the other states.

Table 3. Population Demographics for States Where Essentia Health Has a Presence Stratified by Race/Ethnicity

Measure		% Idaho		% Minnesota		% North Dakota		% Wisconsin	
		Caucasian	Non-Caucasian	Caucasian	Non-Caucasian	Caucasian	Non-Caucasian	Caucasian	Non-Caucasian
Sex	Male	49.1	56.5	49.2	51.2	50.2	48.0	49.5	47.4
	Female	50.9	43.5	50.8	48.8	49.8	52.0	50.5	52.6
Age Ranges	18-34 Years	31.1	45.5	27.9	53.9	30.4	55.6	27.4	46.3
	35-64 Years	51.7	43.2	54.6	39.3	49.3	34.5	54.3	40.6
	>=65 Years	17.1	11.3	17.5	6.8	20.3	9.9	18.3	13.1
Household Income <$35,000		37.3	67.9	24.4	43.7	30.5	60.0	34.9	62.4
Education	<High School	7.2	30.3	3.8	6.9	7.2	19.7	5.1	14.6
	Completed High School	61.6	51.1	54.7	52.4	59.7	61.0	63.7	64.0
	College Graduate	31.2	18.6	41.5	40.7	33.1	19.3	31.1	21.5
Unmarried and Not Living With A Partner		28.8	38.3	30.3	48.4	30.6	55.7	32.3	46.2
At Least 1 Child In Household		44.7	55.2	41.1	64.7	37.3	61.4	38.4	49.6
Rurality	Non-Rural	64.0	61.1	69.4	86.6	40.8	23.6	67.6	83.7
	Rural	36.0	38.9	30.6	13.4	59.2	76.4	32.4	16.3

Figure 5 includes the University of Wisconsin Population Health Institute (UWPHI) County Health Rankings[7] for Social and Economic Factors for Clearwater, Idaho, and Lewis Counties compared to other counties in Idaho. A rank of one is the best, and two counties in Idaho were not ranked (Camas and Clark). The underlying data for these ranks are included in Table 4 which also includes the error margin and Idaho average, as well as the national benchmark, the point at which only 10% of counties in the nation do better. Ranks for several components of the overall Social and Economic Factors ranks for the three counties are in the lower half of all counties, leading to the overall Social and Economic Factors ranks being 40 (Clearwater County), 34 (Idaho County), and 24 (Lewis County) of 42. All counties are ranked especially low for income, and as evidenced in Table 4, the percentages of children in poverty in all three counties, especially Lewis County, are higher than the Idaho average and national benchmark.

Figure 5. UWPHI County Health Rankings Social and Economic Factors Ranks

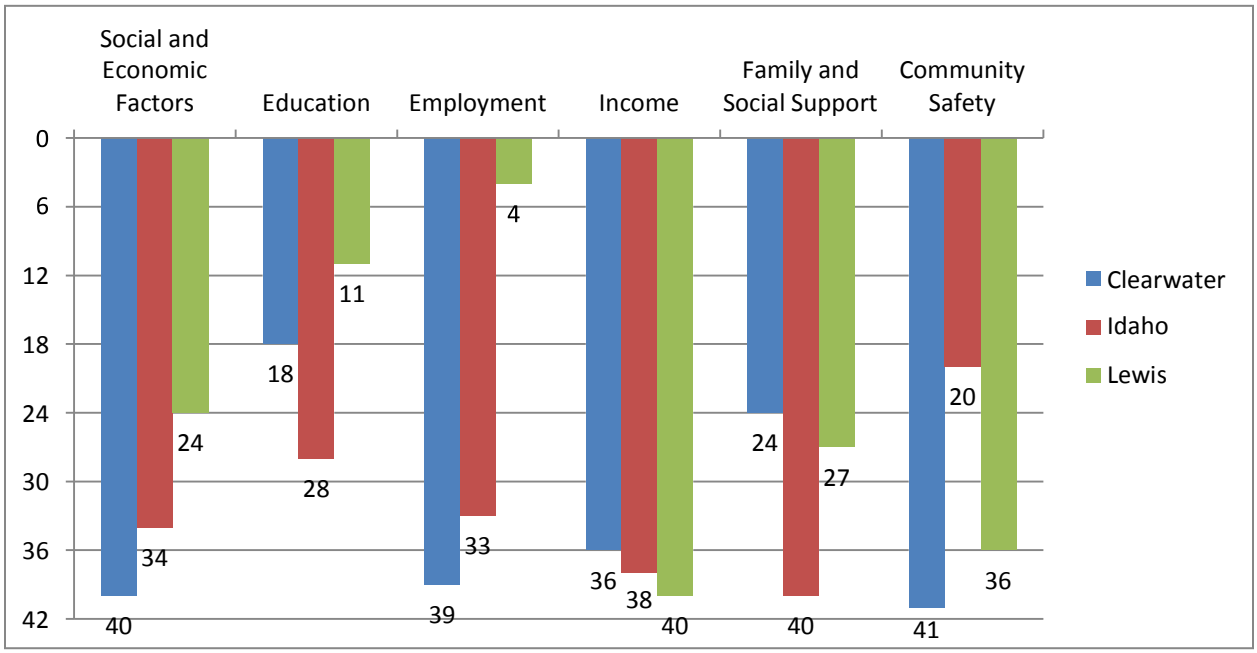


Table 4. UWPHI County Health Rankings Social and Economic Factors Data

Social & Economic Factors Category	Social & Economic Measure	Clearwater County	Idaho County	Lewis County	Idaho State	National Benchmark
Education	High school graduation, % of ninth grade cohort that graduates in 4 years, 2008-2009	95%	84%	91%	81%	-
	Some college, % of adults aged 25-44 years with some post-secondary education, 2006-2010	43% (31-55%)	45% (35-54%)	55% (24-87%)	62%	68%
Employment	Unemployment, % of population age 16+ unemployed but seeking work, 2010	15.5%	11.6%	6.3%	9.3%	5.4%
Income	Children in poverty, % of children under age 18 in poverty, 2010	26% (18-35%)	27% (19-34%)	29% (21-37%)	20%	13%
Family/Social Support	Inadequate social support, % of adults without social/emotional support, 2005-2010	17% (14-21%)	20% (17-23%)	-	17%	14%
	Children in single-parent households, % of children that live in household headed by single parent, 2006-2010	25% (16-35%)	34% (24-43%)	27% (14-41%)	23%	20%
Community Safety	Violent crime rate per 100,000 population, 2007-2009	380	168	294	242	73

2.3. Additional Demographic Data

Additional demographic data for Clearwater, Idaho, and Lewis Counties are included in Table 5. The populations of the three counties were estimated at 8,590, 16,308, and 3,889 persons, respectively, in the most recent census with 21.7%-23.2% age 65 years and over. Females constitute 45.7%, 47.6%, and 50.0% of the populations, respectively. By race and ethnicity, the populations of Clearwater and Idaho Counties are not very diverse, with Caucasians constituting approximately 92% of the populations overall. There is slightly more diversity in Lewis County with Caucasians constituting 88.5% of the population overall. The counties have a high household ownership rate averaging 71.5% or more over a 4-year timeframe. Over 85% of the population aged 25 and older are high school graduates and over 13% of this same group are college graduates (4-year degree). A larger percentage of the population lives below the federal poverty level in Idaho and Lewis Counties (17.1% and 18.2%, respectively) than in Clearwater County (10.3%). The per capita income averaged over a 4-year timeframe was $18,865-$20,238, and the median household income for this same time frame was over $35,000. These three counties are all considered rural.

Table 5. Clearwater, Idaho, and Lewis County Demographic Data

Demographic Variables	ClearwaterCounty	Idaho County	Lewis County
Population, 2012 estimate	8,590	16,308	3,889
Persons under 5 years, percent, 2011	4.0%	5.3%	5.7%
Persons under 18 years, percent, 2011	17.1%	20.5%	21.7%
Persons 65 years and over, percent, 2011	23.2%	21.7%	23.0%
Female persons, percent, 2011	45.7%	47.6%	50.0%
White persons not Hispanic, percent, 2011	91.5%	92.3%	88.5%
Black persons, percent, 2011	0.4%	0.3%	0.5%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	3.3%	2.7%	3.5%
American Indian and Alaska Native persons, percent, 2011	2.3%	2.9%	5.1%
Other	2.5%	1.8%	2.4%
Living in same house 1 year & over, percent, 2007-2011	87.0%	87.7%	84.4%
Foreign born persons, percent, 2007-2011	2.0%	1.2%	1.2%
Language other than English spoken at home, percent of persons aged 5+, 2007-2011	4.8%	2.8%	4.1%
High school graduate or higher, percent of persons age 25+, 2007-2011	85.4%	87.8%	88.8%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	14.2%	13.9%	15.2%
Homeownership rate, 2007-2011	80.5%	77.0%	71.5%
Median value of owner-occupied housing units, 2007-2011	$127,600	$142,300	$117,400
Households, 2007-2011	3,612	6,710	1,639
Persons per household, 2007-2011	2.21	2.3	2.27
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$20,238	$19,299	$18,865
Median household income, 2007-2011	$42,043	$36,706	$35,344
Persons below poverty level, percent, 2007-2011	10.3%	17.1%	18.2%
Land area in square miles, 2010	2,457.27	8,477.35	478.8
Persons per square mile, 2010	3.6	1.9	8
Federal Information Processing Standard (FIPS) Code	35	49	61
Rural	Yes	Yes	Yes

Source: US Census Bureau State & County QuickFacts

3. Process and Methods Used to Conduct the Assessment

3.1. Sources and Dates of the Data and Other Information Used in the Assessment

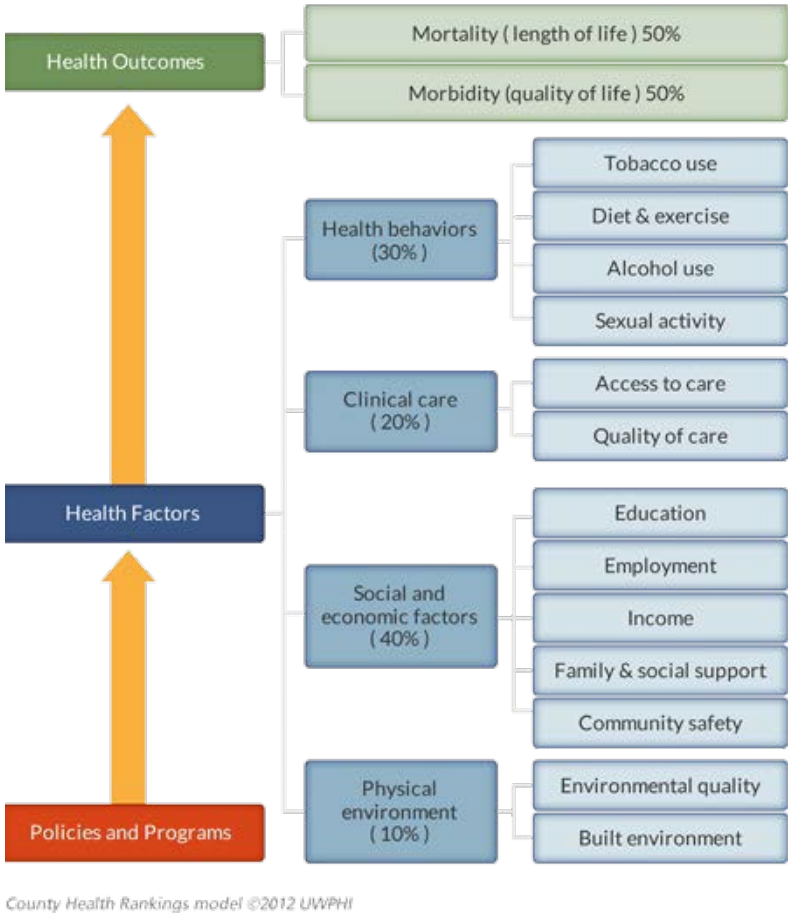
A community health profile consisting of state and county service area demographic, health-related behaviors, health services, and health outcomes data was compiled for the hospital facility and is included in Subsection 2.2 and Section 4. Data for the community health profile were obtained from two sources: the UWPHI County Health Rankings[7] and the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS).[8]

Primary and chronic disease needs of minority groups were assessed through stratification of BRFSS data on race/ethnicity. Primary and chronic disease needs and other health issues of uninsured persons and low-income persons were assessed through stratification of BFRSS data on rurality, a factor that is highly relevant to the rural service area of Clearwater Valley Hospital and Clinics, Inc. The following excerpt[9] authored by researchers at EIRH describes the health disparities experienced by rural populations:

> "In addition to being a medically underserved population, U.S. rural residents experience more disease and greater health and healthcare disparities than urban residents.[10,11] Specifically, compared to the urban population, rural populations have higher prevalence of uninsured adults, adults with chronic conditions such as diabetes and cardiovascular disease, adolescent and adult smoking, and below-guideline consumption of fruits and vegetables.[10-17] Other important disparities in social determinants of health have also been detected for rural U.S. residents including higher poverty levels and lower levels of attained education."

UWPHI County Health Rankings[7] data from 2012 were utilized in this assessment. These data are compiled by the County Health Rankings team from a variety of sources including, but not limited to, BFRSS, The Dartmouth Institute, the National Center for Health Statistics, the United States Census, and the United States Department of Agriculture. For this assessment, both the county rankings and the data underlying the rankings were utilized from the full County Health Rankings Model (Figure 6). The data presented here were downloaded in September 2012 with primary care physicians data updated in May 2013. Ranks are not shown if all underlying data are missing or unreliable. As described earlier, a rank of one is best, and two counties in Idaho were not ranked (Camas and Clark). The national benchmark is "the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (e.g., high school graduation) or negatively (e.g., adult smoking)." Readers are directed to the County Health Rankings website[7] for further information on data and methods.

Figure 6. UWPHI County Health Rankings Model



As the 2012 County Health Rankings used years of data ranging from 2002 to 2011, with several measures, such as diet and exercise, using 2009 data,[7] BRFSS data from 2009 were utilized for congruency. These data were also the most recently available BRFSS data during the initial stages of the CHNA.

BRFSS is the largest surveillance system in the world. BRFSS data are collected using a random-digit dial telephone survey targeting adults 18 through 99 years of age. These data are collected under the aegis of the CDC in collaboration with all US states and most US territories. Once collected, BRFSS data are weighted by state or territory to represent the non-institutionalized US adult population. BRFSS data are cross-sectional and are focused on health risk factors and behaviors, as well as chronic diseases. All analyses were performed on weighted data as is recommended by the CDC. The weighting, calculated by the CDC, uses the

most recently available census data to provide a stratified representation of the nation's non-institutionalized population.

BRFSS data collected in 2009 and made available in 2010 were analyzed for this CHNA. These data were the most recently available BRFSS data during the initial stages of the CHNA and correspond to the County Health Rankings data. In the analyses presented here, a number of variables were either re-coded or computed. All re-coding entailed collapsing categories and removing the responses don't know and refused. The following variables were computed: HSD, SES, and race/ethnicity. HSD was computed from the response categories of four different variables (health insurance status, personal healthcare provider, deferment of medical care because of cost, and routine medical exam). These variables were chosen because they all impact how individuals interact with and access the health care system. The specific response categories were: did not have health insurance, did not have a healthcare provider, deferred medical care because of cost, and did not have a routine medical exam, all within the last 12 months. Having one or more of these constituted having a HSD.

SES is comprised of two categorical variables: education and income. In keeping with convention, data categories from each of these individual variables were coded as low, mid-range, or high and numbered 1, 2, or 3, respectively. The variables with numbered factors or categories were then added together to create the composite variable of SES. Categories for education included: low = less than high school (coded as 1), mid-range = high school graduate (coded as 2), and high = at least some college (coded as 3). Categories for income were: low = <$25,000 (coded as 1), mid-range = $25,000 - <$50,000 (coded as 2), and high = > $50,000 (coded as 3). The possible range for the SES variable was 2 – 6 points. Subsequently, these points were indexed in the following manner: low = 2-3 points, mid-range = 4-5 points, and high = 6 points. These cut-points were purposive. For the lowest range of the index, 2 points was the floor (smallest possible point assignment). For the mid-range of the index, 4 points was the floor, and for the high range of the index, 6 points was the floor. Any points below the floor for the mid-range were assigned to the lowest index category just as any points below the floor for the highest index category were assigned to the mid-range index category.

The race/ethnicity variable was calculated from participant responses to two separate survey questions—one regarding race and the other regarding Latino/Hispanic ethnicity. Caucasian, non-Hispanic was coded as Caucasian, and all other racial/ethnic categories were coded as non-Caucasian.

The Metropolitan Statistical Area (MSA) variable included in BRFSS was used to define geographic locale. MSA was re-coded by collapsing categories into those of rural and non-rural. Rural residents were defined as persons living either within an MSA that had no city center or

outside an MSA. Non-rural residents included all respondents living in a city center of an MSA, outside the city center of an MSA but inside the county containing the city center, or inside a suburban county of the MSA.

3.2. Analytical Methods Applied/Process Used to Identify Community Health Needs

Data in the community health profile in Subsection 2.2 and Section 4 was presented to community members at a Community/Patient Focus Group held at Hearthstone Bakery in Kamiah, ID on October 9, 2012. The Community/Patient Focus Group was held in tandem with St. Mary's Hospital, Inc. Participants were residents of the two hospital facilities' service areas. After a presentation of the CHNA project and process, as well as the community health profile data, a facilitated discussion was held among participants, hospital facility staff members, and a researcher from EIRH. The participants were asked to consider the data and identify the community's health needs. The data provided evidence of the severity of various health issues, as well as disparities that may exist due to geographic local (i.e. rural versus non-rural or across counties or states) or race/ethnicity. When identifying the health needs, participants were asked to consider the feasibility and thus potential effectiveness of interventions implemented by a health system to address those health needs. Further details on the process used to identify the community health needs are provided in Section 6.

3.3. Information gaps that impact ability to assess the health needs of the community served by the hospital facility

As noted, the county health rankings and data from the UWPHI, as well as data from BRFSS, were used to identify community health needs. In the future, we intend to work directly with the state-level BRFSS staff to ensure that rural populations are sufficiently sampled to provide adequate data. When possible, we will attempt to ensure that the data collected are sufficient for further county-level analyses. In this iteration of the CHNA, we analyzed state-level data according to a rural/non-rural stratification. This was done to ensure stable estimates. County-level data were not always available and when available were not always stable.

3.4. Coordination with Other Hospitals and Collaboration with Other Organizations

In the interest of efficiency, cost effectiveness, and alignment with Essentia Health population health strategies, the hospital facility's CHNA was conducted in a coordinated process with fourteen other Essentia Health hospital facilities. While still allowing for tailoring to each particular hospital facility, procedures were standardized across hospital facilities. The hospital facilities included in this coordinated process are: Bridges Medical Center, doing business as (DBA) Essentia Health Ada in Ada, MN; Clearwater Valley Hospital and Clinics, Inc. in Orofino,

ID; Deer River Healthcare Center, Inc., DBA Essentia Health Deer River in Deer River, MN; Essentia Health Virginia, LLC, DBA Essentia Health Virginia in Virginia, MN; Graceville Health Center, DBA Essentia Health Holy Trinity Hospital in Graceville, MN; Innovis Health, LLC, DBA Essentia Health West in Fargo, ND; Minnesota Valley Health Center, Inc. in Le Sueur, MN; Northern Pines Medical Center, DBA Essentia Health Northern Pines in Aurora, MN; Pine Medical Center, DBA Essentia Health Sandstone in Sandstone, MN; SMDC Medical Center, DBA Essentia Health Duluth in Duluth, MN; St. Joseph's Medical Center, DBA Essentia Health St. Joseph's Medical Center in Brainerd, MN; St. Mary's Hospital of Superior, DBA Essentia Health St. Mary's Hospital-Superior in Superior, WI; St. Mary's Hospital, Inc. in Cottonwood, ID; St. Mary's Medical Center, DBA Essentia Health St. Mary's Medical Center in Duluth, MN; and St. Mary's Regional Health Center, DBA Essentia Health St. Mary's-Detroit Lakes in Detroit Lakes, MN. Since Essentia Health West joined the group on February 1, 2013, not all aspects of the Essentia Health West CHNA are coordinated with those of the other hospital facilities. Clearwater Valley Hospital and Clinics, Inc. did and will collaborate more closely with one of the Essentia Health hospitals in particular – St. Mary's Hospital, Inc. in Cottonwood, ID – by holding joint Community/Patient Focus Groups, Town Hall Meetings, and Intervention Planning Meetings. Additional collaboration between the two hospitals will occur as the interventions progress.

The hospital facility did not collaborate with organizations outside of Essentia Health in identifying or prioritizing the community's health needs. However, as described in Subsection 5.2, various community organizations were and will be consulted when selecting interventions to address the community's health needs. More formal collaboration with organizations outside of Essentia Health is planned during intervention implementation. Details such as the research and evaluation protocol for the selected interventions will be presented at Intervention Planning Meetings to potential collaborators and hospital facility employees with authority to commit resources to implement the interventions. Many of these individuals will have likely attended the previous Town Hall Meeting at which the given intervention was selected. At the Intervention Planning Meetings, selected interventions will be further tailored to the particular hospital facility and community's programs and resources. The hospital facility's first Intervention Planning Meeting is scheduled for July 11, 2013. In addition to individuals affiliated with Essentia Health, organizations represented by likely invitees to the first Intervention Planning Meeting include the Diabetes Advisory Group, Community Education, a local school, Public Health – Idaho North Central District, Seniors in Shape Program, the tribal community, and University of Idaho Extension. Other entities may be added to the list as meeting planning proceeds. For future Intervention Planning Meetings, potential invitees include social service and service organization representatives, city and county government officials, tribal government/leadership/representatives and/or other minority population group members/representatives, primary care and other healthcare providers, lead

county public health officials, industry/business leaders/representatives, educators/educational administrators, and other relevant entities.

3.5. Contracted Third Parties

The hospital facility did not contract with third parties to assist with conduct of the CHNA.

4. Community Health Profile

Demographic and social and economic data presented to community members at the Community/Patient Focus Group as part of their community health profile are included in Subsection 2.2. The following tables and figures include the remainder of the presented data.

Figure 7 includes the Health Outcomes, Mortality, and Morbidity ranks for Clearwater, Idaho, and Lewis Counties. The ranks for Clearwater County are moderately-low to low. The mortality rank is based on 2006-2008 premature death, defined as years of potential life lost before age 75 per 100,000 population (age-adjusted) and is 8,062 for Clearwater County and 6,890 for Idaho County versus 6,351 for the state of Idaho and the national benchmark of 5,466. Premature death data for Lewis County were unreliable or missing. Table 6 indicates that Clearwater and Idaho Counties had a higher percentage of individuals reporting fair or poor health than in Lewis County and the Idaho average, both of which were higher than the national benchmark. Clearwater County also had a higher average number of physically unhealthy days reported in the past 30 days compared to the other two counties and the Idaho average, all of which were higher than the national benchmark.

Figure 7. UWPHI County Health Rankings Health Outcomes Ranks

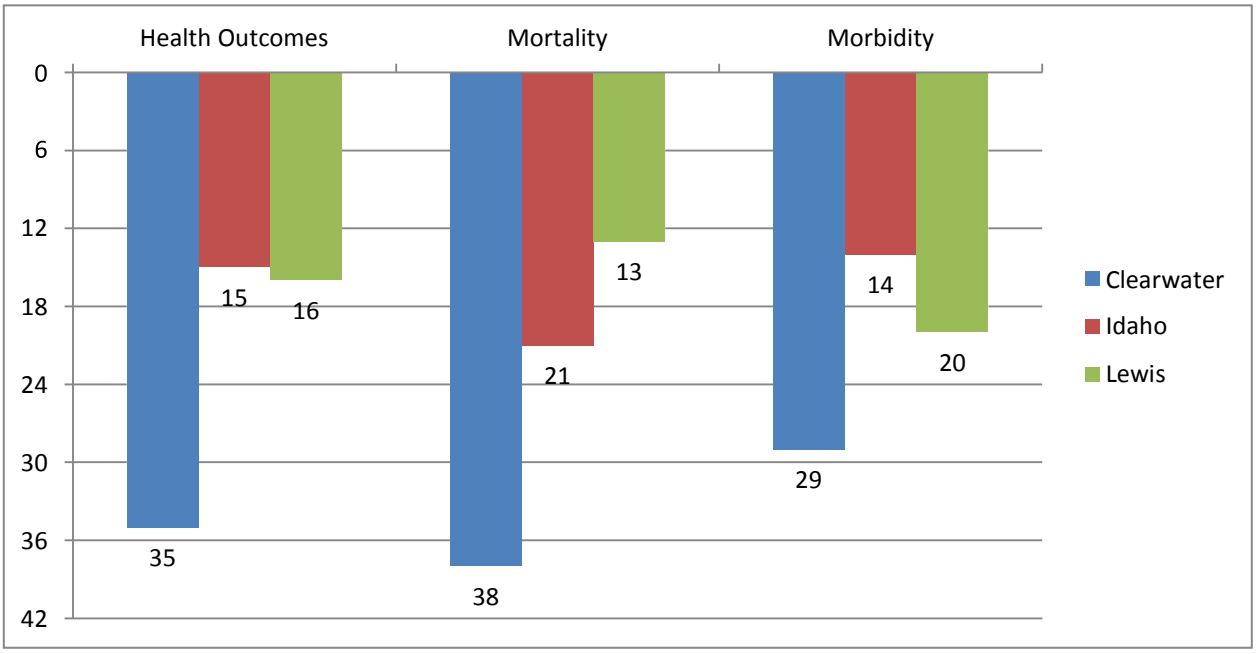


Table 6. UWPHI County Health Rankings Health Outcomes Data

Measure of Morbidity	Clearwater County	Idaho County	Lewis County	Idaho State	National Benchmark
Poor or fair health, % of adults reporting fair or poor health (age-adjusted), 2004-2010	20% (16-25%)	21% (18-25%)	16% (11-21%)	14%	10%
Poor physical health days, average number of physically unhealthy days reported in past 30 days (age-adjusted), 2004-2010	4.4 (3.5-5.2)	3.6 (3.0-4.1)	3.5 (2.5-4.5)	3.5	2.6
Poor mental health days, average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2004-2010	3.2 (2.5-3.9)	2.7 (2.1-3.2)	3.3 (2.2-4.4)	3.3	2.3
Low birthweight, % of live births with low birthweight (< 2500 grams), 2002-2008	5.8% (3.8-7.9%)	5.5% (4.2-6.9%)	-	6.6%	6%

The overall Health Factors rank for the counties composing the hospital facility's service area are 40 (Clearwater County), 32 (Idaho County), and 33 (Lewis County) of 42. Four types of health factors are ranked: Health Behaviors, Clinical Care, Social and Economic, and Physical Environment. Health Behaviors ranks are shown in Figure 8 with accompanying data included in Table 7. The overall Health Behaviors ranks are low for all three counties. The Diet and

Exercise rank is also low for all three counties as evidenced in Table 7 by higher percentages of obesity and physical inactivity compared to the Idaho average and national benchmark.

Figure 8. UWPHI County Health Rankings Health Behaviors Ranks

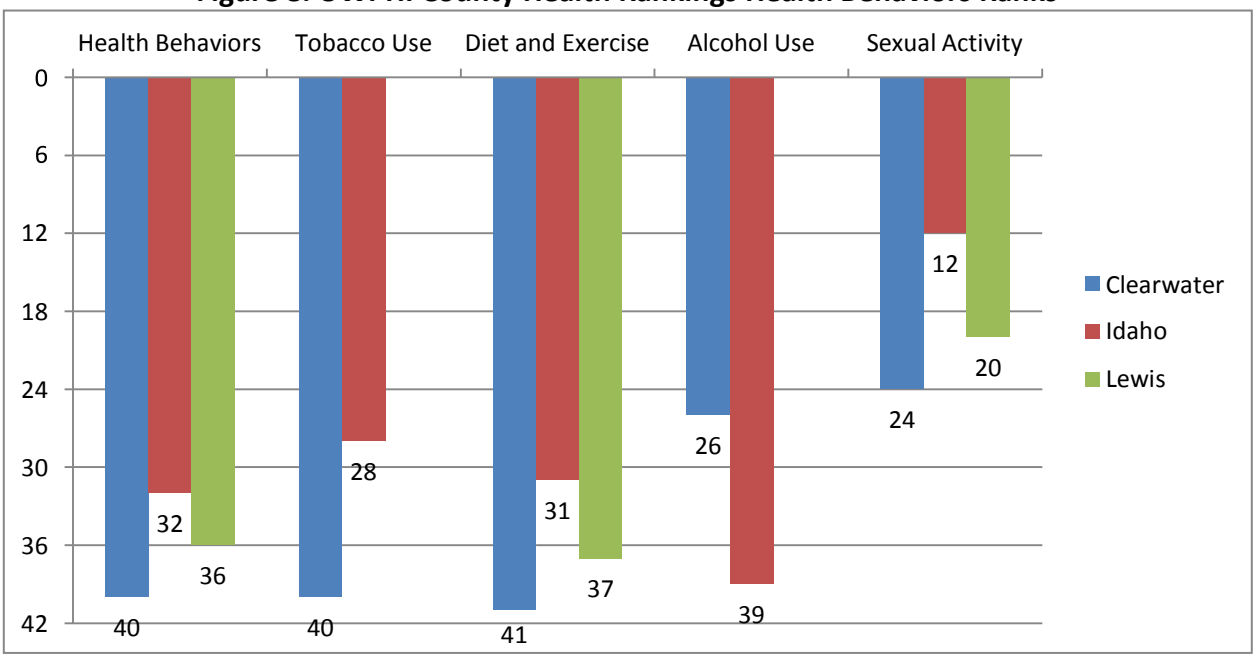


Table 7. UWPHI County Health Rankings Health Behaviors Data

Health Behavior Category	Health Behavior Measure	Clearwater County	Idaho County	Lewis County	Idaho State	National Benchmark
Tobacco Use	Adult smoking, % of adults that report smoking ≥ 100 cigarettes and currently smoking, 2004-2010	25% (20-30%)	20% (17-23%)	-	17%	14%
Diet & Exercise	Adult obesity, % of adults that report a body mass index ≥ 30 kg/m², 2009	32% (28-37%)	30% (26-33%)	30% (25-36%)	27%	25%
	Physical inactivity, % of adults aged 20 and over reporting no leisure time physical activity, 2009	27% (23-32%)	26% (23-29%)	27% (21-33%)	20%	21%
Alcohol Use	Excessive drinking, binge plus heavy drinking, 2004-2010	13% (9-17%)	20% (17-23%)	-	15%	8%
	Motor vehicle crash deaths per 100,000 population, 2002-2008	-	40 (28-51)	-	19	12
Sexual Activity	Sexually transmitted infections, chlamydia rate per 100,000 population, 2009	245	123	195	252	84
	Teen birth rate per 1,000 female population, ages 15-19, 2002-2008	38 (29-46)	31 (25-36)	38 (25-51)	40	22

The state of Idaho tends to perform well compared to the other states with respect to some behavioral risk factors (Table 8). BRFSS data indicate that compared to the other states, Idaho has the lowest percentage of individuals who are obese, have less than moderate physical activity, report binge drinking, and consume fruits and vegetables less than five times daily. However, Idaho has the highest proportion of individuals who did not receive a seasonal flu shot and have high cholesterol.

Table 8. Population Risk Factors and Disease Status for States Where Essentia Health Has a Presence

Measure		2009 BRFSS (%)			
		Idaho	Minnesota	North Dakota	Wisconsin
No Seasonal Flu Shot		64.5	49.8	57.4	57.4
Overweight or Obese	BMI 25-<30	36.2	37.9	37.8	36.4
	BMI >=30	25.1	25.4	28.4	29.2
Less Than Moderate Physical Activity		42.5	47.3	47.7	47.2
Diabetes		8.0	6.4	7.5	8.2
Hypertension		26.1	22.3	27.1	28.1
High Cholesterol		37.2	33.9	34.8	35.8
Asthma		12.7	9.6	12.0	13.7
Arthritis		23.7	20.9	27.4	25.2
Angina or CVD		3.9	3.5	3.6	4.3
Binge Drinking		12.6	20.1	20.9	22.9
Consume Fruit & Vegetables < 5 Times Daily		75.4	78.1	77.5	77.3

In all states in which Essentia Health has a presence, there is a higher prevalence of fair or poor self-defined health status among individuals living in rural versus non-rural areas (Table 9). Further examination of population risk factors and disease status in these states stratified by geographic local supports the poorer self-defined health status in rural areas. In all states, the prevalence of diabetes, hypertension, arthritis, myocardial infarction, and stroke is higher in rural areas compared to non-rural. In Idaho, the prevalence of overweight and obesity, high cholesterol, angina or CVD, no seasonal flu shot, and inadequate consumption of fruits and vegetables is higher in rural versus non-rural areas.

Table 9. Population Risk Factors and Disease Status for States Where Essentia Health Has a Presence Stratified by Geographic Locale (Rural/Non-Rural)

Measure		% Idaho		% Minnesota		% North Dakota		% Wisconsin	
		Non-Rural	Rural	Non-Rural	Rural	Non-Rural	Rural	Non-Rural	Rural
Self-Defined Health Status	Good To Excellent	86.2	82.4	91.1	86.8	90.2	87.2	88.7	86.9
	Fair To Poor	13.8	17.6	8.9	13.2	9.8	12.8	11.3	13.1
Overweight or Obese	BMI 25-<30	35.6	37.3	38.0	37.5	38.7	37.2	36.3	36.8
	BMI >=30	24.9	25.5	23.7	29.3	23.8	31.3	29.7	28.2
Less Than Moderate Physical Activity		42.5	42.5	45.7	51.2	47.0	48.1	47.3	46.9
Binge Drinking		12.7	12.6	19.5	21.4	18.3	22.6	22.8	23.0
Diabetes		7.7	8.4	5.8	7.7	6.6	8.1	8.1	8.6
Hypertension		25.4	27.5	20.8	26.0	24.9	28.5	27.3	29.8
High Cholesterol		36.5	38.7	32.7	36.8	34.5	34.9	36.2	34.8
Asthma		12.8	12.5	10.3	7.7	11.2	12.5	14.8	11.4
Arthritis		22.2	26.4	18.7	26.3	25.1	28.9	24.3	27.1
Myocardial Infarction		3.3	4.2	2.2	4.5	3.7	4.0	3.1	4.1
Angina or CVD		3.5	4.5	2.7	5.3	3.8	3.5	4.2	4.4
Stroke		2.3	2.7	2.0	2.9	2.3	3.2	1.8	3.0
No Seasonal Flu Shot		62.1	68.6	48.6	52.5	53.6	59.8	57.5	57.2
Fewer Than 5 Servings Daily of Fruit and Vegetables		74.0	77.8	77.2	80.3	77.4	77.5	76.6	78.9

Stratifying various population risk factors and disease statuses by race/ethnicity in states where Essentia Health has a presence indicates a higher prevalence of fair to poor self-defined health among non-Caucasians versus Caucasians in all states (Table 10); the prevalence difference is particularly large in Idaho versus the other three states. The prevalence of obesity, asthma, and not having had a seasonal flu shot is higher among non-Caucasians than Caucasians in all states. In Idaho, the prevalence of inadequate physical activity and diabetes is also higher among non-Caucasians than Caucasians, and the prevalence difference is particularly large for inadequate physical activity.

Table 10. Population Risk Factors and Disease Status for States Where Essentia Health Has a Presence Stratified by Race/Ethnicity

Measure		% Idaho		% Minnesota		% North Dakota		% Wisconsin	
		Caucasian	Non-Caucasian	Caucasian	Non-Caucasian	Caucasian	Non-Caucasian	Caucasian	Non-Caucasian
Self-Defined Health Status	Good To Excellent	86.4	72.9	90.0	88.7	89.4	79.6	88.7	83.8
	Fair To Poor	13.6	27.1	10.0	11.3	10.6	20.4	11.3	16.2
Overweight or Obese	BMI 25-<30	36.5	33.4	37.5	41.4	38.5	31.6	36.6	34.9
	BMI >=30	24.5	30.6	25.0	29.2	27.2	39.2	28.1	38.5
Less Than Moderate Physical Activity		41.7	48.5	47.0	49.8	48.2	43.7	47.1	48.2
Diabetes		7.7	10.0	6.4	6.4	7.2	10.0	8.3	7.6
Hypertension		26.2	25.5	22.5	20.7	27.4	24.9	28.3	26.0
High Cholesterol		37.6	34.1	34.5	27.2	35.8	24.5	35.9	34.1
Asthma		12.5	14.0	8.9	16.6	11.3	17.7	12.9	20.4
Arthritis		24.3	19.6	21.5	14.9	27.5	26.9	25.8	20.0
Angina or CVD		3.9	3.7	3.7	1.4	3.7	2.9	4.5	2.6
No Seasonal Flu Shot		64.2	66.6	49.5	53.1	57.0	60.6	56.3	67.0
Fewer Than 5 Servings Daily F&V		75.4	75.0	78.3	75.7	78.0	72.7	77.2	78.3

The UWPHI County Health Ranking for Clinical Care overall is low for Lewis County (Figure 9). All three counties have low ranks for Quality of Care. Table 11 indicates that all counties have high preventable hospital stay rates compared to the Idaho average and national benchmark. Mammography screening in Idaho County is lower than in the other two counties, the Idaho average, and the national benchmark.

Figure 9. UWPHI County Health Rankings Clinical Care Ranks

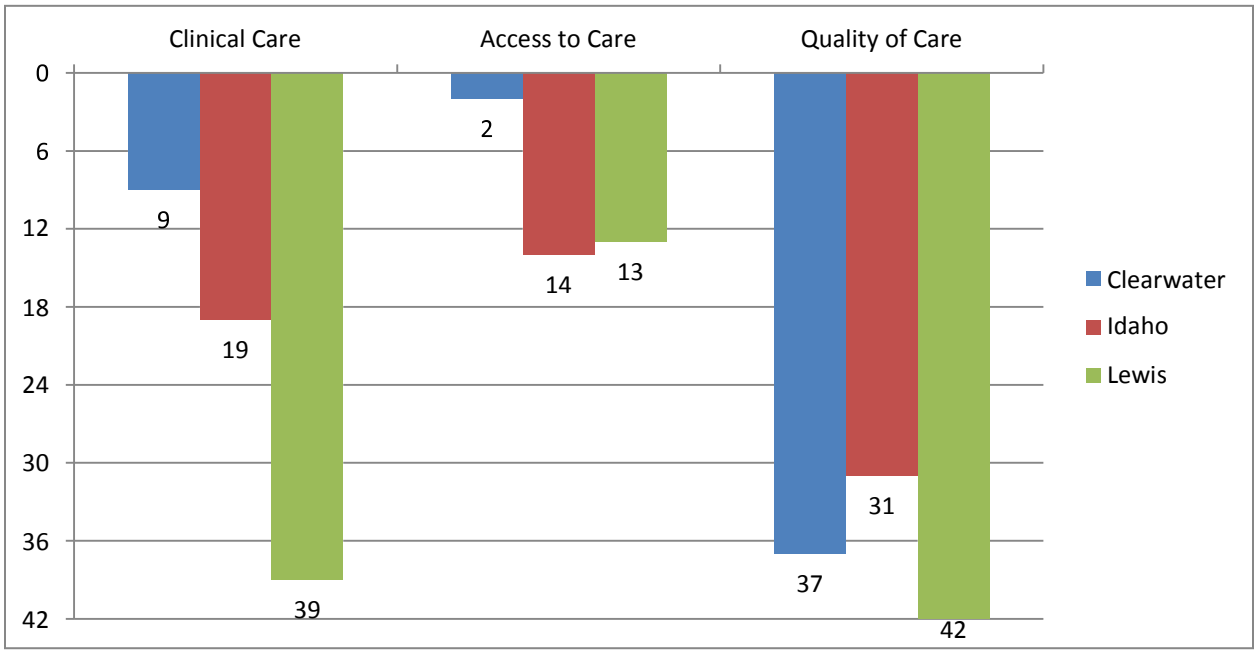


Table 11. UWPHI County Health Rankings Clinical Care Data

Clinical Care Category	Clinical Care Measure	Clearwater County	Idaho County	Lewis County	Idaho State	National Benchmark
Access to Care	Uninsured, % of population under age 65 without health insurance, 2009	21% (19-23%)	22% (20-24%)	20% (18-22%)	19%	11%
	Primary care physicians, ratio of population to primary care physicians, 2010-2011	816:1	1916:1	-	1586:1	945:1
Quality of Care	Preventable hospital stays, hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees, 2009	110 (91-128)	66 (55-77)	100 (80-121)	45	49
	Diabetic screening, % of diabetic Medicare enrollees that receive HbA1c screening, 2009	87% (71-100%)	88% (74-100%)	73% (57-90%)	82%	89%
	Mammography screening, % of female Medicare enrollees that receive mammography screening, 2009	75% (57-91%)	52% (41-62%)	58% (41-74%)	63%	74%

Table 12 includes data on population health services for states where Essentia Health has a presence. Compared to the other states, Idaho has the highest prevalence of all measures of poorer health services included in the table.

Table 12. Population Health Service Information for States Where Essentia Health Has a Presence

Measure		2009 BRFSS (%)			
		Idaho	Minnesota	North Dakota	Wisconsin
Do not Have Personal Healthcare Provider		27.0	20.8	23.9	15.2
Last Routine Medical Check-up	≤12 Months Ago	56.3	70.9	62.7	64.5
	>12 Months Ago	43.7	29.1	37.3	35.5
Self-Defined Health Status	Good To Excellent	84.8	89.9	88.4	88.1
	Fair To Poor	15.2	10.1	11.6	11.9
Do Not Have Health Insurance		18.7	8.0	10.7	10.3
Deferred Medical Care Because Of Cost		14.2	10.3	6.2	10.0

Stratifying population health service and SES data by geographic locale indicates that in all states, there is a higher prevalence of not having health insurance and low SES in rural versus non-rural areas (Table 13). In Idaho, other measures of poorer health services are also more prevalent in rural versus non-rural areas, including not having a personal healthcare provider, having had a routine medical check-up more than twelve months ago, and deferring medical care because of cost. Consequently, the prevalence of having at least one HSD is higher in rural versus non-rural Idaho.

Table 13. Population Health Service and SES Information for States Where Essentia Health Has a Presence Stratified by Geographic Locale (Rural/Non-Rural)

Measure		% Idaho		% Minnesota		% North Dakota		% Wisconsin	
		Non-Rural	Rural	Non-Rural	Rural	Non-Rural	Rural	Non-Rural	Rural
Do Not Have Personal Healthcare Provider		26.2	28.4	21.3	19.6	20.6	26.1	14.2	17.5
Do Not Have Health Insurance		16.8	22.0	7.6	8.9	8.3	12.3	9.0	13.2
Last Routine Medical Check-up	≤12 Months Ago	57.5	54.3	70.0	73.1	64.0	61.8	65.3	62.7
	>12 Months Ago	42.5	45.7	30.0	26.9	36.0	38.2	34.7	37.3
Deferred Medical Care Because of Cost		13.3	15.9	10.9	8.8	5.3	6.8	9.8	10.4
At Least 1 Health Service Deficit*		55.4	59.1	43.6	40.7	46.7	52.9	42.4	48.3
Socioeconomic Status	Low	33.8	42.8	19.0	29.8	23.0	33.1	32.7	41.7
	Middle	50.0	48.7	50.6	56.4	54.9	56.0	48.9	50.0
	High	16.3	8.4	30.4	13.8	22.0	10.9	18.4	8.3

* Defined as lacking health insurance, lacking a healthcare provider, deferring medical care because of cost, or failing to obtain a routine medical exam, all within the last twelve months.

In Table 14, disparities across race/ethnicity with respect to population health service and SES become apparent. In all four states, there is a higher prevalence of not having a personal healthcare provider, having had a routine medical check-up more than twelve months ago, not having health insurance, and deferring medical care because of cost among non-Caucasians compared to Caucasians. Consequently, the prevalence of having at least one HSD is higher among non-Caucasians than Caucasians in all four states. Furthermore, low SES is more prevalent among non-Caucasians than Caucasians in all four states. Differences in prevalence across race/ethnicity are larger in Idaho than the other three states for not having a personal healthcare provider, having had a routine medical check-up more than twelve months ago, not having health insurance, and low SES.

Table 14. Population Health Service and SES Information for States Where Essentia Health Has a Presence Stratified by Race/Ethnicity

Measure		% Idaho		% Minnesota		% North Dakota		% Wisconsin	
		Caucasian	Non-Caucasian	Caucasian	Non-Caucasian	Caucasian	Non-Caucasian	Caucasian	Non-Caucasian
Do Not Have a Personal Healthcare Provider		25.0	42.2	19.8	31.5	22.5	36.5	13.9	25.9
Last Routine Medical Check-up	≤12 Months Ago	57.3	48.7	71.4	65.8	62.9	61.0	64.7	62.8
	>12 Months Ago	42.7	51.3	28.6	34.2	37.1	39.0	35.3	37.2
No Health Insurance		16.5	35.9	7.6	11.8	9.0	26.3	9.2	19.1
Deferred Medical Care Because of Cost		13.3	21.8	8.9	24.3	5.2	14.7	8.6	21.6
Socioeconomic Status	Low SES	33.3	67.4	20.8	35.5	26.4	54.2	32.8	57.2
	Middle SES	52.1	28.2	53.1	42.9	57.5	37.8	51.0	34.6
	High SES	14.5	4.5	26.0	21.6	16.1	8.1	16.1	8.2
At Least 1 Health Service Deficit*		55.1	69.5	41.5	56.3	48.9	64.0	43.4	50.6

* Defined as lacking health insurance, lacking a healthcare provider, deferring medical care because of cost, or failing to obtain a routine medical exam, all within the last twelve months.

Lewis County has a lower overall Physical Environment rank than Clearwater and Idaho Counties; however, all counties are ranked moderately-low for Environmental Quality (Figure 10). Lewis County is also ranked moderately-low for Built Environment. Examination of the data driving the ranks (Table 15) indicates there were 10-13 air pollution-particulate matter days in these three counties and zero air pollution-ozone days. Both Clearwater and Lewis Counties have very limited access to recreational facilities compared to Idaho County and State,

as well as the national benchmark. Both Idaho and Lewis Counties have more limited access to healthy foods than Clearwater County, the Idaho average, and the national benchmark.

Figure 10. UWPHI County Health Rankings Physical Environment Ranks

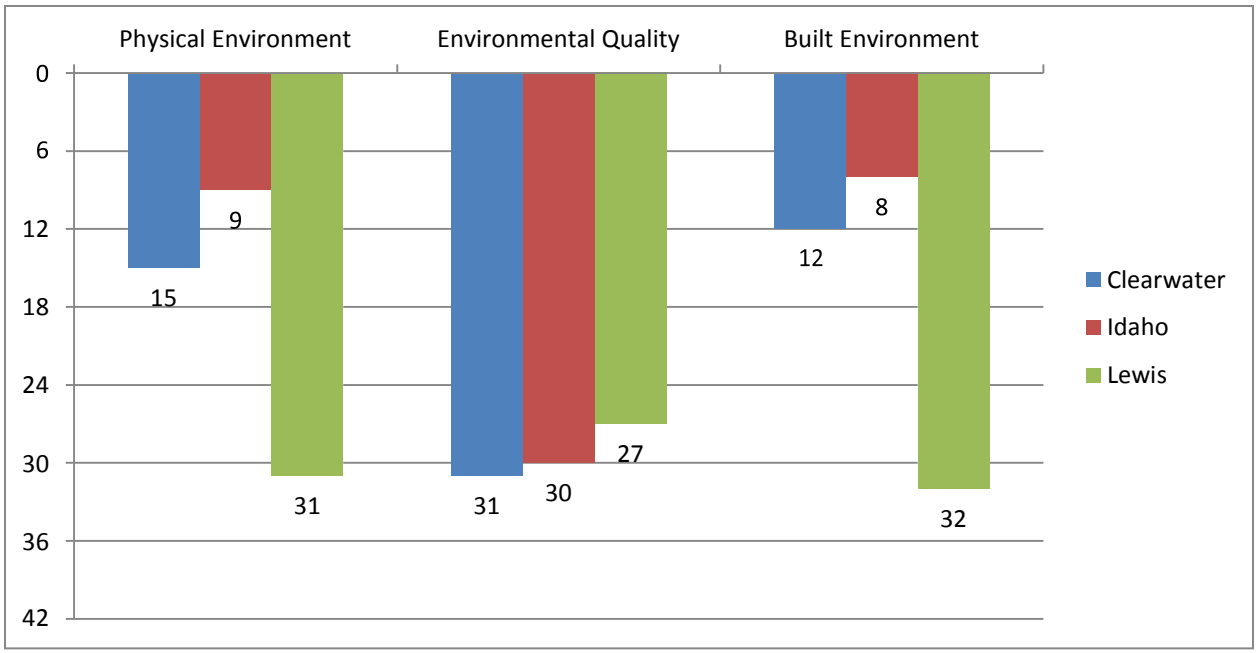


Table 15. UWPHI County Health Rankings Physical Environment Data

Physical Environment Category	Physical Environment Measure	Clearwater County	Idaho County	Lewis County	Idaho State	National Benchmark
Environmental Quality	Air pollution – particulate matter days, annual number of unhealthy air quality days due to fine particulate matter, 2007	13	11	10	10	0
	Air pollution – ozone days, annual number of unhealthy air quality days due to ozone, 2007	0	0	0	2	0
Built Environment	Access to recreational facilities, rate of recreational facilities per 100,000 population, 2009	0	13	0	10	16
	Limited access to healthy foods, % of population who are low-income and do not live close to a grocery store, 2006	4%	14%	19%	9%	0%
	Fast food restaurants, % of all restaurants that are fast-food establishments, 2009	29%	23%	33%	46%	25%

While the tables and figures above considered several health outcomes and risk factors by geographic locale and race/ethnicity, Table 16 breaks down a particular health risk factor, smoking, by other measures. In all four states, the prevalence of smoking is higher among non-Caucasians than Caucasians, individuals living in rural versus non-rural areas, and individuals with at least one HSD versus zero. The most striking relation, however, is the gradient in current smoking across SES wherein the prevalence of current smoking increases as SES decreases. These data exemplify how relations can exist among health-related factors, such as smoking and SES. These data, however, do not denote causality.

Table 16. Examination of a Specific Health Issue: The Case of Smoking

Measure		% Idaho		% Minnesota		% North Dakota		% Wisconsin	
		Current Smoker	Do Not Smoke	Current Smoker	Do Not Smoke	Current Smoker	Do Not Smoke	Current Smoker	Do Not Smoke
Overall		16.3	83.7	16.8	83.2	18.6	81.4	18.8	81.2
Race/Ethnicity	**Caucasian**	16.1	83.9	16.1	83.9	16.1	83.9	17.8	82.2
	Non-Caucasian	17.5	82.5	23.6	76.4	40.6	59.4	26.6	73.4
Geographic Locale	**Non-Rural**	15.1	84.9	16.5	83.5	13.3	86.7	18.5	81.5
	Rural	18.4	81.6	17.4	82.6	22.0	78	19.4	80.6
SES	**Low**	27.7	72.3	31.8	68.2	30.8	69.2	29.6	70.4
	Middle	11.2	88.8	15.7	84.3	16.6	83.4	16.3	83.7
	High	4.3	95.7	6.2	93.8	7.7	92.3	4.8	95.2
Health Service Deficit*	**No HSD**	10.6	89.4	12.7	87.3	13.5	86.5	13.4	86.6
	At Least 1 HSD	20.3	79.7	22.4	77.6	23.6	76.4	25.6	74.4

* Defined as lacking health insurance, lacking a healthcare provider, deferring medical care because of cost, or failure to obtain a routine medical exam, all within the last twelve months.

5. Input from Persons Who Represent the Broad Interests of the Community Served by the Hospital Facility

5.1. When and How These Persons Were Consulted

Persons representing the broad interests of the community were consulted on two occasions, both of which occurred in tandem with St. Mary's Hospital, Inc. First, as described in Subsection 3.2, a Community/Patient Focus Group was held for community members to identify and prioritize their community health needs. Second, persons were and will be consulted at Town Hall Meetings, which are the first step in addressing each prioritized health need. The Town Hall Meeting for the highest priority health need was held on January 3, 2013. During the Town Hall Meeting, intervention options for meeting the health need were presented, and participants selected the option best suited to their community. See Appendix A for further detail. Town Hall Meetings for the second and third priorities will occur in late

2013/early 2014 and late 2014/early 2015, respectively. Further consultation with potential collaborators will occur after each Town Hall Meeting at Intervention Planning Meetings (see Subsection 3.4).

5.2. Organizations Consulted

Along with individuals affiliated with Essentia Health, individuals from the following organizations attended the first Town Hall Meeting (names and titles available upon request): Community/Patient Focus Group, Public Health – Idaho North Central District, Business Psychology Associates, Allen Counseling Services, Region II Mental Health Board, and Nimiipuu Health.

Individuals representing the following organizations were invited to but did not attend the first Town Hall Meeting: Clearwater County, Cottonwood City Council, Seniors in Shape Program, St. Mary's Hospital, Inc. Foundation, and Syringa Hospital.

Possible prospective Town Hall Meeting participants for the second and third priority health needs include: the Community/Patient Focus Group participants, social service and service organization representatives, city and county government officials, tribal government/leadership/representatives and/or other minority population group members/representatives, primary care and other healthcare providers, lead county public health officials, industry/business leaders/representatives, educators/educational administrators, and other relevant entities.

5.3. Individuals with Special Knowledge of or Expertise in Public Health

An employee of Public Health – Idaho North Central District (name and title available upon request) attended the Community/Patient Focus Group and the first Town Hall Meeting and provided input on the community health needs and intervention options for addressing the highest priority health need. This individual's special knowledge or expertise in public health derives from their employment with a public health district and their work providing health education and information to the public and coordinating trainings and workshops on various health related topics. This individual and/or other public health representatives will be invited to the first Intervention Planning Meeting as well as future Town Hall and Intervention Planning Meetings.

5.4. Federal, Tribal, Regional, State, or Local Health or Other Departments or Agencies with Current Data or Other Information Relevant to the Health Needs of the Community

Subsection 5.3 describes input provided by Public Health – Idaho North Central District. Additionally, two individuals from Nimiipuu Health attended both the Community/Patient Focus Group and the first Town Hall Meeting and provided input on the community health needs and intervention options for addressing the highest priority health need. These individuals provide health education and home visits to the tribal community.

5.5. Individuals Who are Leaders, Representatives, or Members of Medically Underserved, Low-Income, and Minority Populations and Populations with Chronic Disease Needs

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 as described in Subsection 3.1, all attendees of the Community/Patient Focus Group and Town Hall Meetings are representatives and/or members of medically-underserved and low income populations, as well as populations with chronic disease needs. Community/Patient Focus Group participants were specifically instructed to consider themselves as representatives of the community-at-large. Participants at the Town Hall Meetings served more formal leadership or representative roles. The current and former Chairs of Regional Mental Health Boards attended both the Community/Patient Focus Group and the first Town Hall Meeting. Elected officials from Clearwater County and Cottonwood City Council (names and titles available upon request) attended the Community/Patient Focus Group and were invited to the first Town Hall Meeting. Through their elected offices, they by definition have leadership or representative roles for the citizens in the hospital facility's service area.

In Clearwater, Idaho, and Lewis Counties, over 88% of individuals are Caucasian (Table 5). However, as attendees at the Community/Patient Focus Group were instructed to act as representatives of the entire community, and data stratified by race/ethnicity were presented, health needs of minority populations were considered. Additionally, two individuals from Nimiipuu Health attended both the Community/Patient Focus Group and the first Town Hall Meeting and provided input on the community health needs and intervention options for addressing the highest priority health need. These individuals provide health education and home visits to the tribal community.

6. Community Health Needs Identified Through the CHNA

6.1. Process and Criteria Used in Prioritizing the Needs

After the Community/Patient Focus Group participants identified health needs for the community, they were directed to vote by a show of hands for the top-priority health needs. Similar to the process of identifying the health needs, prioritization criteria included the severity of the health need, disparities that may exist due to geographic local or race/ethnicity, and the feasibility and thus potential effectiveness of interventions implemented by a health system to address those health needs.

6.2. Standardization and Prioritized Description of Identified Health Needs

Upon completion of all Community/Patient Focus Groups for the Essentia Health hospital facilities participating in the coordinated CHNA process, it became apparent that the prioritized health needs for each community fell into similar thematic categories. These health needs were subsequently standardized across the communities in order to leverage the value of a coordinated process across a health system by, for example, sharing resources and processes for addressing similar health needs.

Some health needs were inherently standardized across the communities. As none of these health needs were the highest-priority in communities served by hospital facilities participating in Essentia Health's coordinated CHNA process, interventions to address these health needs have not yet been selected. These health needs include:

- Reduction of excessive/binge drinking
- Tobacco use primary prevention/cessation
- Immunizations

Other health needs were composed of clusters of related concepts that only slightly varied across communities. These clusters were aggregated into four health needs. All communities served by hospital facilities participating in Essentia Health's coordinated CHNA process identified one of two of these aggregated health needs as their highest-priority. Consequently, interventions addressing these two health needs have been selected. The aggregated health needs include:

- Health needs selected as highest-priority by communities and for which interventions have been selected
    - Obesity, physical activity, and nutrition as risk factors for chronic diseases, including type 2 diabetes: Participants at almost all Community/Patient Focus Groups identified obesity, physical activity, and nutrition as health needs. This constellation of risk factors is pertinent to development of a variety of chronic diseases, including type 2 diabetes, which was one of the chronic conditions discussed at several Community/Patient Focus Groups. As evidenced in Table 9, the prevalence of diabetes is higher in rural areas in all states in which Essentia Health has a presence. Furthermore, individuals in rural areas are more likely to receive inadequate diabetic care than their non-rural counterparts.[18,19] Consequently, type 2 diabetes is a particularly apt health outcome to focus on with respect to addressing negative outcomes of obesity, physical inactivity, and poor nutrition. All hospitals identifying this health need as their highest priority will implement an enhanced type 2 diabetes self-management education (DSME) intervention, as described in Appendices A and B, to address it.
    - Access to healthcare: Participants at the Community/Patient Focus Groups discussed issues related to healthcare cost/insurance, availability and assignment of primary care providers, provision of mental healthcare, and transportation for healthcare. These various issues were aggregated into the health need of access to healthcare, defined as enhanced healthcare for the local population. The four hospital facilities participating in the coordinated CHNA process across Essentia Health that selected access to healthcare as their highest-priority health need will implement either an enhanced type 2 DSME intervention or a collaborative care for the management of depressive disorders intervention. The former intervention enhances healthcare for the local population by 1) providing DSME as community benefit to the extent feasible, 2) involving primary care providers, and 3) either providing a healthcare service that does not currently exist or expanding the impact of existing services. The latter intervention focuses on mental healthcare provision.
- Health needs selected as lower-priority by communities and for which interventions have not yet been selected for most hospitals
    - Preventive care, encompassing primary prevention (e.g. health education, wellness plans, immunizations) and secondary prevention/screening: This health need is an aggregation of general wellness, prevention/wellness, and holistic wellness/primary prevention, which includes issues such as health education, wellness plans, immunizations, and primary and secondary prevention. This health need was the second-highest priority for Essentia Health St. Mary's

Hospital-Superior and will be addressed by the enhanced type 2 DSME intervention in 2014.

- Secondary prevention/screening: Participants at the Essentia Health St. Mary's Hospital-Superior Community/Patient Focus Group while choosing preventive care as their second prioritized health need, selected the sub-category of secondary prevention/screening as their third prioritized need.

Additional health needs identified for the community served by Essentia Health West include:

- Access to mental healthcare, particularly availability of mental health services
- Substance use and influence , particularly alcohol use and abuse
- Violence and safety, particularly child abuse and neglect

The ten health needs in the bulleted lists above compose the significant system-wide health needs identified for the hospital facilities participating in Essentia Health's coordinated CHNA process. Each hospital facility will address the three highest priority health needs for their community. The hospital facilities will not directly meet the seven unprioritized health needs due to resource constraints. Rather than inadequately addressing all health needs, the hospital facilities will focus resources, financial and otherwise, on their community's three prioritized health needs in order to foster success in meeting those health needs. Despite not directly meeting the unprioritized health needs, interventions addressing the three prioritized health needs may partially address the unprioritized health needs that overlap with the prioritized health needs. If the unprioritized health needs remain in the next CHNA cycle, they may be directly addressed at that time.

The Clearwater Valley Hospital and Clinics, Inc. and St. Mary's Hospital, Inc. Community/Patient Focus Group prioritized the following health needs that will each be addressed, in order, by a 3-year intervention (Figure 3):

1. Access to healthcare, defined as enhanced healthcare for the local population
2. Obesity, physical activity, and nutrition as risk factors for chronic diseases, such as type 2 diabetes
3. Tobacco use primary prevention/cessation.

7. Existing Healthcare Facilities and Other Resources Within the Community Available to Meet the Community Health Needs Identified Through the CHNA

Existing healthcare facilities and other resources within the community available to meet the community health needs identified through the CHNA are listed in the Compendium of Resources in Appendix C.

7.1. Process for Identifying and Prioritizing Resources/Services to Meet the Community Health Needs

Existing healthcare facilities and other resources were identified by provision of a template Compendium of Resources to the hospital facility. The template was a grid of the three prioritized health needs crossed with separate resource categories including healthcare facilities, human, financial, programmatic, and infrastructure. A sampling of local events was also requested for the purpose of planning future community outreach. The hospital facility completed the template through internet searching, existing community knowledge, contacting relevant individuals for further information, and transferring information from a Resource Directory already in existence for the hospital facility. While some resource types, such as programmatic resources, are divided by health need, resources included for one health need may be useful in meeting the other health needs as well. Prioritization of resources to meet the community health needs will be based on availability and relevance to planned interventions.

8. Making the CHNA Report Widely Available to the Public

This report was made widely available to the public by the following methods:

- Posting a PDF of the report under the "Community Benefit/CHNA" tab on the hospital facility's homepage along with instructions for downloading it
- Providing paper copies without charge at the hospital facility upon request

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Acknowledgments

Essentia Health thanks all participants at past and future Community/Patient Focus Groups, Town Hall Meetings, and Intervention Planning Meetings. Essentia Health also thanks all individuals who will participate in ensuring the success of interventions introduced to meet the community's health needs.

Appendix A – Implementation Strategy

The following implementation strategy was approved by the Clearwater Valley Hospital and Clinics, Inc. Board of Directors on May 7, 2013. The implementation strategy describes the enhanced DSME intervention being delivered primarily by a Certified Diabetes Educator (CDE) or equivalent. As the National Diabetes Prevention Program does not require CDE certification for delivery, an individual with other qualifications may be the primary meeting leader in the finalized intervention. CDEs and/or other health care professionals will be involved in the intervention as needed and as is feasible.

Introduction

As mandated in *IRS Notice 2011-52 Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-exempt Hospitals* (1), the following implementation strategy addresses each of the community health needs identified through the Community Health Needs Assessment (CHNA) conducted for the 2013 taxable year for Clearwater Valley Hospital and Clinics, Inc. This implementation strategy begins with a brief description of the general CHNA process. Each of the health needs identified by the CHNA is then listed along with either a description of how the hospital facility plans to meet the health need or an explanation for why the hospital facility does not intend to meet the health need.

General CHNA Process

Coordination among Essentia Health Hospital Facilities

In the interest of efficiency, cost effectiveness, and alignment with Essentia Health population health strategies, fifteen Essentia Health hospital facilities are involved in a coordinated CHNA process. While still allowing for tailoring to each particular hospital facility, procedures are standardized across hospital facilities. These hospital facilities include: Bridges Medical Center, doing business as (DBA) Essentia Health Ada in Ada, MN; Clearwater Valley Hospital and Clinics, Inc. in Orofino, ID; Deer River Healthcare Center, Inc., DBA Essentia Health Deer River in Deer River, MN; Essentia Health Virginia, LLC, DBA Essentia Health Virginia in Virginia, MN; Graceville Health Center, DBA Essentia Health Holy Trinity Hospital in Graceville, MN; Innovis Health, LLC, DBA Essentia Health West in Fargo, ND; Minnesota Valley Health Center, Inc. in Le Sueur, MN; Northern Pines Medical Center, DBA Essentia Health Northern Pines in Aurora, MN; Pine Medical Center, DBA Essentia Health Sandstone in Sandstone, MN; SMDC Medical Center, DBA Essentia Health Duluth in Duluth, MN; St. Joseph's Medical Center, DBA Essentia Health St. Joseph's Medical Center in Brainerd, MN; St. Mary's Hospital of Superior, DBA Essentia Health St. Mary's Hospital-Superior in Superior, WI; St. Mary's Hospital, Inc. in Cottonwood, ID; St. Mary's Medical Center, DBA Essentia Health St. Mary's Medical Center in Duluth, MN; and St. Mary's Regional Health Center, DBA Essentia Health St. Mary's-Detroit Lakes in Detroit Lakes, MN. Since Essentia Health West joined

the group on February 1, 2013, not all aspects of the Essentia Health West CHNA are coordinated with those of the other hospital facilities.

Identification and Prioritization of Health Needs

In brief, community health profiles consisting of state and county service area demographic, health-related behaviors, health services, and health outcomes data were compiled for each hospital facility. The relevant profile was presented to community members at community/patient focus groups held at or near each hospital facility. Community/patient focus groups for Clearwater Valley Hospital and Clinics, Inc. and St. Mary's Hospital, Inc. in Cottonwood, ID were held in tandem. Participants were asked to identify and prioritize three amenable community health needs based on the data. As participants at the various focus groups throughout all participating hospitals identified and prioritized similar health needs, they were aggregated into a collection of ten system-wide health needs. Each of the top three health needs for each hospital facility will be addressed through a 3-year intervention. The first intervention will begin in 2013, the second in 2014, and the third in 2015.

Town Hall Meetings

The first step in addressing each prioritized health need is a Town Hall meeting. Town Hall meetings will be held annually with each focused on one of the three priority health needs. During the Town Hall meetings, intervention options for meeting the relevant health need will be presented, and participants will select the option best suited to their community. Possible prospective participants include: the community/patient focus group participants, social service and service organization representatives, city and county government officials, tribal government/leadership/representatives and/or other minority population group members/representatives, primary care and other health care providers, lead county public health officials, industry/business leaders/representatives, educators/educational administrators, and other relevant entities. The Town Hall meeting for the top-priority health need, as described below, has already occurred in tandem with St. Mary's Hospital, Inc. Town Hall meetings for the second and third priorities will occur in late 2013/early 2014 and late 2014/early 2015, respectively.

Intervention Planning Meetings

Further details such as the research and evaluation protocol for the selected interventions will be delineated after the Town Hall meetings. These details will be presented at Intervention Planning meetings to potential collaborators and hospital facility employees with authority to commit resources to implement the interventions. Many of these individuals will have likely attended the previous Town Hall meeting. At the Intervention Planning meetings, interventions will be further tailored to the particular hospital facility and community's programs and resources.

Appendix A
Clearwater Valley Hospital and Clinics, Inc., Orofino, ID
Implementation Strategy

Health Need 1

Description of Health Need

The community/patient focus group selected access to health care, defined as enhanced health care for the local population, as the highest-priority health need.

Town Hall Meeting

The Town Hall meeting was held on January 3, 2013 via videoconference. Individuals invited to the meeting included the community/patient focus group participants, as well as individuals from the following organizations: Allen Counseling Services, Business Psychology Associates, Clearwater County, Clearwater Valley Hospital and Clinics, Inc., Cottonwood City Council, Nimiipuu Health/Community Health Department, Public Health Board, Public Health – Idaho North Central District, Region II Mental Health Board, Seniors in Shape Program, State Lottery, St. Mary's Hospital, Inc., St. Mary's Hospital, Inc. Foundation, Syringa Hospital, and Tribal Cancer Coalition.

The intervention options presented to the group were adapted from the Community Preventive Services Task Force (CPSTF) (2). These options included: A) type 2 diabetes self-management education (DSME) in community gathering places, B) type 2 diabetes care coordination, and C) collaborative care for the management of depressive disorders. These interventions were selected because they were recommended by the CPSTF (2), feasible for a health system, and have measurable outcomes that can be tracked over time.

The Clearwater Valley Hospital and Clinics, Inc. and St. Mary's Hospital, Inc.'s meeting participants voted for option A for the intervention to meet their first health need. However, an enhanced version of this intervention will be implemented. The idea of a hybrid of option A and another intervention recommended by the CPSTF (creation of or enhanced access to places for physical activity combined with informational outreach activities) arose at the Essentia Health Holy Trinity Hospital Town Hall meeting. This hybrid is hereafter referred to as *enhanced DSME*. As enhanced DSME is being implemented in several Essentia Health hospitals and is an augmentation of the intervention voted on by the Clearwater Valley Hospital and Clinics, Inc. and St. Mary's Hospital, Inc.'s Town Hall meeting participants, the community benefit will be greater by also implementing enhanced DSME in the service area for these hospitals.

Description of Selected Intervention

According to CPSTF, "DSME is the process of teaching people to manage their diabetes. The goals of DSME are to control the rate of metabolism (which affects diabetes-related health), to prevent short- and long-term health conditions that result from diabetes, and to achieve for clients the best possible

quality of life, while keeping costs at an acceptable level" (3). In brief, the DSME intervention will involve a group of type 2 diabetes patients attending one to four group meetings per month related to type 2 diabetes self-management over a one-year period in a community gathering place. The primary meeting leader will be a Certified Diabetes Educator (CDE) or other qualified individual. With a three-year intervention, there will be three, one-year series of DSME meetings.

Part of the *enhanced* aspect of enhanced DSME is including a wider group of individuals in the intervention. The wider group will involve individuals with prediabetes who will be identified through methods such as applying a risk score to data from electronic medical records or self-reported at screening events. Blood glucose may also be measured at screening events. Screening events will occur during the first and second years of the intervention, so individuals identified at these events would begin DSME meetings in years two and three. The wider group of individuals will also involve families of patients attending the DSME meetings who will be invited to participate in all activities.

The other part of the *enhanced* aspect of enhanced DSME is greater focus on strategies for improved nutrition and physical activity. Nutrition-related activities for the DSME meeting series may involve cooking classes, grocery store tours, or education on topics such as label reading and understanding a type 2 diabetes-friendly diet. In addition to informing participants on physical activity strategies and options in the community, the intervention will attempt to reduce barriers to physical activity through, for example, reducing fees at local fitness facilities, providing transportation to facilities, or offering fitness classes live and/or on local television. While not currently diabetic, these aspects of the intervention will benefit adults identified as prediabetics and family members as well, given that poor nutrition and inadequate physical activity are risk factors for type 2 diabetes, as well as other chronic conditions such as cardiovascular disease.

The primary anticipated impacts of this intervention differ by the population group of interest. For individuals with type 2 diabetes, anticipated impacts include decreased body mass index, improved glycemic control, better lipid profiles, improved knowledge of type 2 diabetes self-management, improved knowledge of the importance of blood pressure monitoring and control, improved nutrition knowledge, increased exercise frequency, and increased health care engagement. Through these same improvements, the anticipated impact of this intervention for prediabetics is reduced type 2 diabetes risk. The anticipated impact for family members without type 2 diabetes or prediabetes is improved knowledge of type 2 diabetes self-management and consequently enhanced support for their diabetic or prediabetic family member. As described above, family members may also benefit personally from improved nutrition and physical activity.

Intervention Planning Meeting

The Intervention Planning Meeting is slated to occur on July 11, 2013. The current "Compendium of Resources" table accompanying this implementation strategy describes specific programs, resources, and potential collaborators for implementing the intervention. Selected representatives from this table will be invited to the Intervention Planning Meeting. While not all resources in the table will be utilized, they present a menu from which to tailor the intervention to the hospital facility and community's needs and capabilities. In particular, Clearwater Valley Hospital and Clinics, Inc. currently does not have a CDE. The first priority will be identifying and certifying an individual with CDE credentials or the equivalent. According to the National Certification Board for Diabetes Educators, eligibility requirements for sitting for the certification exam include a discipline/licensure requirement, DSME professional practice experience, continuing education hours, and an application (4). Individuals in the community who may meet these requirements include local registered nurses, pharmacists, physicians, or dieticians. Additionally, the hospital may seek to become an American Diabetes Association (ADA) Recognized Education Program. Given that possibility and the current lack of a CDE or identification of an individual with equivalent credentials, DSME meetings may not start immediately, but providing these resources for the community is still a step toward meeting the health need. Other potentially-useful resources included in the current Compendium of Resources are the local YMCAs for possibly both fitness opportunities and meeting space, national forests for outdoor recreational activity options, and the Clearwater County Fair & Lumberjack Days for a screening event. The base guideline for the hospital's financial contribution is 0.1% of net patient revenue less bad debt [i.e. 0.1%*(NPR-BD)] for each of the three interventions, each of which will last three years with the first beginning in Financial Year 2014. Additionally, all hospitals are strongly encouraged by Bert Norman, Essentia Health's Chief Financial Officer, to reallocate current Community Benefit funding to supplement the base financial contribution guideline.

Health Need 2

Description of Health Need

The community/patient focus group selected obesity, physical activity, and nutrition as risk factors for chronic diseases, such as type 2 diabetes, as the second-highest priority health need.

Town Hall and Intervention Planning Meetings

A Town Hall meeting to select an intervention to meet this health need will be held late 2013 or early 2014. The Intervention Planning Meeting is slated to occur in May 2014. The current "Compendium of Resources" table accompanying this implementation strategy describes potentially-useful programs, resources, and collaborators for implementing the intervention. Selected representatives from this

table may be invited to the Intervention Planning Meeting. While not all resources in the table will be utilized, and new ones may develop or be discovered over time, they present a menu from which to tailor the intervention to the hospital facility and community's needs and capabilities. The anticipated impact of an intervention addressing obesity, physical activity, and nutrition as risk factors for chronic diseases, such as type 2 diabetes, is a reduction of body mass index and improvement in physical activity and nutrition resulting in improved measures of health status, such as glycemic control, lipids, and blood pressure, and thus decreased risk of related chronic diseases.

Health Need 3

Description of Health Need

The community/patient focus group selected tobacco use primary prevention/cessation as the third-highest priority health need.

Town Hall and Intervention Planning Meetings

A Town Hall meeting to select an intervention to meet this health need will be held late 2014 or early 2015. The Intervention Planning Meeting is slated to occur in May 2015. The current "Compendium of Resources" table accompanying this implementation strategy describes potentially-useful programs, resources, and collaborators for implementing the intervention. Selected representatives from this table may be invited to the Intervention Planning Meeting. While not all resources in the table will be utilized, and new ones may develop or be discovered over time, they present a menu from which to tailor the intervention to the hospital facility and community's needs and capabilities. The anticipated impact of an intervention addressing tobacco use is a reduction (through primary prevention and/or cessation) in the number of individuals reporting tobacco use in the service area.

Unprioritized Health Needs and Plans

The other Essentia Health system-wide health needs identified among the hospital facilities participating in the coordinated CHNA process include:

1. Preventive care, encompassing primary prevention (e.g. health education, wellness plans, immunizations) and secondary prevention/screening
2. Immunizations
3. Substance use and influence (Essentia Health West)
4. Reduction of excessive/binge drinking
5. Secondary prevention/screening
6. Access to mental health care (Essentia Health West)
7. Violence and safety (Essentia Health West)

Appendix A
Clearwater Valley Hospital and Clinics, Inc., Orofino, ID
Implementation Strategy

The hospital facility does not intend to directly meet the health needs listed above due to resource constraints. Rather than inadequately addressing all health needs, the hospital facility will focus resources, financial and otherwise, on its community's three prioritized health needs in order to foster success in meeting those needs. Despite not directly meeting the unprioritized health needs, interventions addressing the three prioritized needs may partially address the unprioritized needs that overlap with the prioritized needs. For example, enhanced DSME will involve screening for prediabetes and discouraging excessive drinking as it relates to type 2 diabetes. DSME for individuals with prediabetes is itself secondary prevention in that the goal is to prevent disease progression. If the unprioritized health needs remain in the next CHNA cycle, they may be directly addressed at that time.

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Appendix B – Intervention Protocols for First Health Need

The following protocols will be implemented to address the hospital facility's highest priority health need. They were refined to this form over the course of discussions with both community members and Essentia Health staff. The final implemented intervention may differ further to conform to the needs and resources of the hospital facility and community.

Part A: Type 2 Diabetes Prevention Intervention Protocol

This intervention is directed at adults assessed as being prediabetic. In some instances adults diagnosed with diabetes during the past six months who are currently on no antihyperglycemic medication or are on metformin only and, at a minimum, have previously been seen at a diabetes self-management program for individual instruction on diabetes meal planning and self-monitoring of blood glucose will be included as participants in this program (see Part B: Enhanced Type 2 Diabetes Education Intervention Protocol). Prediabetic participants will be identified through blood screening or the Centers for Disease Control and Prevention Prediabetes Screening Test (1) provided at community screening events. The intervention also includes family members and others who constitute an individual's support system. With these inclusion criteria, primary, secondary, and tertiary prevention are addressed by this intervention as displayed in the diagram below. The intervention is community-based and entails elements of physical activity education and participation, nutrition education, and developing enhanced cooking and shopping skills. This intervention was informed by previous studies (2,3) and utilizes the National Diabetes Prevention Program and the *Lifestyle Intervention* curriculum (4). Additional measurements are included to track results.

The overall approach is culturally competent in terms of diet, social emphasis, family participation, and incorporation of cultural health beliefs.

Dietitians or other community workers will arrange and conduct group visits to local grocery stores to help individuals apply dietary information learned. Social support will be fostered through support from family members and friends, group participants, the intervention team, and community workers.

The weekly support group sessions will provide opportunities for participants and family members/friends to meet in an informal and safe atmosphere to discuss their problems in preventing diabetes, ask questions in a non-threatening environment, review previously-learned information and skills, and participate in cooking demonstrations. Also, group leaders will emphasize the importance of support from family members and encourage support persons to improve their health habits. Individual participants will be provided the opportunity to discuss their concerns and problems, and members of the group, facilitated by a CDE, dietitian, or other professional, will assist each other in solving problems.

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Clearwater Valley Hospital and Clinics, Inc., Orofino, ID
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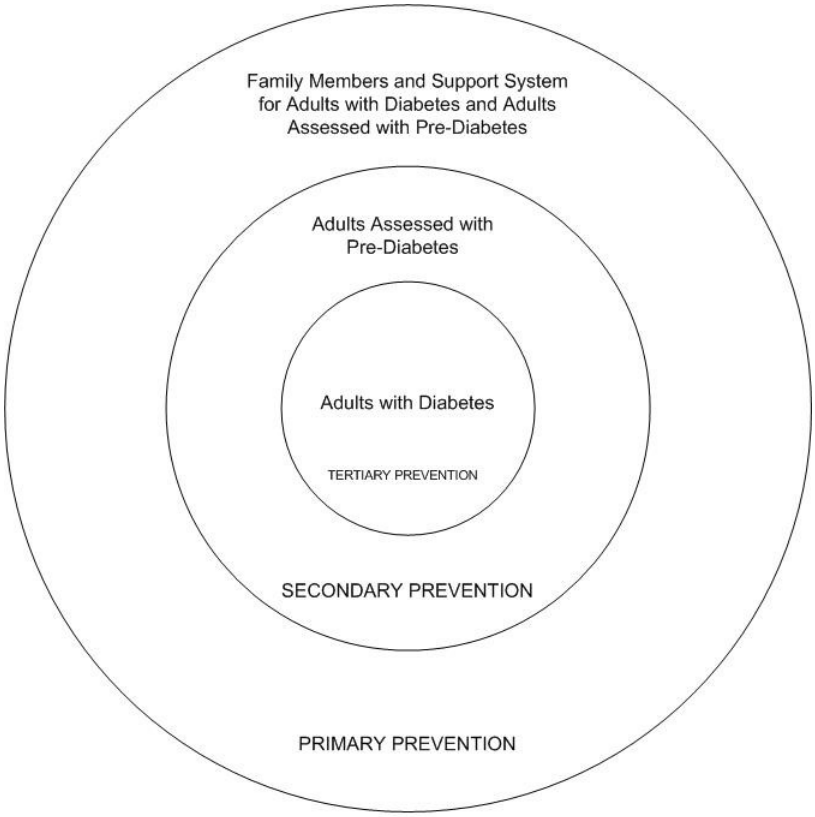

Intervention Participants

Participants will receive the year-long intervention in any number of community-based facilities such as schools, churches, county agricultural extension offices, adult day care centers, and health clinics.

Primary outcomes are:

- Nutrition knowledge
- Glycosylated hemoglobin (HbA1c)
- Fasting blood glucose (FBG)
- Lipid panel
- Body mass index (BMI)
- Physical activity

Body weights will be measured with a balance beam scale with individuals in street clothing and without shoes. Heights will be obtained using a secured stadiometer. BMI will be calculated as [weight(kg)/height(meters)^2]. HbA1c, FBG, and cholesterol testing will be arranged for the program participants and the results reviewed with the individuals.

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The National Diabetes Prevention Program

In the National Diabetes Prevention Program, lifestyle change classes led by trained coaches meet for 16 core sessions as participants focus on losing 5% to 7% of their body weight and increasing physical activity to 150 minutes each week. After the initial 16 sessions, classes meet monthly for 6-8 months.

Who: To be eligible, participants may be at risk for prediabetes and type 2 diabetes if they answer yes to a few of the following questions:

- I am 45 years of age or older.
- I am overweight.
- I have a parent with diabetes.
- I have a sister or brother with diabetes.
- My family background is African American, Hispanic/Latino, American Indian, Asian American, or Pacific Islander.
- I had diabetes while I was pregnant (gestational diabetes), or I gave birth to a baby weighing 9 pounds or more.
- I am physically active less than three times a week

Pre-diabetic participants will meet eligibility criteria outlined in the Centers for Disease Control and Prevention Diabetes Prevention Recognition Program Standards and Operating Procedures. The intervention may also include some adults with a recent diagnosis of type 2 diabetes and, in some activities, family members and others who constitute an individual's support system.

What: The National Diabetes Prevention Program is designed to bring to communities evidence-based lifestyle change programs for preventing type 2 diabetes. It is based on the Diabetes Prevention Program research study led by the National Institutes of Health and supported by Centers for Disease Control and Prevention.

Why: The lifestyle program shows that making modest behavior changes, such as improving food choices and increasing physical activity to at least 150 minutes per week, results in participants losing 5% to 7% of their body weight. These lifestyle changes reduce the risk of developing type II diabetes by 58% in people at high risk for diabetes. People with prediabetes are more likely to develop heart disease and stroke.

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

Adapted from (5).

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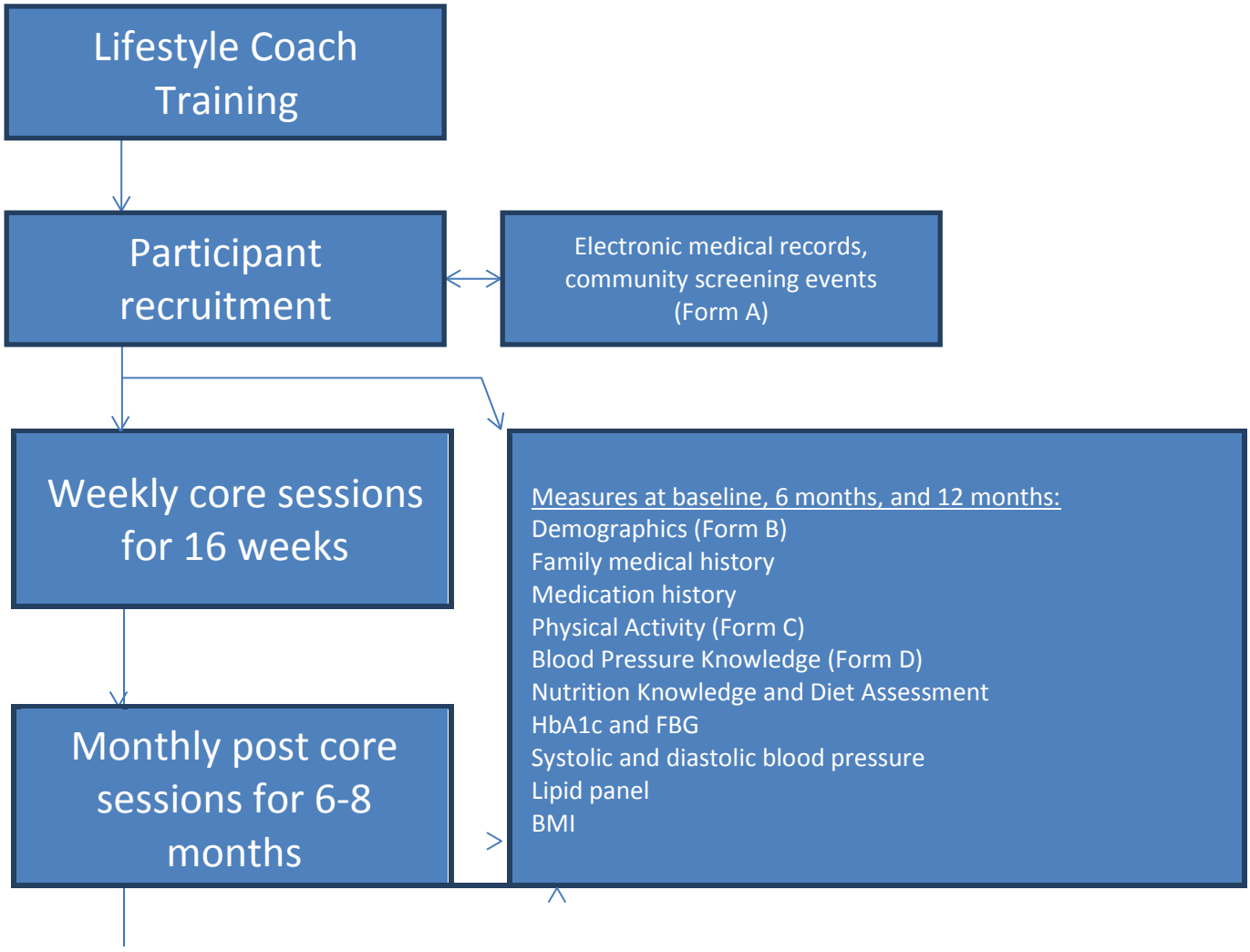
Type 2 Diabetes Prevention Intervention Flow Chart



Participant objectives

- Attend all 16 weekly core sessions in designated community setting
- Change unhealthy lifestyle behaviors
  - Increase activity
    - 150 minutes/week
  - Improve food choices
    - Keep diary & follow fat gram goal
  - Lose weight, if overweight
    - 5-7% of body weight
- Attend post core sessions offered monthly for 6-8 months

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Table 1. Description of the Intervention			
Baseline	Intervention[1]		Mid- and Post-Intervention
Measures	**16 Core Sessions (one/week)**	**6-8 Post Core Sessions (one/month)**	Measures (6 and 12 months)
Demographics[2] (Form B)	Introduction	Use post core curriculum and: -review previously learned content -assess participants' knowledge and skills regarding topic being addressed -discuss ongoing barriers to adopting healthy lifestyle changes--- engaging in group problem-solving -open discussion of any topic group chooses/ introduces	Demographics
Family medical history	Be a Fat and Calorie Detective		Family medical history
Medication history	Three Ways to Eat Less Fat and Fewer Calories		Medication history
Physical Activity (Form C)	Healthy Eating		Physical Activity
Blood Pressure Knowledge (Form D)	Move Those Muscles		Blood Pressure Knowledge
Nutrition Knowledge and Diet Assessment	Being Active – A Way of Life		Nutrition Knowledge and Diet Assessment
HbA1c and FBG	Tip the Calorie Balance		HbA1c and FBG
Blood pressure	Take Charge of What's Around You		Blood pressure
Lipid panel	Problem Solving		Lipid panel
BMI	Four Keys to Healthy Eating Out		BMI
	Talk Back to Negative Thoughts		
	The Slippery Slope of Lifestyle Change		
	Jump Start Your Activity Plan		
	Make Social Cues Work For You		
	You Can Manage Stress		
	Ways to Stay Motivated		

[1]Activities such as fitness classes, cooking classes, and grocery store tours should be incorporated when possible.

[2]Age, gender, age at diagnosis, race/ethnicity, education attainment, marital status, children, annual household income, health insurance status

•OVERALL CHARACTERISTICS OF THE INTERVENTION•

- 16 weekly core sessions plus 6-8 monthly post core sessions
- Longitudinal (follow-up for one year)
- Community-based — schools, churches, adult day care centers, agricultural extension centers, and community health clinics sites
- Designed to promote group problem-solving to address individual's health questions and issues
- Organized to obtain support from family, friends, group participants, nurses/dietitians/community workers
- Incorporates activities to reduce barriers to physical activity and nutrition

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FORM A: CDC Prediabetes Screening Test[1]

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

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

Prediabetes You Could Be at Risk

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

Take the Test — Know Your Score!

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

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

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Know Your Score

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

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

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

At-Risk Weight Chart

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

[1] Appendix B: CDC Prediabetes Screening Test. Centers for Disease Control and Prevention Diabetes Prevention Recognition Program Standards and Operating Procedures. [Online][Cited: May 9, 2013] http://www.cdc.gov/diabetes/prevention/pdf/DPRP_Standards_09-02-2011.pdf

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

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FORM B. Demographics Survey

What is your date of birth?

What is your sex?

Present Marital Status:

- o Married
- o Common law
- o Separated
- o Divorced
- o Widowed
- o Single

Number of children under 18 living at home: ____

Total number of people living in your home: ____

How many years have you lived in this community? _____

Education and Employment Questions

What is the highest level of schooling you have completed?

- o Some elementary school
- o Elementary school graduation
- o Some high school
- o High school graduation diploma
- o Some trade, technical, or vocational school
- o Some community college or university
- o Community college or university graduation diploma
- o Don't know
- o I prefer not to respond

Are you currently working for pay (wages, salary, self-employment)?

- o No
- o Yes ___*(If yes, answer the following question)*

For the year ending December 31, please think of the total income, before deductions, from all sources, for all household members, including yourself. Please look at this list and choose which range it falls into.

- o No income or income loss
- o Under $19, 999
- o $20,000 - $39,999
- o $40,000 - $59,999
- o $60,000 - $79,999
- o $80,000 and over
- o Don't know
- o I prefer not to respond

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FORM C:

1. Physical Activity Self-Assessment	**Points**	**Total**
Frequency (How often you do physical Activity) (Select 1)➔		
Daily or almost daily	35	
3 - 5 times per week	25	
1-2 times per week	15	
Less often	6	
Intensity (How hard do you do physical activity.) (Select 1)➔		
Sustained heavy breathing & perspiring (ex. jogging)	35	
Intermittent heavy breathing	25	
Moderately heavy (ex. recreational sports, cycling)	15	
Moderate (ex: volleyball, softball)	6	
Light (ex. fishing, strolling)	1	
Time (how long do you do physical activity each time) (Select 1)➔		
Over 30 minutes	30	
21-30 minutes	20	
10-20 minutes	10	
Under 10 minutes	2	
Total Physical Activity Score		

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FORM D:

3. Blood Pressure Knowledge Questions	True*	False*
1. A blood pressure of 120/80 is considered average.	x	
2. A blood pressure of 160/100 is high.	x	
3. Exercising every day may make blood pressure go down.	x	
4. A low sodium diet can lower blood pressure.	x	
5. Losing weight can make blood pressure go down.	x	
6. When someone's blood pressure is too high, they usually have a headache.		x
7. When someone's blood pressure is too high, they usually feel fine and do not know that it is high.	x	
8. High blood pressure can cause heart attacks.	x	
9. High blood pressure can cause cancer.		x
10. High blood pressure can cause kidney problems.	x	
11. People with high blood pressure should eat less salt.	x	
12. Orange juice is usually high in salt.		x
13. Canned vegetables are usually high in salt.	x	
14. Bananas are high in salt.		x
15. Canned soup is usually high in salt.	x	

* The "x's" will not be shown on the participant surveys
Source: Adapted from Williams MV, Baker DW, Parker RM, Nurss JR. Relationship of functional health literacy to patients' knowledge of their chronic disease. A study of patients with hypertension and diabetes. Arch Intern Med 1998;158:166-72.

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Part B: Enhanced Type 2 Diabetes Education Intervention Protocol

This intervention is directed at adults with type 2 diabetes. These individuals will be identified through electronic medical records or through provider referral. The intervention also includes family members and others who constitute an individual's support system. Additionally, the core of the intervention, the National Diabetes Prevention Program, will include individuals with prediabetes (see Part A: Type 2 Diabetes Prevention Intervention Protocol). With these inclusion criteria, primary, secondary, and tertiary prevention are addressed by this intervention as displayed in the diagram below. The intervention is community-based and entails elements of physical activity education and participation, nutrition education and developing enhanced cooking and shopping skills, and self-monitoring of glucose levels and blood pressure. This intervention was informed by previous studies (2,3) and utilizes the National Diabetes Prevention Program (NDPP) and the *Lifestyle Intervention* curriculum (4). It is supplemented by topics outlined in the National Standards for Diabetes Self-Management Education and Support (6) and additional measurements to track results.

The overall approach is culturally competent in terms of diet, social emphasis, family participation, and incorporation of cultural health beliefs.

Dietitians or other community workers will arrange and conduct group visits to local grocery stores to help individuals apply dietary information learned. Social support will be fostered through support from family members and friends, group participants, the intervention team, and community workers.

The weekly support group sessions will provide opportunities for participants and family members/friends to meet in an informal and safe atmosphere to discuss their problems in managing diabetes, ask questions in a non-threatening environment, review previously-learned information and skills, and participate in cooking demonstrations. Also, group leaders will emphasize the importance of support from family members and encourage support persons to improve their health habits. Individual participants will be provided the opportunity to discuss their concerns and problems, and members of the group, facilitated by a CDE, dietitian, or other professional, will assist each other in solving problems.

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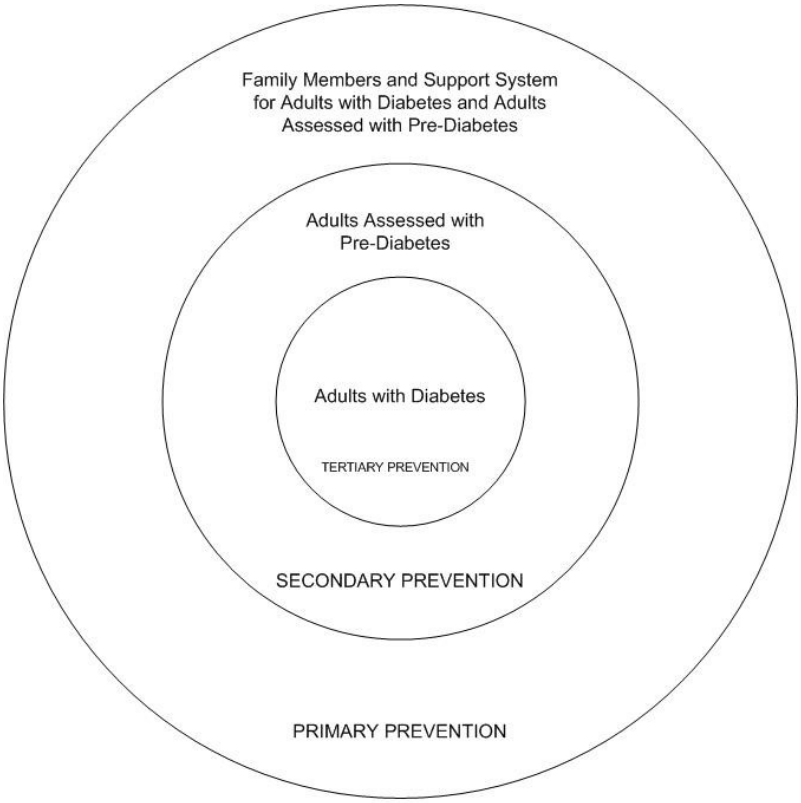

Intervention Participants

Participants will receive the year-long intervention in any number of community-based facilities such as schools, churches, county agricultural extension offices, adult day care centers, and health clinics.

Primary outcomes are:

- Nutrition knowledge
- Diabetes related knowledge
- Glycosylated hemoglobin (HbA1c)
- Fasting blood glucose (FBG)
- Lipid panel
- Body mass index (BMI)
- Physical activity

Body weights will be measured with a balance beam scale with individuals in street clothing and without shoes. Heights will be obtained using a secured stadiometer. BMI will be calculated as [weight(kg)/height(meters)^2]. HbA1c, FBG, and cholesterol testing will be arranged for the program participants and the results reviewed with the individuals.

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In the NDPP, lifestyle change classes led by trained coaches meet for 16 core sessions as participants focus on losing 5% to 7% of their body weight and increasing physical activity to 150 minutes each week. After the initial 16 sessions, classes meet monthly for six-eight months. This content also forms the foundation of type 2 diabetes management and is, therefore, an essential piece of this intervention.

Who: To be eligible, participants must

- Be diagnosed during the past six months with type 2 diabetes as defined by the American Diabetes Association (7):
    - Fasting plasma glucose $\geq$ 126 mg/dL, OR
    - HB A1c ≥ 6.5%, OR
    - 2 hour plasma glucose ≥ 200 mg/dL during an oral glucose tolerance test, OR
    - A random plasma glucose ≥ 200 mg/dL in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis

AND

- Be on no antihyperglycemic medication or on metformin only, AND
- Have previously been seen at a diabetes self-management program for individual instruction on diabetes meal planning and self-management of blood glucose

In some activities, the enhanced diabetes education intervention will also include family members and others who constitute an individual's support system.

What: The NDPP is designed to bring to communities evidence-based lifestyle change programs for preventing type 2 diabetes. It is based on the Diabetes Prevention Program research study led by the National Institutes of Health and supported by Centers for Disease Control and Prevention. The National Standards for Diabetes Self-Management Education and Support are designed to define quality diabetes education and support and are reviewed and revised approximately every five years by key stakeholders and experts within the diabetes education community (4).

Why: The lifestyle program shows that making modest behavior changes, such as improving food choices and increasing physical activity to at least 150 minutes per week, results in participants losing 5% to 7% of their body weight. These lifestyle changes can slow the progression of type 2 diabetes and lower the risk of chronic complications associated with diabetes.

When: Participants work with a lifestyle coach in a group setting to receive a 1-year lifestyle change program that includes 16 core sessions (1 per week) and 6-8 post-core sessions (1 per month). The diabetes education content will be delivered by a Certified Diabetes Educator (CDE) whenever possible, or by a designated healthcare professional.

Adapted from (5).

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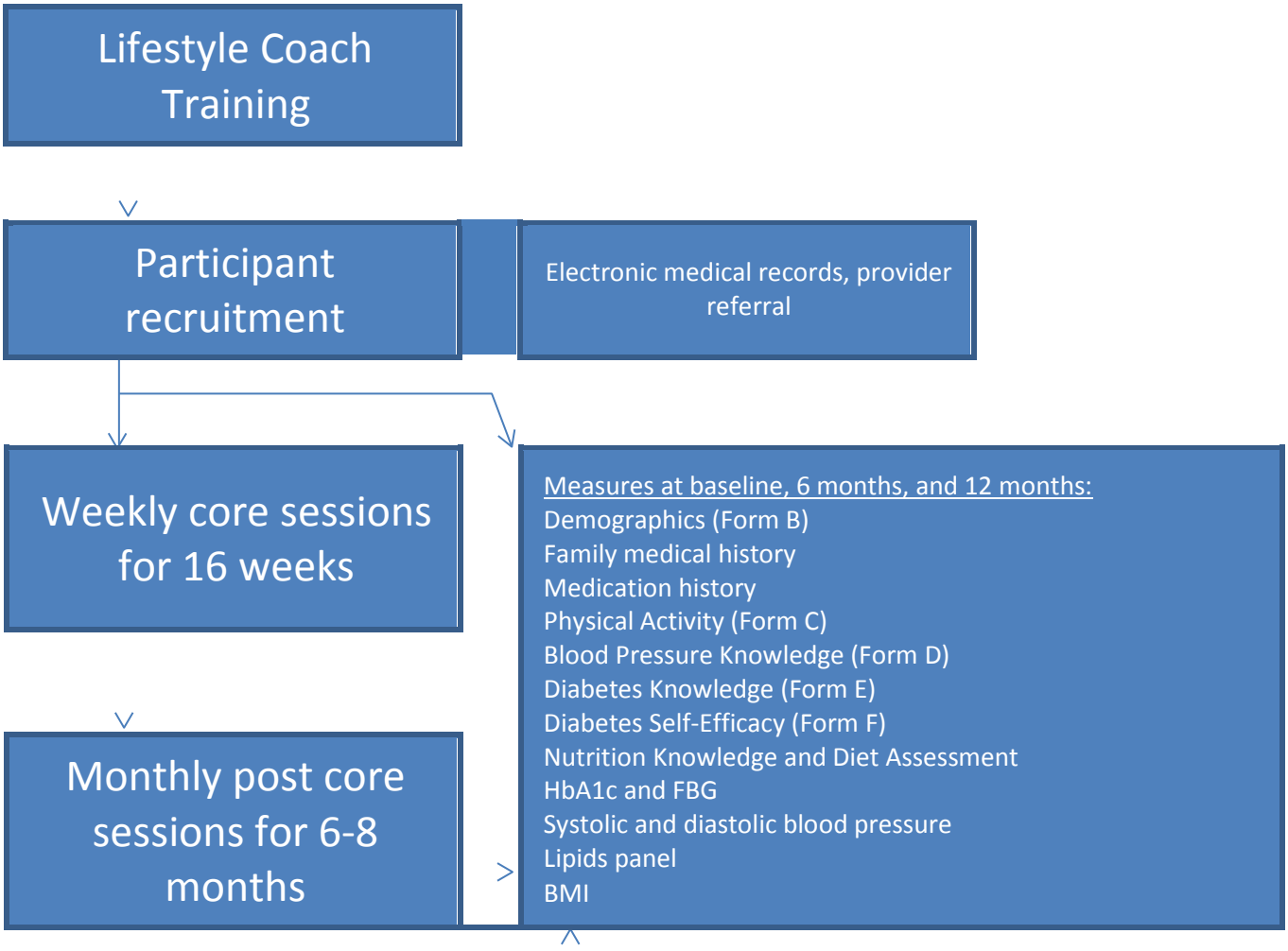
Enhanced Type 2 Diabetes Education Intervention Flow Chart



Participant objectives

- Attend all 16 weekly core sessions in designated community setting
- Change unhealthy lifestyle behaviors
  - Increase activity
    - 150 minutes/week
  - Improve food choices
    - Keep diary & follow fat gram goal
  - Lose weight, if overweight
    - 5-7% of body weight
- Attend post core sessions offered monthly for 6-8 months

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Table 1. Description of the Intervention			
Baseline	Intervention[1]		Mid- and Post-Intervention
Measures	**16 Core Sessions (one/week)[3]**	**6-8 Post Core Sessions (one/month)[3]**	Measures (6 and 12 months)
Demographics[2] (Form B)	Introduction	Use post core curriculum and: -review previously learned content -assess participants' knowledge and skills regarding topic being addressed -discuss ongoing barriers to adopting healthy lifestyle changes--- engaging in group problem-solving -open discussion of any topic group chooses/ introduces	Demographics
Family medical history	Be a Fat and Calorie Detective		Family medical history
Medication history	Three Ways to Eat Less Fat and Fewer Calories		Medication history
Physical Activity (Form C)	Healthy Eating		Physical Activity
Blood Pressure Knowledge (Form D)	Move Those Muscles		Blood Pressure Knowledge
Diabetes Knowledge (Form E)	Being Active – A Way of Life		Diabetes Knowledge
Diabetes Self-Efficacy (Form F)	Tip the Calorie Balance		Diabetes Self-Efficacy
Nutrition Knowledge and Diet Assessment	Take Charge of What's Around You		Nutrition Knowledge and Diet Assessment
HbA1c and FBG	Problem Solving		HbA1c and FBG
Blood pressure	Four Keys to Healthy Eating Out		Blood pressure
Lipid panel	Talk Back to Negative Thoughts		Lipid panel
BMI	The Slippery Slope of Lifestyle Change		BMI
	Jump Start Your Activity Plan		
	Make Social Cues Work For You		
	You Can Manage Stress		
	Ways to Stay Motivated		

[1]Activities such as fitness classes, cooking classes, and grocery store tours should be incorporated when possible.
[2]Age, gender, age at diagnosis, race/ethnicity, education attainment, marital status, children, annual household income, health insurance status
[3]Supplemental information will be provided on: Describing the diabetes disease process and treatment options; using medication(s) safely and for maximum therapeutic effectiveness; monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making; and preventing, detecting, and treating acute and chronic complications.

•OVERALL CHARACTERISTICS OF THE INTERVENTION•

- 16 weekly core sessions plus 6-8 monthly post core sessions
- Longitudinal (follow-up for one year)
- Community-based — schools, churches, adult day care centers, agricultural extension centers, and community health clinics sites
- Designed to promote group problem-solving to address individual's health questions and issues
- Organized to obtain support from family, friends, group participants, nurses/dietitians/community workers
- Incorporates activities to reduce barriers to physical activity and nutrition

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FORM E:

2. Diabetes knowledge questions	True*	False*
1. Normal fasting blood sugar is between 70 mg/dl (3.9 mg/dl) and 100 mg/dl (5.5 mmol/L) (for someone without diabetes)	x	
2. Insulin and diabetes pills make your blood sugar go down.	x	
3. A person with diabetes should check their feet for sores every day.	x	
4. When you exercise, your blood sugar goes down.	x	
5. If you feel shaky, sweaty and hungry, it usually means your blood sugar is low.	x	
6. If diabetes is not well controlled, it can injure both kidneys and nerves.	x	
7. A person with diabetes should get their eyes checked every year.	x	
8. If you feel thirsty, you could have low blood sugar.		x
9. If your hemoglobin A-1C blood test is < 10%, then your diabetes is in good control.		x
10. For people with diabetes, the goal for the 'bad cholesterol' (LDL) is >100.		x

* The "x's" will not be shown on the participant surveys

Source: Adapted from Williams MV, Baker DW, Parker RM, Nurss JR. Relationship of functional health literacy to patients' knowledge of their chronic disease. A study of patients with hypertension and diabetes. Arch Intern Med 1998;158:166-72.

Notes:
9 - hemoglobin A-1C blood test is measured in a percentage and the goal is;
<7% in a person with diabetes
<6% in a person without diabetes
#10 – Bad cholesterol (LDL) the goal is <100

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FORM F:

STANFORD PATIENT EDUCATION RESEARCH CENTER

Self-Efficacy for Diabetes

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

1. How confident do you feel that you can eat your meals every 4 to 5 hours every day, including breakfast every day?
2. How confident do you feel that you can follow your diet when you have to prepare or share food with other people who do not have diabetes?
3. How confident do you feel that you can choose the appropriate foods to eat when you are hungry (for example, snacks)?
4. How confident do you feel that you can exercise 15 to 30 minutes, 4 to 5 times a week?
5. How confident do you feel that you can do something to prevent your blood sugar level from dropping when you exercise?
6. How confident do you feel that you know what to do when your blood sugar level goes higher or lower than it should be?
7. How confident do you feel that you can judge when the changes in your illness mean you should visit the doctor?
8. How confident do you feel that you can control your diabetes so that it does not interfere with the things you want to do?

not at all confident 1 2 3 4 5 6 7 8 9 10 totally confident

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Scoring

The score for each item is the number circled. If two consecutive numbers are circled, code the lower number (less self-efficacy). If the numbers are not consecutive, do not score the item. The score for the scale is the mean of the six items. If more than two items are missing, do not score the scale. Higher number indicates higher self-efficacy.

Characteristics

Tested on 186 subjects with diabetes.

No. of Items	Observed Range	Mean	Standard Deviation	Internal Consistency Reliability	Test-Retest Reliability
8	1-10	6.87	1.76	.828	NA

Source of Psychometric Data

Stanford English Diabetes Self-Management study, ongoing.

Comments

This 8-item scale was originally developed and tested in Spanish for the Diabetes Self-Management study. For internet studies, we add radio buttons below each number. There is another way that we use to format these items, which takes up less space on a questionnaire, shown also in the PDF document. This scale is available in Spanish.

References

Unpublished.

This scale is free to use without permission

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1000 Welch Road, Suite 204
Palo Alto CA 94304
(650) 723-7935
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self-management@stanford.edu
http://patienteducation.stanford.edu

Funded by the National Institute of Nursing Research (NINR)

References

1. Appendix B: CDC Prediabetes Screening Test. Centers for Disease Control and Prevention Diabetes Prevention Recognition Program Standards and Operating Procedures. Accessible at: http://www.cdc.gov/diabetes/prevention/pdf/DPRP_Standards_09-02-2011.pdf.

2. Diabetes Educ. 1999;25(2):226-236.

3. Diabetes Care. 2002;25(2):259-68.

4. Centers for Disease Control and Prevention. National Diabetes Prevention Program. Accessible at: http://www.cdc.gov/diabetes/prevention/.

5. Michigan State University Extension. National Diabetes Prevention Program. Accessible at: http://events.anr.msu.edu/event.cfm?folder=NDPPGeneseeMay2013.

6. Diabetes Care. 2013;36(Supp 1):S100-S108.

7. Diabetes Care. 2013;36(Supp 1):S13.

Appendix C – Compendium of Resources

Category	Description and/or examples	Access to health care community resources	Obesity, physical activity, and nutrition as risk factors for chronic diseases, including diabetes, community resources	Tobacco use primary prevention/cessation community resources
Health care facilities (Essentia and other)	**Hospitals, primary care clinics**	Public Health Department Offices • North Central District Health Department, 105 115th St., Orofino, ID 83544, 208-476-7850 • Lewis County Health Department, North Central District, 132 N. Hill St, Kamiah, ID 83536, 208-935-2124 • Public Health – Idaho North Central District, 903 W. Main Street, Grangeville, ID 83530, 208-983-2842; may have meeting spaces and materials available for presentations and may promote classes on their website • www.idahopublichealth.com Dentists • Bryan J. Petersen DDS, 120 North A St, Grangeville, ID, 208-983-1651 • Mountain View Dentistry, 615 W North St, Grangeville, ID, 208-983-0105 • Nelson Family Dentistry, 412 W Main St, Grangeville, ID, 208-983-2422 • Andrea S. Radabaugh DDS, 420 N Division, Craigmont, ID, 208-924-5830 • Michael McCall DDS, 306 Main St, Kamiah, ID, 208-935-2143 • Gentle Family Dentistry, 1265 Riverside Ave, Orofino, ID 83544, 208-476-4315 • Family Dentistry, 636 Michigan Ave, Orofino, ID 83544, 208-476-4917 • Chase Flat Professional Ctr, 13826 Highway 12, Orofino, ID 83544, 208-476-4413 Pharmacies • Irwin Drug, 146 W Main, Grangeville, ID, 208-983-1090 • Arnzen Drug, 429 Main Street, Cottonwood, ID 83522, 208-962-3401		

		• Glenwood, Orofino, 1105 Michigan Avenue, Orofino, ID 83544, 208-476-5727 • Kamiah Drug, Kamiah, 208-935-0102, 318 Main St., Kamiah, ID 83536, Ph. 208-935-2301, Fx. 208-935-2477 • NIMIIPUU Health, P.O. Box 367, 111 Bever Grade, Lapwai, ID 83540, 208-843-2271, Toll-free 888-891-2920 • Northwest Value, Orofino, 13010 Highway 12, Orofino, ID 83544, 208-476-4145 • Riverside Pharmacy, 13010 Highway 12, Orofino, ID 83544, 208-476-0329 Hospitals • St. Mary's Hospital, 701 Lewiston St., Cottonwood, ID 83522, 208-962-3251 • Clearwater Valley Hospital, 301 Cedar, Orofino, ID 83544, 208-476-4555 Clinics • St. Mary's Elk City Medical Clinic, 133 Hwy 14, Elk City, ID 83525, 208-842-2652 • Orofino Medical Clinic, 301 Cedar, Orofino, ID 83544, 208-476-5777 • Kooskia Medical Clinic, 201 Thenon Street, Kooskia, ID 83539, 208-926-7801 • Pioneer Medical Clinic, 105 Carle Street, Pierce, ID 83546, 208-464-2578 • Cottonwood Medical Clinic, 701 Lewiston Street, Cottonwood, ID 83522, 208-962-3267 • Kamiah Medical Clinic, 518 Oak, Kamiah, ID 83536, 208-935-2585 • Nezperce Medical Clinic, 501 Oak, Nezperce, ID 83543, 208-937-2496 • Grangeville Clinic, 617 West North 2nd Ste 2, Grangeville, ID 83530, 208-983-6027 • Craigmont Medical Clinic, 320 N. Division, Craigmont, ID 83523, 208-924-5504 Other facilities • Clearwater Health & Rehabilitation, 1204 Shriver Rd, Orofino, ID 83544, 208-476-4568 • Grangeville Health & Rehabilitation Center, 410 NE 2nd St, Grangeville, ID 83530, 208-983-1131 • Nimiipuu Health, P.O. Box 367, Lapwai, ID 83540, 208-843-2271 ext 2967, (208) 843-2102 fax • Nimiipuu Tribal Health, 313 3rd Street Kamiah, ID 83536, 208-935-0733, 888-891-0733 • Brookside Landing Assisted Living Facility, 431 Johnson Ave, Orofino, ID 83544, 208-476-2000		
Human	**Entities invited to the**	Invited entities included: • Community/patient focus group	Prospective entities include: • Community/patient focus group	Prospective entities include:

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	Town Hall meeting	participants • Allen Counseling Services • Business Psychology Associates • Clearwater County • Clearwater Valley Hospital • Cottonwood City Council • Nimiipuu Health/Community Health Department • Public Health – Idaho North Central District • Region II Mental Health Board • Seniors in Shape Program • St. Mary's Hospital • St. Mary's Hospital Foundation • Syringa Hospital • Tribal Cancer Coalition	participants • Social service organization representatives (e.g. Human Needs Council) • Service organization representatives (e.g. hospital auxiliary) • City and county government officials (e.g. County Commissioner) • Tribal government/leadership/representatives if applicable and/or other minority population group members/representatives (e.g. Nimiipuu Health) • Primary care and other health care providers (e.g. Clearwater Valley and St. Mary's Hospitals and Clinics) • Lead county public health officials (e.g. Public Health – Idaho North Central District) • Industry/business leaders/representatives (e.g. Chamber) • Educators/educational administrators (e.g. school board) • Other relevant entities	• Community/ patient focus group participants • Social service organization representatives (e.g. Human Needs Council) • Service organization representatives (e.g. hospital auxiliary) • City and county government officials (e.g. County Commissioner) • Tribal government/ leadership/ representatives if applicable and/or other minority population group members/ representatives

				(e.g. Nimiipuu Health) • Primary care and other health care providers (e.g. Clearwater Valley and St. Mary's Hospitals and Clinics) • Lead county public health officials (e.g. Public Health – Idaho North Central District) • Industry/ business leaders/ representatives (e.g. Chamber) • Educators/ educational administrators (e.g. school board) • Other relevant entities

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Human	**Additional Individuals**	Certified Diabetes Educator • St. Mary's Hospital, 701 Lewiston St., Cottonwood, ID, 208-962-3251 Registered dieticians • Kamiah Medical Clinic, 518 Oak, Kamiah ID, 83536, 208-935-2585 • Healthy Horizons, Kamiah, ID 83536, 208-935-0544 Primary care providers who could participate in intervention • CMO, 301 Cedar Orofino, ID 83544, 208-475-4555 • CMO, 701 Lewiston Street, Cottonwood, ID 83522, 208-962-3267 Separate coalitions existing with Public Health, Tribe, and Human Needs Councils – Medical Home Plus project, diabetes awareness, colorectal cancer awareness, smoking cessation		
Financial	**Grants and hospital contribution**	The base guideline for the hospital's financial contribution is 0.1% of net patient revenue less bad debt [i.e. 0.1%*(NPR-BD)] for each of the three interventions, each of which will last three years with the first beginning in Financial Year 2014. Additionally, all hospitals are strongly encouraged by Bert Norman, Essentia Health's Chief Financial Officer, to reallocate current Community Benefit funding to supplement the base financial contribution guideline. $150K from 2012 to 2015 from federal outreach grant for nurse case management and community referral coordinators;		

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		active project management including representatives from key community partnerships. Grant awarded to St. Mary's Hospital. State medical home pilot project, with special emphasis on nurse case management. Grant awarded to Clearwater Valley Hospital and St. Mary's Hospital.		
Financial	**Grants**	2012/2013 grant for telepsychiatry. Grant awarded to Clearwater Valley Hospital.		
Programmatic	**Community health activities already occurring**	• Nurse case management • Community referral coordinators • Access to psychiatric care via telepsychiatry • Medical home practice transformation • Revising resource directory for online search functionality	School programs on activity and nutrition • Fuel Up to 60, Nezperce School District #302, 615 2nd Avenue, Nezperce, ID 83543, 208-937-2551 • Walk at Recess Program, Mountain View School District #244, 714 Jefferson St. Grangeville, ID 83530, 208-983-0990 BMI recorded and care recommendations provided by primary care provider and included on clinic visit summaries Yoga • Emergence, 73 Spirit Horse Lane, Grangeville, ID 83530, 208-507-0165, 500 hours RYT/Yoga Therapist, Yoga Therapy, Integrative Health Coaching, Yoga for Cancer and Heart Disease certification (108 hours), and Gentle Yoga Classes at Methodist Church • 318 N Florence St, Grangeville, ID	Tar Wars prevention presentations at schools, Idaho Tar Wars Coordinator, 208-939-3373 Smoke-free public spaces advocacy led by Public Health Idaho North Central District Tobacco use status and cessation recommendations provided by primary care providers and included on clinic visit summaries Tobacco Cessation Program, Syringa Hospital, 983-1700

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			83530, 406-544-0781, 200 hour, Hatha Yoga teacher • Orofino Physical Therapy, 1005 Michigan Avenue, Orofino, Idaho 83544, 208-476-9365/ PT, 476-7103, cell - 208-827-1800, CYI/ 745 hour, Tues and Thurs evening classes, gentle yet challenging Hatha yoga. • River Bend Yoga, 3969 Hwy 13, Sites, ID 83552, 208-926-4341, Anusara Yoga/200 hour, Anusara yoga/Hatha yoga	
Programmatic	**Community health activities already occurring**	Public Health-Idaho North Central District is conducting a regional (10-county) assessment of community opinions on key health needs; all hospitals in the region have agreed to discuss joint opportunities to impact those needs. Clearwater Valley and St. Mary's Hospitals and Clinics helped instigate this process. Director, 208-799-0344. Extension • Clearwater County Extension, 208-476-4434, 2200 Michigan Ave, Orofino ID 83544, www.extension.idaho.edu, Fax 208 476-4111 • University of Idaho Extension Nutritionist, (208) 983-2667 • Nutrition classes for low income Diabetes Advisory Group, 215 10th St, Lewiston, ID 83501, 208-199-3100. The Diabetes Advisory Group is an active, sustainable partnership engaged in activities related to promoting the Idaho Diabetes State Plan 2008 – 2013, Centers for Disease Control Intervention Focus Areas, and the National Diabetes Education Program (NDEP). St. Mary's Hospital Diabetes Support Group, Oscar's Restaurant, 101 East Main St., Grangeville, ID 83522 OR Kamiah Bible Church, 521 10th St., Kamiah, ID, 208-962-3267. Information and resource sharing.		

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Infrastructure	**Buildings or other built environment features that may be useful for interventions, e.g. gyms, community centers, walking paths, etc.**	Transportation services • All-ways Transportation, 208-746-0257, 877-437-5237, 2036 3rd Avenue N, Lewiston, ID 83501, allways1@questoffice.net, www.all-waytransportationinc.com. Serves Clearwater, Idaho and Lewis counties, 24hr advanced notice, Medicaid or private pay fee $15 one way, $30 for non-ambulatory, Wheelchair Accessible. • Appaloosa Express Transit, 120 Beaver Grade, P.O. Box 365, Lapwai, ID 83540, Phone: (208) 843-7324, extension 1, Fax: (208) 843-7343, https://crcasino.com/nez-perce-express/ • Fixed Route Service http://www.nezperce.org/wp-content/uploads/2018/08/FixedRouteTrifoldRevisedJanuary2018.pdf • On Demand Service http://www.nezperce.org/wp-content/uploads/2018/08/OD-Trifold-revised-January-1-2018.pdf Monday-Friday 5:30 am – 7:00 pm, wheelchair lift.	Churches • Community Church: Winchester, 924-5700, 621 Algoma, Winchester, ID 83555 • Catholic: Holy Trinity, 937-2300, 506 Willow, Nezperce, ID 83543 • Baptist: Pleasant View, 839-2220, 110 Everest Street, Whitebird, ID 83554, www.lifewaylink.com • Valley Bible Church: Kooskia, 926-0182, 319 N. Main, Kooskia, ID 83539 • Assembly of God: Clearwater Valley, 935-0414, 1011 Yates St., Kamiah, ID 83536 • Baptist: Pine Ridge, 935-2360, 108 Pine Road, Kamiah, ID 83536 • Catholic: St. Catherine's, 476-5121, 407 7th St., Kamiah, ID 83536 • Community Presbyterian, 935-2602, 620 7th., Kamiah, ID 83536 • First Presbyterian: Kamiah, 935-2602, 935-0211, Rt. 1 Box 20 C, 7th and Hill, Kamiah, ID 83536 • The Life Center PCG, 935-0362, 4432 Hwy 12, PO Box 1381, Kamiah, ID 83536 • Baptist: Mt Idaho, 983-1170, 983-7697, 75 Mt Idaho Loop Rd, Grangeville, ID, 83530, www.lifewaylilnk.com • Baptist: Mountain Shadows, 983-2225, 983-2349, 215 North C Street,	

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		• Biggs, 877-983-9309 • Canyon Area Bus Service, CABS,		

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		Local Transit Coordinator, PO Box 76, Riggins, ID 83549, w-208-628-2227, h-208-628-3780 • Asotin County PTBA offers Dial-A-Ride and fixed route service to Clarkston and Asotin. For more information please visit their website at http://www.asotincoptba.com • COAST, Public Transportation, The Council on Aging & Human Services' transportation Program, www.coa-hs.org, 210 South Main, PO Box 107, Colfax, WA 99111. Serves Nez Perce, Idaho, Clearwater, Lewis and Latah Counties. 509-397-2935, 800-967-2899, Fax: 509-397-9229. 24-48 notice, wheelchair accessible • Idaho County Rideshare, 877-983-9309, 24 hour notice, Wheelchair Accessible, Lewiston to McCall. • The Lewiston fixed route and ADA para-transit service is provided by the City of Lewiston. For more information, please visit their website at http://www.cityoflewiston.org/index.aspx?nid=808. 208-298-1340	Grangeville, ID 83530 • Calvary Chapel of Grangeville, 983-life, 517 W. North Street, Grangeville, ID 83530, • Catholic: 983-0403, 625 Lake Street, Grangeville, ID 83530 • Christian Reformed, 983-2417, 983-0955, 521 N. Junction St., Grangeville, ID 83530 • Christian: Grangeville, 983-2549, F 983-0411, 402 W. S. 1st Street, Grangeville, ID 83530, www.grangevillechristianchurch.org • Church of God: Grangeville, The Hub, 507-0085, 121 E. N. 2nd ST, Grangeville, ID 83530 • Church of the Nazarene: Grangeville, 983-0552, 515 W. N. 2nd St, PO Box 125, Grangeville, ID 83530 • Church of the Rock, 983-0917, 115 W. North 7th, Grangeville, ID 83530 • Episcopal: Holy Trinity, 983-1458, 983-6075, 311 S. Hall, Grangeville, ID, 83530. Cost to use meeting rooms is free. Rooms can be used for self-help groups. • Gospel Tabernacle: Grangeville, 983-1047, 983-0927, 340 Hwy 95 N, Grangeville, ID 83530 • Lutheran: Trinity, 983-0562, 210 N. Mill, Grangeville, ID 83530	

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		• Idaho County Rideshare, 1-877-983-9309 (cell phone so dial 1-877 even for local Grangeville calls) • Idaho Medicaid Transportation, 1-877-503-1261 (American Medical Response –AMR), 48 hour notice unless emergency • Medicaid pre-authorization 1-800-296-0509 • Mountain Community Transit, 208 634-0003. Transport to/from McCall, New Meadows, Riggins. • Nimiipuu Transportation, CHR program. Kamiah 208-935-0733. Lapwai 208-843-2271. • Orofino Cab Co., Orofino, ID, 208-476-4632, 208-476-8151, fold-up wheel chair, Orofino area only. • Palouse Ride Share Network, Palouse-Clearwater Environmental Institute, PO Box 8596, Moscow, ID 83843, 208-882-1444, www.palouserideshare.org, Region 2, 75 communities. • Prairie Transit, 800-710-4345, 208-962-3975, 210 N. Foster, Cottonwood, ID 83522, on call, Medicaid Approved.	• Methodist: United, 983-1913, 404 W. Main, Grangeville, ID 83530, • Catholic: Assumption, 460 Maple Street, Ferdinand, ID, 83542, 208-962-3214 • Catholic: St. Mary's, 962-7370, 962-3214, Church & King, Cottonwood, ID 83522 • Community Church: Cottonwood, 962-7762, 962-7070, 510 Gilmore, Cottonwood, ID 83522 • Weippe Wesleyan Church, 220 N. Main, PO Box 208, Weippe, ID 83553, 208-435-4470 • Ascension Lutheran Church, 476-5622, 215 115th Street, Orofino, ID 83544, 208-476-5622, Cell (307) 331-2803, office hours 9 am to Noon, funds up to $100 to help with needs. • Church of the Nazarene, 476-5158, 802 Michigan Ave, Orofino, ID 83544, recycled clothing • Covenant House Christian Center, 476-7857, 476-3803, 12517 Hartford Avenue, Orofino, ID 83544 • First Baptist Church, 476-5412, 291 118th St., PO Box 1070, Orofino, ID 83544 • Orofino Community Church, 476-3019,	

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		• Senior Citizen Center, 983-2033, seniors and disabled – provided by COAST volunteers • Tolo Transportation, 208-451-0252, 208-983-0055, Medicaid Approved medical Transportation, Idaho County and hospitals in Lewiston, Cottonwood, Orofino and Grangeville, 24 hr prior Medicaid authorization. • Valley Transit, 208-743-2545, offers Idaho Medicaid service in the LC Valley and to Moscow. For more information on Valley Transit's services, please visit their website at http://www.r2transit.com • NorthWestern Trailways, 509-662-2183, 1-800-366-6975, 300 S Columbia St, Wenatchee, WA 98801. Providing Daily Bus Service between Spokane - Wenatchee - Everett - Tacoma-Omak - Wenatchee – Ellensburg-Boise - Coeur d'Alene -Lewiston - Pullman - Sandpoint	14233 Highway 12, Orofino, ID 83544, www.orofinocc.com, • Orofino Tabernacle, 476-3757, 476-3817 • Peace Lutheran Church, 208-476-3212, 509-758-8261, 13946 1st Avenue, Orofino, ID, 83544 • Seventh-day Adventist Church, 476-9174, 476-7840, 46418 Highway 12, PO Box 2447, Orofino, ID 83544, www.orofino.adventistnw.org, Food Bank open Tuesdays from 9 am-1 pm • St. Theresa's Catholic Church, 476-5121, 446 Brown Avenue, PO Box 1169, Orofino, ID 83544, Food Bank, Tuesday and Thursday, 476-3460. Cost to use the Littler Flower Room is $75. Schools and colleges with meeting spaces and/or fitness facilities • Cottonwood School District, 208-962-3971, District Office, 208-962-3971. Cost is free. • Mountain View School District, 208-983-0990, Cost is free.	

			• Kamiah School District, 208-935-2991, http://www2.kamiah.org/ • District School Administration, Craigmont-Reubens-Winchester, 208-924-5411, 112 Boulevard, Craigmont, ID 83523 • Nezperce Public Schools, 208-937-2551, 615 2nd, Nezperce, ID 83543 Community centers • Pierce Community Center, 208-464-2443, 105 W. Carle St, Pierce, ID 83546 Senior centers • Clearwater County Senior Citizens Center, 930 Michigan Ave, PO Box 93, Orofino, ID 83544, 208-476-4238. Tuesday & Friday, 12:00 noon • Senior Citizens Center Cottonwood Community Church, 510 Gilmore, RT 1, Box 134, Cottonwood, ID 83522, 208-962-7762, Tuesday, 12:00 noon • Grangeville Senior Center, Box 446, Grangeville, ID 83530-0446, 208-983-2033, Monday & Friday, 12:00 noon • Hilltop Senior Citizens Center, 115 1st Street West, Box 42, Weippe, ID 83553 (208) 435-4553, Monday – Thursday, 12:00 noon • Kamiah Senior Citizens Society, Inc., 125	

			N. Maple, PO Box 551, Kamiah, ID 83536, 208-935-0244, Wednesday & Friday, 12:00 noon • Senior Citizens Center Kooskia Community Center, 26 S. Main St., PO Box 126, Kooskia, ID 83539, 208-926-8897, Monday & Thursday, 12:00 noon • Nezperce Senior Citizens Center, 510 Cedar, Nezperce, ID 83543, 208-937-2465, Monday through Thursday, 12:00 noon • Riggins Senior Meal Site, By the Park Restaurant, 411 N Main, Riggins, ID 83549, 208-628-3245, Thursday, 1:00 pm MST • Winchester Senior Citizens Center, Nezperce Avenue, Winchester, ID 83555, Wednesday, 12:00 noon Gym/fitness centers • YWCA, 208-743-1535, 208-476-0731, 320 Michigan, #203, Orofino, ID 83544 • YWCA, 221 W. Main #21, Grangeville, ID 83530, 208-743-1535, 208-983-0888, www.ywcaidaho.org Local TV station(s) and other media (e.g. newspapers) • Clearwater Tribune, 208-476-4571, 161 Main St., PO Box 71, Orofino, ID 83544,	

			• http://www.clearwatertribune.com/ • Cottonwood Chronicle, 503 King St. or P.O. Box 157, Cottonwood, ID 83522-0157, 208-962-3851, Fax 208-962-7131 • The Clearwater Progress, 208-935-0838, P.O. Box 428 Kamiah, ID 83536 • The Current News, 208-628-2340, PO Box 1483, Riggins, ID 83549 • Idaho County Free Press, 900 W. Main St., PO Box 690, Grangeville, ID 83530, 208-983-1200 Hiking in national forests Grocery stores • Country Store, 106 20 Hwy 12, Orofino, ID 83544, 208-476-4091, supplements, general healthy food choices • Herbs and Things, 10 N Main, Kooskia, ID 83539, 208-926-4372, supplements, general healthy food choices • The Health Food Store, 221 W. Main, Grangeville, ID 83530, 208-983-1276, supplements, general healthy foods Ski trails and/or slopes • Bald Mountain Ski Hill, Clearwater Ski Club, PO Box 49, Pierce, ID 83546, 208-	

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			464-2311 at the Hill, 208-435-4782 in town Public golf courses • Orofino Golf and Country Club, 3430 Debertin Dr, Orofino, ID 83544, 208-476-3117 • Kayler's Bend, Silva Ln, Peck, ID 83545, 208-485-6841	
Local events	**Sporting events, festivals**	Trevor Haag Memorial Tournament, July 18th -21st , Orofino City Park, VFW Field, Fields Behind OES, 208-827-1988 Clearwater County Fair & Lumberjack Days, September 12th - 15th, Orofino City Park, 208-476-4334 Clearwater County Fair		