Chippewa Valley Hospital and Oakview Care Center
A Member of Adventist Health System

2014-16 Community Health Plan

Chippewa Valley Hospital, in conjunction with Pepin County Health Department, conducted a Community Health Needs Assessment ("CHNA") in 2013. This Community Health Plan identifies the Hospital's planned programs, services and outcome measures based on prioritized Community Health Need. Jointly and collaboratively, Chippewa Valley Hospital and Pepin County Health Department comprehensively assessed the health needs of County residents with keen focus on those needs that, when properly addressed, are most likely to bring meaningful change to overall health of those served.

Data collection, aggregation and analysis were completed with the goal of identifying the top presenting healthcare needs in the CVH Community. Pepin County, in conjunction with CVH, created a Committee of Community Health Improvement Process Stakeholders ("CHIPS") that represented the broad community as well as low income, minority and underserved populations. Five representatives from CVH served on this Committee, along with representatives from the health clinics located on the hospital campus. CHIPS worked cooperatively to analyze the data and prioritize the issues to be addressed by those in the Community with the appropriate resources and expertise. CVH prioritized the following health needs for targeted improvement. Specific goals and measures are summarized in the Community Health Plan spreadsheet ("CHP"). The CHP lists targeted interventions and measurable outcome statements for each effort. The interventions engage Community Partners. The Plan was posted by May 15, 2014 at the same web location noted below.

Chronic Disease Management

Alcohol and Other Substance Abuse

Healthy Growth and Development

Communicable Disease

Chippewa Valley Hospitals' fiscal year is January – December. For 2014, the CHP will be deployed beginning May 15 and evaluated at the end of the calendar year. In 2015 and beyond, the Plan will be implemented and evaluated annually for the 12-month period beginning January 1 and ending December 31. Evaluation results will be posted annually and attached to our IRS Form 990.

If you have questions regarding this Community Health Plan or the Community Health Needs Assessment, please contact Anne Herman, Adventist Midwest Health Corporate Responsibility Officer, at anne.herman@ahss.org.

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[1]The full Community Health Needs Assessment can be found at www.keepingyouwell.com under the Community Benefit heading.

[2]It is important to note that the Community Health Plan does not by any means include all Community Benefit activities. Those activities are also included on Schedule H of our Form 990.

Measures Not Finally Selected for Priority: The following measures were not finally selected for priority based on the following:

Access to Healthcare : *Access to Primary and Secondary Services – Adventist Bolingbrook Hospital*
Rationale: *During this assessment period, Adventist Bolingbrook Hospital, in conjunction with VNA, opened a Federally Qualified Healthcare Center on the hospital campus, increasing healthcare access to primary and secondary health services for those community members with financial need.*

Prevention and Management of Chronic Care Issues : *Heart Disease [blood cholesterol levels]*
Rationale: *While this tested well on the Impact Analysis Matrix, using the Decision Tree, it was determined that this is a commonly available prevention measure at most surrounding providers. It is frequently a part of community health fairs and routine physician visits.*

Behavioral Health and Substance Abuse
Rationale: *Adventist Midwest Health provides comprehensive inpatient programs for behavioral health (Adventist GlenOaks Hospital and Adventist Hinsdale Hospital) and outpatient programs for both behavioral health and substance abuse (Adventist Hinsdale Hospital). Serving the Adventist Midwest Health Community, the Hospitals support County initiatives to bring these necessary services to those in need. Prioritizing Access to Care as one of the selected Health Priorities will assist Adventist Midwest Health in extending services for those who currently lack such access.*

About Adventist Midwest Health

Adventist Midwest Health is a Member of Adventist Health System, the largest not-for-profit protestant health care provider in the Nation. Adventist Midwest Health Hospitals in Illinois include Adventist Bolingbrook Hospital; Adventist GlenOaks Hospital; Adventist Hinsdale Hospital, and Adventist La Grange Memorial Hospital.
As not-for-profit hospitals, Adventist Midwest Health continues the tradition of providing benefit to the community, with the ultimate goal of improving community health and increasing access to care. All of the net income (profit margin) generated by the hospitals are reinvested back into hospital programs and services. This benefits the patients and communities we serve instead of individual owners or shareholders.

Chippewa Valley Hospital

2014-2016 Community Health Plan

OUTCOME GOALS							OUTCOME MEASUREMENTS							
CHNA Priority	**Outcome Statement**	**Target Population**	**Strategies/Outputs**	**Outcome Metric**	**Current Year Baseline**	**Year 1 Outcome Goal - #**	**Year 1 Actual**	**Year 2 Outcome Goal - #**	**Year 2 Actual**	**Year 3 Outcome Goal - #**	**Year 3 Actual**	**Hospital $**	**Matching $**	**Comments**
Chronic Disease Management	Provide accessible, meaningful opportunity for community members to learn and integrate strategies for health management of chronic diseases.	Community members at large	Develop interdisciplinary educational materials on chronic diseases that are prevalent in the Pepin County Service Area and present them in a meaningful educational forum accessible to the Community.	Number of Educational Sessions Held; # of Attendees per Session	n/a: Classes not currently offered	1 event on Diabetes: 10 Participants; 1 event on Depression: 10 participants; 1 event on life changes and management of related health issues: 10 participants; 1 event on Hypertension and High Cholesterol: 10 participants		1 event on Diabetes: 15 Participants; 1 event on Depression: 10 participants1 event on Hypertension and High Cholesterol: 15 participants		1 event on Diabetes: 20 Participants; 1 event on Depression: 20 participants1 event on Hypertension and High Cholesterol: 20 participants		1,600		
	Participate in a Community Health Fair to promote healthy behaviors to prevent chronic disease.	Community members at large	Work cooperatively with Durand Emergency Services and other Community Partners to promote Community participation in preventive health activities: Blood pressure education; Blood pressure monitoring; Diabetes education and accuchecks; and Prescription Medication education	Annual Fair Held; # of Participants; # of Participants referred for further healthcare services secondary to hypertension; # of Participants referred for further healthcare services secondary to abnormal blood sugar	n/a: Classes not currently offered	1 Health Fair: 100 participants; 5 participants screened and appropriately referred secondary to HTN; 3 participants screened and appropriately referred secondary to high blood sugar		1 Health Fair: 120 participants; 7 participants screened and appropriately referred secondary to HTN; 4 participants screened and appropriately referred secondary to high blood sugar		1 Health Fair: 150 participants; 9 participants screened and appropriately referred secondary to HTN; 5 participants screened and appropriately referred secondary to high blood sugar			Safety Council: $500; Police/Fire: In-kind Services	

CHNA Priority	Outcome Statement	Target Population	Strategies/Outputs	Outcome Metric	Current Year Baseline	Year 1 Outcome Goal - #	Year 1 Actual	Year 2 Outcome Goal - #	Year 2 Actual	Year 3 Outcome Goal - #	Year 3 Actual	Hospital $	Matching $	Comments
Alcohol and Other Substance Abuse	Provide accessible, meaningful opportunity for community members to learn and integrate strategies for health management of chronic diseases.	Community members at large	Develop interdisciplinary educational materials on chronic diseases that are prevalent in the Pepin County Service Area and present them in a meaningful educational forum accessible to the Community.	Number of Educational Sessions Held; # of Attendees per Session	n/a: Classes not currently offered	1 event on alcohol/substance abuse: 10 participants; 1 event on Tobacco Abuse and Side Effects		1 event on Alcohol/Substance Abuse: 15 participants		1 event on alcohol/substance abuse: 20 participants				
Healthy Growth and Development	Provide accessible, meaningful opportunity for community members to learn and integrate strategies for health management of chronic diseases.	Community members at large	Develop interdisciplinary educational materials on chronic diseases that are prevalent in the Pepin County Service Area and present them in a meaningful educational forum accessible to the Community.	Number of Educational Sessions Held; # of Attendees per Session	n/a: Classes not currently offered	1 event on Obesity: 40 Participants		1 Event on Obesity; 60 Participants		1 Event on Obesity; 70 Participants				
Communicable Disease	Provide accessible, meaningful opportunity for community members to learn and integrate strategies for health management of chronic diseases.	Community members at large	Develop interdisciplinary educational materials on chronic diseases that are prevalent in the Pepin County Service Area and present them in a meaningful educational forum accessible to the Community.	Number of Educational Sessions Held; # of Attendees per Session	n/a: Classes not currently offered	1 event on Lymes Disease: 10 participants		1 event on Lymes Disease: 15 participants		1 event on Lymes Disease: 20 participants				