Community Health Needs Assessment (CHNA)
Implementation Strategy

Augusta Health
78 Medical Center Dr,
Fishersville, VA 22939

I. General Information

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Date Written Plan Was Adopted by Organization's Authorized Governing Body: April 26, 2017

Date Written Plan Was Required to Be Adopted: May 15, 2017

Authorizing Governing Body that Adopted the Written Plan: Augusta Health Board of Directors

Was Written Plan Adopted by Authorized Governing Body by End of Tax Year in Which CHNA was Made Available to the Public? Yes

Address of Hospital Organization: 78 Medical Center Drive, Fishersville, VA 22939

II. Community Health Needs Sources and Lists of Needs Identified in Written Report

List of Community Health Needs Identified in CHNA Written Report, Ranked by CHNA's Priority:

The Augusta Health 2016 Community Health Needs Assessment (CHNA) has eight sections containing both quantitative and qualitative data comparing the data from the service area of the hospital to state and national data as well as Healthy People 2020 goals. Secondary public health data on disease incidence and mortality, as well as behavioural risk factors, were gathered from numerous sources including the Center for Applied Research and Environmental Systems (CARES), the Centers for Disease Control and Prevention Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Centers for Disease Control & Prevention, Office of Public Health Science Services, Healthy People 2020, the 2015 PRC National Health Survey and numerous other sources. Demographic data were collected from the US Census Bureau American Family Survey, US Census Bureau County Business Patterns, and US Census Bureau Decennial Census.

The CHNA incorporated primary data from both quantitative and qualitative sources. Quantitative data input included the PRC Community Health Survey conducted with a stratified random sample of 400

individuals age 18 and older in the Total Service Area, including 100 in Staunton City, 100 in Waynesboro City and 200 in Augusta County. Once the interviews were completed, they were weighted in proportion to the actual population distribution so as to appropriately represent the Service Area as a whole. For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is +/- 4.9% at the 95 percent level of confidence.

Qualitative primary data was also solicited from key informants, those individuals who have a broad interest in the health of the community, through an Online Key Informant Survey. A total of 300 business, community, government, media, public health and social service leaders including 51 physicians were identified by Augusta Health and invited via email to participate. In all, 206 community stakeholders took part in the Key Informant Survey, including several individuals who work with low-income, minority populations or other underserved populations.

In addition to gathering input from key informants, input and guidance also came from a group of community stakeholders representing a cross-section of community-based agencies and organizations that convened on June 16, 2016 by Augusta Health. Professional Research Consultants (PRC) began the meeting with a presentation of key findings of the CHNA, highlighting the significant health issues identified from the research within 11 key areas of opportunity including: Access to Health Care Services, Cancer, Chronic Kidney Disease, Dementia, Diabetes, Heart Disease and Stroke, Injury and Violence, Mental Health, Nutrition, Physical Activity and Weight, Oral Health and Respiratory Diseases. Following a review, the participants were asked to evaluate each health issue on two criteria: 1) Scope and Severity (to gauge the magnitude of the problem) and 2) Ability to Impact (to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources).

Twenty-three (23) members of the Augusta Health CHNA Implementation Team met on September 6, 2016 to review the final priorities identified by the community stakeholders. The team reviewed the priority ranking of the significant health issues. Using OptionFinder, an audience response polling system, the team rated each of the issues on a 7 point scale on an additional prioritization criteria where 7=Extremely important for the health system to focus on, 4=Somewhat important for the health system to focus on and 1=Not important for the health system to focus on. Each of the participants was asked to only vote "7" for their top three priority areas. The priority areas (in rank order) were as follows:

Community Stakeholders	CHNA Implementation Team
1. Nutrition, Physical Activity and Weight	1. Nutrition, Physical Activity and Weight
2. Diabetes	2. Diabetes
3. Mental Health	3. Mental Health
4. Heart Disease and Stroke	4. Heart Disease and Stroke
5. Substance Abuse	5. Access to Healthcare Services
6. Access to Healthcare Services	6. Cancer
7. Cancer	7. Substance Abuse
8. Tobacco	8. Dementia, including Alzheimer's Disease
9. Injury and Violence	9. Respiratory Diseases
10. Respiratory Diseases	10. Tobacco
11. Dementia, including Alzheimer's Disease	11. Chronic kidney disease
12. Chronic Kidney Disease	12. Injury and Violence
13. Oral Health	13. Oral Health

The top three areas of focus selected based on these criteria ratings include:

1. Nutrition, Physical Activity and Weight
2. Diabetes
3. Mental Health

III. List of Collaborating Organizations

Final participation in the CHNA included representatives from the following organizations:

Adult Services/Adult Protective Services	Chaplain Volunteers	St. John the Evangelist Catholic Church
Augusta Behavioral Health	City of Staunton	State Economic Development
Augusta Care Partners	City of Waynesboro	Staunton City Schools
Augusta County	City of Waynesboro Economic Development	Staunton Parks and Recreation
Augusta County Government	Community Action Partnership of SAW	Staunton Senior Center
Augusta County Health Department	Community Foundation of the Central Blue Ridge	Staunton-Augusta Health Department
Augusta County Parks and Recreation Department	Covenant Presbyterian Church	Telecom Company
Augusta County Public School District	Daikin Applied	Temple House of Israel
Augusta County Sheriff's Office	Daily Living Center Adult Day Health Care	The News Leader
Augusta Free Press	Ebenezer Baptist Church	United Way of Greater Augusta
Augusta Health	EyeOne	Valley Hope Counseling Center
Augusta Health Augusta Medical Group	Fishersville and St. Paul's United Methodist Churches	Valley Mission, Inc.
Augusta Health Cancer Program	Franklin, Denney, Ward and Dryer PLC	Valley Program for Aging Services
Augusta Health Community Committee Member	Girl Scouts of Virginia Skyline Council	Virginia School for the Deaf and the Blind
Augusta Health Home Health	Mary Baldwin College	Virginia Department of Health
Augusta Health Medical Center	MDGI Medical Director	Virginia Department of Veterans Services
Augusta Health Prescription Services	Medcor	Virginia Organizing
Augusta Regional Clinic	Mental Health America of Augusta	Volunteers
Blue Ridge Community College	Middle River Regional Jail	Waynesboro City Public Schools
Blue Ridge Court Services	Mount Carmel Presbyterian Church	Waynesboro Mennonite Church
Blue Ridge Legal Services	Murphy Deming College of Health Sciences	Waynesboro Police Department
Blue Ridge Oral and Maxillofacial Surgery	News Virginian	Waynesboro Women's Health
Boys and Girls Club of Waynesboro, Staunton and Augusta	NIBCO	Waynesboro YMCA
Cancer Patient and Family Advisory Council	Orthopedic Associates, Ltd	Waynesboro/Augusta Health Department
Carillion Clinic - Waynesboro	Project GROWS	Western State Hospital
CASA for Children	Shenandoah Valley Social Services	Wilson Workforce and Rehabilitation Center
Central Shenandoah Valley Office on Youth		

IV. Health Needs Planned to Be Addressed By Facility

List of Health Needs the Facility Plans to Address

Augusta Health, through its mission to promote the health and well-being of our community through access to excellent care, has developed goals, objectives and strategies to address selected top priority health needs in the areas of: 1) Nutrition, Physical Activity and Weight, 2) Diabetes and 3) Mental Health. The action plans will be implemented in collaboration with various community partners over the next three years.

In addition to the three top priority focus areas, Augusta Health will be implementing community benefit programs to address other priority health needs that support important clinical services offered by Augusta Health.

Nutrition, Physical Activity and Weight

As outlined on pages 171 through 193 of the CHNA, while the Total Area (39.2%) has a higher than US Average (27.4%) daily consumption of five or more fruits and vegetables, the percentages are significantly lower for low income residents (23.2%) and men (26.8%). Those who live in Waynesboro City (31.3%) as well as those with low income (34.8%) and women (27.2%) are more likely than the Total Area residents (19.1%) to indicate that they find it "very" or "somewhat" difficult to buy affordable fresh produce. According to the US Department of Agriculture Food Access Research Atlas, 7,650 individuals in the service area have low food access. A total of 35.5% of Total Area adults report drinking an average of at least one sugar-sweetened beverage per day in the past week, higher than the US average of 30.2%. Men (41.8%) and those in the 18 to 49 age group (48.7%) are more likely to indicate that they had 7+ sugar-sweetened beverages in the past week.

A total of 27.8% of Total Area adults report no leisure-time physical activity in the past month, which is higher than the state (13.5%). Lack of leisure-time physical activity is higher among those who live in Waynesboro City (27.7%) and other areas of Augusta County (31.3%), as well as with men (36.4%), adults age 65 and older (41.0%) and lower income residents (40.0%). A total of 72.5% of adults reported that they do not participate in any type of physical activities or exercises to strengthen their muscles. Only 15.6% of Total Area adults regularly participate in adequate levels of both aerobic and strengthening activities, which is lower than the Healthy People 2020 goal of 20.1% or higher. Women (12.0%), those over age 65 (10.2%) and middle to high income residents (5.9%) are more likely not to meet the physical activity requirements.

More than 6 in 10 (61.9%) of Total Area adults are overweight. Furthermore, 32.4% of Total Area adults are obese. Waynesboro City residents (46.9%), men (36.2%), those in the 50 to 64 age group (42.7%) and those with low income (50%) are more likely to be obese than the Total Area overall (32.4%). Overweight and obese adults are more likely to report a number of adverse health conditions. Those that are obese report the highest percentage of adverse health conditions including high blood pressure (55.9% vs. 27.8%), high cholesterol (43.1% vs. 24%), activity limitations (32% vs. 8%), arthritis/rheumatism (31.6% vs. 16.1%), diabetes (29.1% vs. 3.7%), fair or poor physical health (28.3% vs. 6.5%), heart disease (13.9% vs. 3.2%) and

kidney disease (13% vs. 3.4%). The percentage of respondents with children reporting child overweight (58%) and obesity (37.8%) is much higher than the US rates (24.2% and 9.5% respectively).

The majority of key informants indicated that nutrition, physical activity and weight are major problems in the community (53.9%). Key informants commented on the large numbers of overweight and obese people in the area, citing that many lack the financial resources and knowledge to appropriately access healthy foods and to choose healthy lifestyles.

Diabetes

As noted on pages 132 through 138 of the CHNA, Staunton City residents (23.8) have a higher diabetes mortality rate than the state (18.5) or US (21.1). Additionally, a total of 13.9% of the Total Area adults report having been diagnosed with diabetes, higher than the state (9.7%). Residents of Waynesboro City (21.5%), men (18.5%), those age 65 and over (30.6%) and low income (27.3%) are more likely to indicate that they have been diagnosed with diabetes.

Almost half (47.5%) of key informants indicated that diabetes is a major problem in the community. The need for additional health education and better disease management services including information about the role of nutrition and healthy weight were noted as needs by the key informants.

Mental Health

Pages 72 through 84 of the CHNA highlight the needs related to Mental Health. While only 8.7% of Total Area residents report that they experience “fair” or “poor” mental health, the percentage is significantly higher in Waynesboro City (25.5%), among those age 50 to 64 (12.2%) and those with low income (20.6%). Significantly more people living in Staunton City (23.3%) and Waynesboro City (22.3%) indicated that they have been diagnosed with a depressive disorder than the Total Area (14.9%). The city residents (Staunton 29.5%, Waynesboro 27.6%) as well as men (28.4%), those age 50 to 64 (27.6%) and those with low income (22.1%) are more likely to report that they have experienced symptoms of chronic depression. Those that live in Waynesboro City (18%) as well as women (15.5%), those aged 18 to 49 (19.5%) and those with low income (16.3%) are more likely to perceive most days as “extremely” or “very” stressful.

The suicide mortality rate for the Total Area (18.9) is higher than the state (12.7) or US (12.7). A total of 24.9% of Total Area adults acknowledge having ever sought professional help for a mental or emotional problem, lower than the US (27.4%). A total of 2.5% of Total Area adults report a time in the past year when they needed mental health services but were not able to get them. Waynesboro City residents (6.4%), men (3.1%) those age 50 to 64 (4.2%) and those with mid-high income (3.7%) were more likely to note that they were unable to get treatment.

The majority (52.8%) of key informants indicated that mental health was a major problem in the community. The majority of the comments received from the key informants regarding mental health related to the lack of access to care and services. There is a perceived need for additional psychiatrists and other clinicians, as well as a need for additional inpatient beds. Counselling is costly; there is a lack of knowledge of how to access the resources that are available and appropriately coordinate care as well.

Identification and Description of How Facility Plans to Address Each Health Need

In response to the identified top priority community needs, Augusta Health has developed three overarching goals and identified specific implementation strategies and programs to address the needs in the three highest priority need areas. Augusta Health has also committed to supporting intervention strategies in other key need areas.

The goals and implementation strategies are as follows:

Goal 1: To improve the wellbeing of Staunton, Augusta County and Waynesboro residents through increased knowledge about and access to healthy foods and participation in physical activity programs.

Objectives include:

A. By December 31, 2017, the LIFE Employee Wellness Program will engage 40% of all employees through the wellness portal and self-paced team activities
B. Reduce the number of employees with prediabetes by expanding the Employee Wellness Program to include integration of the Diabetes Prevention Program
C. Increase participants' perception of functional activity and quality of life
D. Increase the number of eligible reduced cost memberships offered through Silver Sneakers at the Augusta Health Fitness Center
E. Reduce barriers to physical activity of residents with limited financial resources and medical diagnosis by providing reduced/no-cost Augusta Health Fitness memberships which increase participants' perception of functional activity and quality of life
F. Provide employee wellness programming to local businesses
G. Create a nutrition awareness program within all of Augusta Health cafes, the cafeteria and in all vending machines
H. Continue community walking initiatives to increase physical activity among participants
I. Work with community partners to determine the need for and feasibility of: Increased education about and access to healthy foods
J. Coordinate and collaborate wellness services offered between the Community Outreach, Employee Wellness, Fitness Center and Workplace Wellness departments

In the long term (greater than five years), these programs are expected to positively impact overall health status, lifestyle, knowledge about and access to healthy foods, and participation in physical activity programs. Indicators that will be tracked to evaluate the outcomes and impact of the individual programs will include:

- Number and percentage of participants, both employees and community members, in wellness programs
- Number and percentage of participants who completed wellness screenings and programs
- Number and percentage of participants who have improved on outcomes measurements
- Number of session participants
- Weight loss achieved at specific intervals
- Improvement in SF-36 QOL Measure

- Number and percentage of participants indicating increase in energy level or decrease in fatigue
- Number and percentage increase in number of participants per program
- Number and percentage of healthy foods sold in cafes and cafeteria
- Number and percentage of increase in physical activity measurements
- Increase in knowledge, intent to change behavior

Crosswalk to Healthy People 2020 Objectives:

- NWS-7 - Increase the proportion of worksites that offer nutrition or weight management classes or counseling
- NWS-8 - Increase the proportion of adults who are at a healthy weight
- NWS-13 - Reduce household food insecurity and in doing so reduce hunger
- NWS-15 - Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older
- PA-1 - Reduce the proportion of adults who engage in no leisure-time physical activity
- PA-2.1 - Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination
- PA-12 - Increase the proportion of employed adults who have access to and participate in employer-based exercise facilities and exercise programs

Goal 2: To decrease prevalence of prediabetes and improve diabetes management by expanding education offerings and access to services.

Objectives include:

A. Increase access to and participation in outpatient Diabetes Self-Management Education (DSME)
B. Research and develop new diabetes education materials and/or methods of delivery (e.g. web or videos)
C. Improve access to inpatient diabetes education support by determining need for expanding services
D. Initiate CDC Diabetes Prevention Program(s) for persons with or at-risk for prediabetes
E. Explore and expand referral patterns from hospitalists, emergency department, and case management to improve coordination of comprehensive diabetes care (linkages to other providers across the continuum)
F. Work with the local school districts to determine the need for and feasibility of developing youth-centered, hands-on nutrition education for children and teenagers
G. Explore a potential partnership with local organizations to reduce prevalence of prediabetes in our community and improve diabetes management
H. Offer chronic disease and diabetes education classes at the Augusta Health Faith Community Nursing parishes

In the long term (greater than five years), these efforts are expected to reduce the number of prediabetes in the community and increase the self-management of diabetes. Indicators will be tracked to evaluate the outcomes and impacts of individual programs including:

- Positive changes in at least 2 of the AADE-7 Behavioral Goals

- Number and percentage of patients with A1C >9 and decrease in the 30-day readmission rates
- Number and percentage of patients with diabetes who are receiving informational handouts
- Number of views of the education on the website
- Number and percentage of inpatients provided with education per the program requirements
- Number of patients seen by inpatient nurse educator each month
- Number and percentage of inpatients seen by the inpatient diabetes nurse educator who then attend the outpatient diabetes education program
- Improvement in weight
- Increase in number of minutes of physical activity per week per person and overall
- Increases in the number and percentage of patients who follow up with either a practitioner or with diabetes education within 4 weeks of discharge
- Reduction in overall 30-day readmission rates based on education and program
- Increase in knowledge, intent to change behavior

Crosswalk to Healthy People 2020 Objectives:

- D-5.1 - Reduce the proportion of persons with diabetes with an A1C value greater than 9 percent
- D-14 - Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education
- D-16 - Increase prevention behaviors in persons at high risk for diabetes with prediabetes

Goal 3: To increase the number of residents who are connected to the appropriate mental health service at the correct level of care by expanding screenings, improving access and working with community partners to determine additional mental health services needed in Staunton, Augusta County and Waynesboro.

Objectives include:

A. By December 31, 2017, increase the proportion of primary care physicians who screen adult patients in the Accountable Care Organization for depression during office visits from 59% to 70%
B. Improve access to mental health services by defining:
    - The transportation issues and constraints that influence compliance with appointments and care plans by December 31, 2017
    - Options for increasing psychiatry providers in community settings by December 31, 2017
C. Work with community providers to determine the need for and feasibility of:
    - Crisis Hotline Service
    - Crisis Stabilization Unit
    - Social Detox Program

In the long term (greater than five years), these programs are expected to increase mental health education and connectedness through expanding screenings, improving access through community partners and determining additional mental health services needed. Indicators that will be tracked to evaluate the outcomes and impact of the individual programs will include:

- Percentage of patients receiving screening
- Number and percentage of practices performing screening
- Number and percentage of patient referrals

- Number and percentage of no-shows due to lack of transportation
- Number of community partners identified that can provide transportation
- Number and percentage of patients who come to ED presenting mental health symptoms, regardless of admittance status
- Number of community practitioners added
- Track ED admissions who want substance abuse as primary treatment
- Increase in knowledge, intent to change behavior

Crosswalk to Healthy People 2020 Objectives:

- MHMD-9 - Increase the proportion of adults with mental health disorders who receive treatment
- MHMD-10 - Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders
- MHMD-11 - Increase depression screening by primary care providers

V. Health Needs Facility Does Not Intend to Address

During the CHNA process, the data revealed a total of 13 distinct areas of opportunity. Augusta Health's 2017-2019 implementation strategies are designed to address the top three highest priority areas. Augusta Health has selected these three priorities because of its ability to work in partnership with other organizations and agencies to make the greatest impact. Other needs that were identified have the potential to be addressed through collaborative programming that may or may not involve Augusta Health as a facilitator, partner or funder.

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Appendix A
Implementation Strategy Action Plan

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Augusta Health (Augusta) is committed to achieving the "triple aim:" improved health through better quality of care at lower costs. To address the needs of the community, Augusta is committed to the strategies outlined below. Augusta has allocated resources in the form of staff, facilities, programs and financial support over the next three years to ensure the achievement of the implementation strategy goals outlined here in order to provide the necessary education and services to the community.

Goal 1: Improve the wellbeing of Staunton, Augusta County and Waynesboro residents through increased knowledge about and access to healthy foods and participation in physical activity programs

A. By December 31, 2017, the LIFE Employee Wellness program will engage 40% of employees through the wellness portal and self-paced team activities
B. Reduce the number of employees with prediabetes by expanding the Employee Wellness Program to include integration of the Diabetes Prevention Program
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J. Coordinate and collaborate wellness services offered between the Community Outreach, Employee Wellness, Fitness Center and Workplace Wellness departments

Goal 2: Decrease prevalence of prediabetes and improve diabetes management by expanding education offerings and access to services

A. Increase access to and participation in outpatient Diabetes Self-Management Education (DSME)
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C. Improve access to inpatient diabetes education support by determining need for expanding services
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E. Explore and expand referral patterns from hospitalists, emergency department, and case management to improve coordination of comprehensive diabetes care (linkages to other providers across the continuum)
F. Work with the local school districts to determine the need for and feasibility of developing youth-centered, hands-on nutrition education for children and teenagers
G. Explore a potential partnership with local organizations to reduce prevalence of prediabetes in our community and improve diabetes management
H. Offer chronic disease and diabetes education classes at the Augusta Health Faith Community Nursing parishes

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