Community Health Needs Assessment and Implementation Plan 2014–2016

Allina Health

MERCY HOSPITAL

NORTHWEST METRO
Identifying and Responding to Community Needs

MERCY HOSPITAL
4050 Coon Rapids Blvd.
Coon Rapids, MN 55433

Mercy Hospital is a part of Allina Health, a not-for-profit health system dedicated to the prevention and treatment of illness through its family of clinics, hospitals, care services and community health improvement efforts in Minnesota and Western Wisconsin.

Mercy Hospital, located in Coon Rapids, Minnesota, is a 271-bed nonprofit hospital that serves the northwestern Minneapolis-St. Paul metropolitan area.

Nationally recognized for clinical excellence and compassionate care, Mercy offers a wide range of specialty services:

- Cancer Center
- Heart and Vascular Services
- Emergency and Trauma Care
- Orthopedics and Neurosciences
- Mental Health Services
- Surgical Services and da Vinci System
- Women's and Children's Services.

With leading-edge technology, highly skilled, experienced professional staff and physicians, Mercy Hospital offers a healing environment and a humanity that transcends the daily task of caring for patients

Although Mercy treats patients from throughout the Midwest, most come from the north metro communities of Andover, Anoka, Big Lake, Blaine, Brooklyn Park, Cedar, Champlin, Circle Pines, Columbia Heights, Coon Rapids, Elk River, Isanti, New Brighton, Osseo, Saint Francis and Zimmerman.

LEAD PARTIES ON THE ASSESSMENT

Craig Malm, director, Community Benefit and Engagement, Northwest Metro Region

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John Salisbury, student intern, System Office, Allina Health

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2012 Mercy Hospital Key Measures

Licensed beds
271

Staffed beds
254

Total Operating Revenue
$380,470,849

Total Operating Expense
$332,535,523

Total Admits
20,651

Adjusted Admits
31,899

Total Patient Days
73,578

Total Number of ER Visits
57,486

Total Number of Outpatient Visits
136,411

Total Births
2,006

Number of Full Time Equivalents
1,617.4

Mercy Hospital also has a long history of working to improve health in the community it serves through both charitable giving by the Mercy Hospital Foundation and direct programming efforts which address health needs in the community. Examples include:

- **Healthy student partnerships** with community school districts focusing on healthy living and obesity prevention strategies for students and their families. We conduct health screenings at seven area high schools as part of their students' health curriculum and partner with school district nursing services to follow up with high risk students.

- **Faith Community Nurse Program** partners with 35 faith communities. The program's mission is to improve the overall health of a congregational community through a collaborative congregational, community and hospital effort. This program focuses on empowering individuals to become more active partners in the management of their personal health.

- **Family Power Pilot Program:** a collaborative program targeting childhood obesity. Key elements include the following:
  - Healthy lifestyle program based on behavioral change
  - Three participating clinics
  - Coaching model will educate/support children and their parents in mechanisms to achieve and maintain a healthy BMI
  - Targeted at children ages 5–11 at 95% and above BMI

- **Mental Health Medication Assistance Program:** This program offers psychiatric medications for individuals presently encountering barriers in obtaining and/or managing needed medications.

- **Community Mental Health** is a priority:
  - We are partnering with Anoka County Mental Health and the various mental health providers in Anoka County to provide for improved continuity in regards to the care of individuals experiencing mental health crisis.
  - In the past we have partnered with six school districts, Anoka County Mental Health Department, SAVE (Suicide Awareness and Voices of Education), the MN State Department of Human Services, local faith communities and multiple social service agencies to provide community-wide educational events on the issue of mental health and adolescent suicide.

- **Community health promotion and wellness** including:
  - Free community screenings
  - Community health fairs
  - A mobile Wellness Center
  - Community partnerships to identify interventions for high risk populations

- **Domestic assault and sexual assault advocacy services**

Allina Health and Mercy Hospital Service Area

Mercy Hospital is part of Allina Health, a not-for-profit health system of clinics, hospitals and other health and wellness services, providing care throughout Minnesota and western Wisconsin.

Allina Health cares for patients and members of its communities from beginning to end-of-life through:

- 90+ clinics
- 11 hospitals
- 14 pharmacies
- specialty medical services, including hospice care, oxygen and home medical equipment and emergency medical transportation
- community health improvement efforts

Legend:
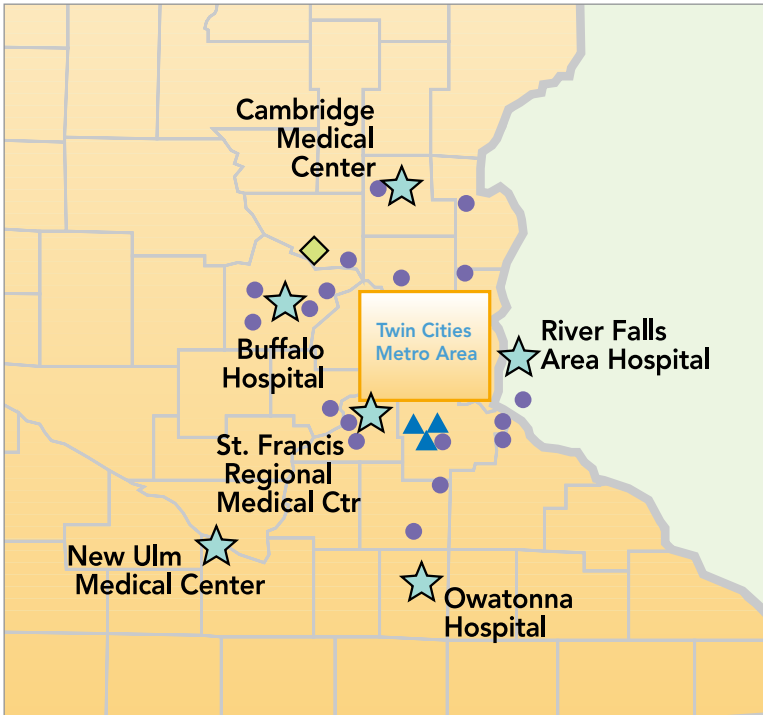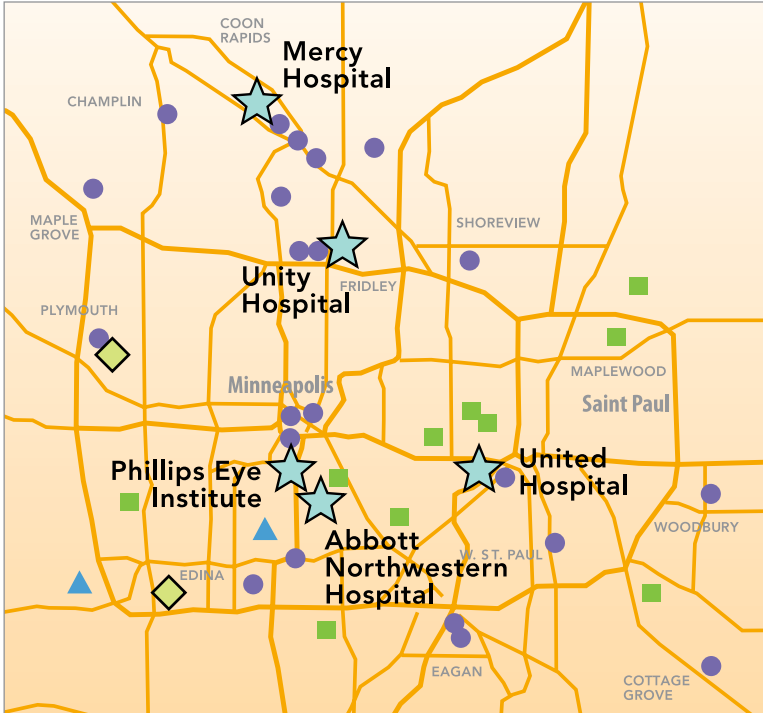
- ⭐ Allina Health Hospital
- ◇ Allina Health Ambulatory Care Center
- ● Allina Medical Clinic
- ■ Aspen Medical Group
- ▲ Quello Clinic

Description of Community Served by Mercy Hospital

For the purposes of community benefit and engagement, Allina Health divides its service area into nine regions.

FIGURE 1: COMMUNITY BENEFIT & ENGAGEMENT REGIONAL MAP
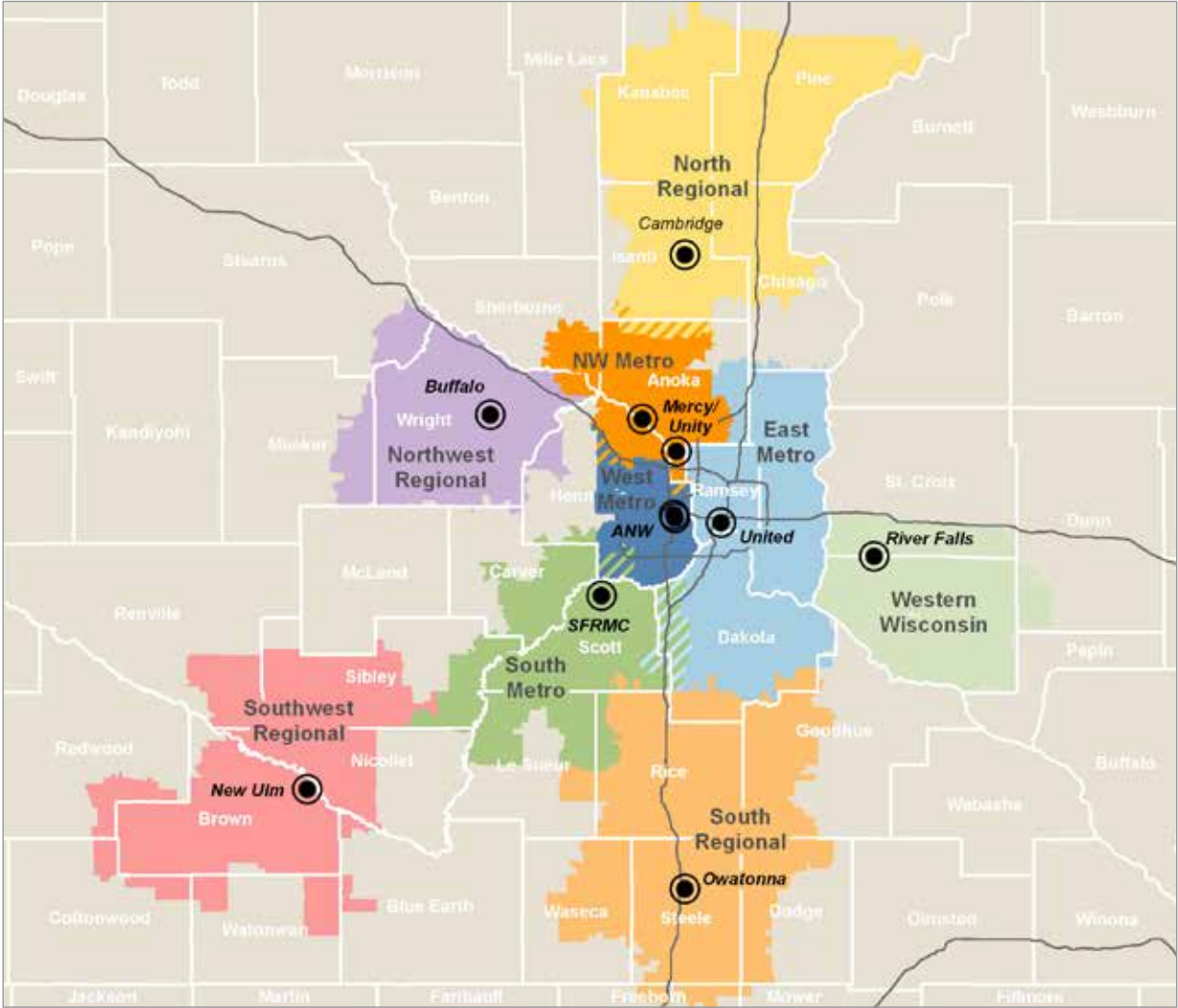
The region associated with Mercy Hospital is known as the Northwest Metro Region and primarily serves Anoka County in Minnesota. For the Northwest Metro Region Community Health Needs Assessment (CHNA), the focus of inquiry was Anoka County. See Appendix A for a detailed report on Anoka County, prepared by Stratis Health. All appendices can be found on the Allina Health website (**allinahealth.org**).

FIGURE 2: NORTHWEST METRO REGION MAP
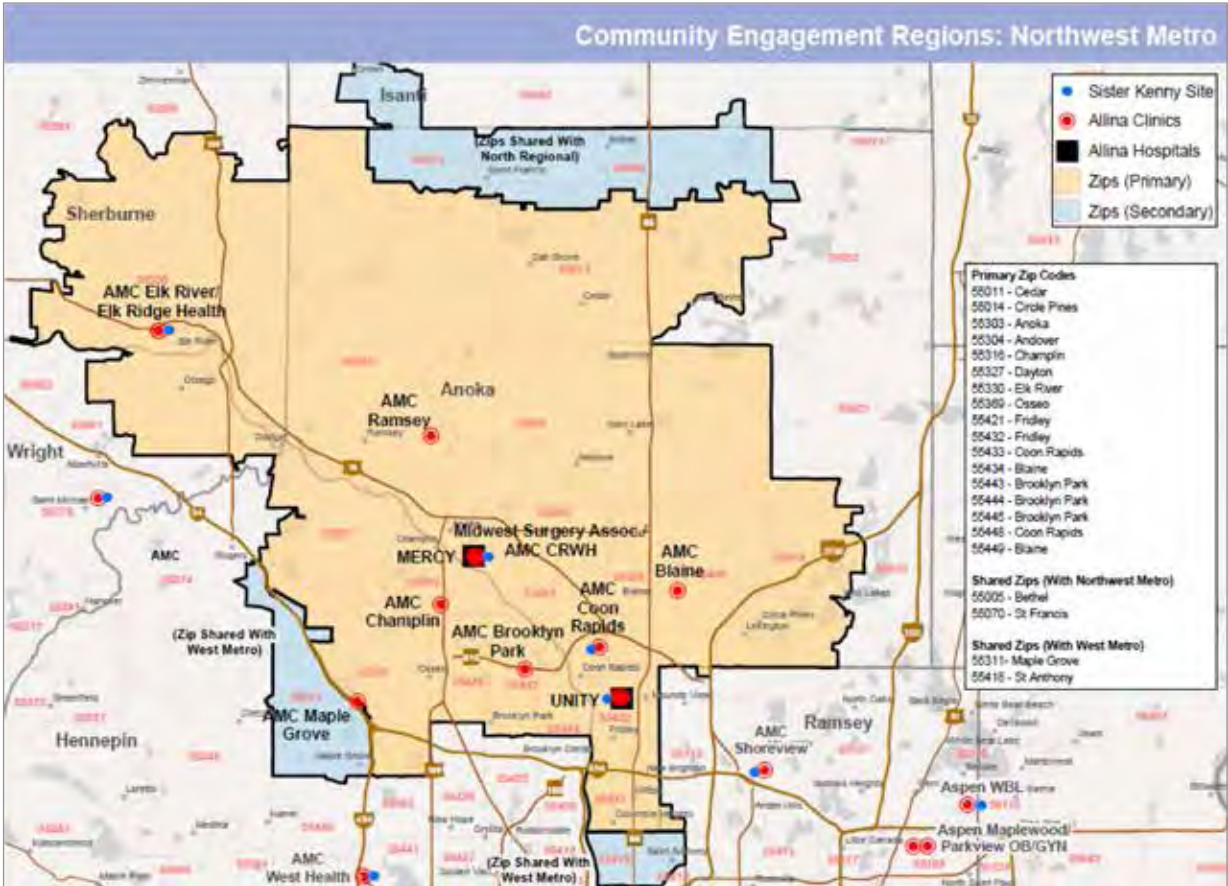
Assessment Partners

Mercy Hospital's CHNA was conducted in collaboration and partnership with community members, community organizations, stakeholders from local public health and internal stakeholders. These partners assisted in the development of the hospital's priorities as well as in building the implementation plan. In addition, Mercy Hospital partnered with Wilder Research, a branch of the Amherst H. Wilder Foundation, to conduct the community health dialogues in the Northwest Metro Region. Wilder Research developed the dialogue plan and materials, provided technical assistance related to recruitment strategies, facilitated the dialogues and synthesized the information into a report. See Appendix B for details on the CHNA partners.

Assessment Process

The Allina Health System Office CHNA team developed a template plan for the 11 hospitals within the system. This plan was based on a set of best practices for community health assessment developed by the Catholic Health Association with the purpose of identifying two to three regional priority areas to focus on for FY 2014-2016. The process was designed to rely on existing public data, directly engage community stakeholders, and collaborate with local public health and other health providers. From there, each hospital was responsible for adapting and carrying out the plan within their regions. The Northwest Metro Region Community Engagement lead guided the effort for Mercy Hospital.

The Mercy Hospital assessment was conducted in three stages: data review and setting priorities, community health dialogues and action planning. The process began in April 2012 with the development of the plan and was completed in August 2013 with the final presentation of the assessment and action plan to Mercy and Unity Hospitals' Northwest Metro Community Health Advisory Council. The following is a description of the assessment steps and timeline.

PHASE 1 — DATA REVIEW AND PRIORITY-SETTING

MAY – JULY 2012

DATA COLLECTION
Compiled existing county-level public health data, developed regional data packets, invited internal and external stakeholders to data review and issue prioritization meetings

SEPTEMBER 2012

DATA REVIEW
Reviewed data packets with stakeholders, selected initial list of regional health-related needs and priorities, identified additional data needs

OCTOBER 2012

ISSUE PRIORITIZATION
Reviewed revised data packet and completed formal prioritization process with stakeholders

PHASE 2 — COMMUNITY HEALTH DIALOGUES

FEBRUARY – MARCH 2013

DATA COLLECTION
Conducted community health dialogues related to priority areas identified in the data review and prioritization process

APRIL 2013

REPORT PRODUCTION
Developed report of findings from needs assessment and community dialogues

PHASE 3 — ACTION PLANNING

APRIL – JUNE 2013

IMPLEMENTATION/PLAN
Internal and external stakeholders reviewed report and developed strategies to address health needs

AUGUST – DECEMBER 2013

APPROVAL
Presented implementation plans to local boards/committees/leaders for approval (August 2013) and sent to Allina Health Board of Directors for final approval (December 2013)

Data Review and Priority-Setting

The first phase in the process was to review data in order to determine two to three regional priority areas. Best practices for community health needs assessments state that this process begins with a systematic look at data related to the health of community members. This allows stakeholders to understand the demographic profile of the community and compare and contrast the effect of health-related issues on the overall well-being of the community. The data review process then allows the stakeholders to make data-driven decisions about the priority areas.

Data Collection and Review

For this phase in the process, Mercy Hospital did not collect primary data, but instead compiled existing public health data to create a set of indicators specific to health in Anoka County. Stakeholders were given this set of indicators, which they reviewed prior to and during meetings, to gain a sense of current health needs. These datasets included:

MINNESOTA COUNTY PROFILES: STRATIS HEALTH

This set of data provided stakeholders with the demographic characteristics of the community. The Minnesota County Profiles describe the characteristics of individual counties. Each report contained data on:

- Demographics: age, gender, race and foreign born
- Socio-economic status: income, education and occupation
- Health status: birth rate and morbidity

MINNESOTA COUNTY-LEVEL INDICATORS FOR COMMUNITY HEALTH ASSESSMENT

The Minnesota County-level Indicators for Community Health Assessment is a list of indicators across multiple public health categories and from various data sources. This list of indicators was developed by the Minnesota Department of Health to assist local health departments (LHD) and community health boards (CHB) with their community health assessments and community health improvement planning processes.

The indicators were placed in six categories: People and Place, Opportunity for Health, Healthy Living, Chronic Diseases and Conditions, Infectious Disease, and Injury and Violence. (http://www.health.state.mn.us/divs/chs/ind/) The main data sources for County-level Indicators were:

- 2011 Minnesota County Health Tables
- Minnesota Student Survey Selected Single Year Results
- 1991–2010 Minnesota Vital Statistics State, County and CHB Trends
- Minnesota Public Health Data Access

These data provided Allina Health and its individual hospitals a standard set of indicators to review across our service area. For a full list of the indicators used, see Appendix C.

COUNTY HEALTH RANKINGS

The County Health Rankings (http://www.countyhealthrankings.org) rank the health of nearly every county in the nation and show that much of what affects health occurs outside of the doctor's office. The County Health Rankings confirm the critical role that factors such as education, jobs, income and environment play in how healthy people are and how long they live.

Published by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, the Rankings help counties understand what influences how healthy residents are and how long they will live. The Rankings look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, access to healthier foods, air pollution levels, income, and rates of smoking, obesity and teen births. The Rankings, based on the latest data publically available, provided assessment stakeholders information on the overall health of Anoka County and comparison data for other counties in the state.

Based on the review of data over the course of these meetings, Mercy Hospital's community health assessment group identified twelve issues to be considered in the next step of the prioritization process.

1. Access to care
2. Alcohol
3. Chronic disease
4. Educational needs
5. Health care-associated infections
6. HIV
7. Maternal infant health
8. Mental health
9. Nutrition, physical activity, & obesity
10. Teen pregnancy prevention
11. Tobacco
12. Violence

Prioritization Process

In order to systematically select priorities, Mercy Hospital used two approaches: the Hanlon Method and group discussion questions. These were chosen to allow participants to assign a numeric value to each priority issue and to ensure that participants engaged in a deeper discussion about how each issue fit within the Mercy Hospital mission and role in the community as a health care provider.

THE HANLON METHOD

The Hanlon Method is a prioritization process which objectively takes into consideration explicitly defined criteria and feasibility factors. The Hanlon Method is used when the desired outcome is an objective list of health priorities based on baseline data and numerical values. For a more detailed description of this process see Appendix D. The method has three major objectives:

- to allow decision-makers to identify explicit factors to be considered in setting priorities

- to organize the factors into groups that are weighted relative to each other

- to allow the factors to be modified as needed and scored individually.

The Hanlon Method ranks health-related issues based on three criteria:

Component A = Size of the problem

Component B = Seriousness of the problem

Component C = Estimated effectiveness
of the solution

Each possible priority is given a numerical score for each component and combined to provide a composite numerical score for each priority. (See Appendix E for full list of health issues and ranked scores.)

DISCUSSION QUESTIONS

Participants were asked to consider the numerical rankings for each issue along with the following questions in choosing their final two to three priority issues. This allowed stakeholders the chance to consider health issues that may have a great impact on their community, but fell short of the top three identified in the ranking method. These questions were based on a set of questions which are commonly used in conjunction to Hanlon-based prioritization work (http://www.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf):

- Does work on this issue fit within the Allina Health mission? Does this fit within work we're already doing?

- What is the role for Allina Health? Leader, partner or supporter? What are the opportunities for collaboration?

- What's the economic impact of the issue? What's the cost to address the problem? What are the costs associated with not doing anything?

- Will the community accept and support Allina Health efforts on this issue?

- Does work on this issue provide an opportunity to address the health needs of vulnerable populations? Can Allina Health impact barriers to health for groups around this issue?

- Are there legal implications involved in addressing the health issue? (e.g., HIPAA privacy concerns, the need for consent for minors, undocumented citizens, etc.)

Notes from this discussion can be found in Appendix F.

Stakeholders were also given a report prepared by the Health Disparities Work Group of Allina Health (see Appendix G). This report was to be used as a resource when considering the needs of vulnerable populations in the region.

Priority Health Needs for 2014–2016

Upon completion of the prioritization process, Mercy Hospital determined the following community health priority needs:

1. Chronic disease prevention and management

Chronic diseases are of a major concern and the Northwest Community Health Council felt that as a major provider of health services in the community, it was important to be active in the area of chronic disease prevention and management. Many individuals and families take their health for granted, and often don't seek preventative care for a variety of reasons. Often, effective education and screenings are not offered to high risk populations such as, uninsured or underinsured, minority populations, and economically disadvantaged. Chronic diseases of concern were diabetes, mental health, heart disease and stroke prevention. Outreach, education, prevention, and intervention are all important elements of maintaining the health of our populations.

2. Childhood obesity

The problem of obesity and the need for individuals and families to eat properly and stay physically active is a critical element of the health of today's population. The obesity epidemic has impacted families across our country, and Minnesota has seen a dramatic increase in the number of individuals who are overweight and obese. Stakeholders identified obesity as a significant health risk for our children by local public health agencies, by Allina Health and other health systems, as well as the Northwest Community Health Council.

Specific to childhood obesity, Healthy People 2010 identified overweight and obesity as 1 of 10 leading health indicators and called for a reduction in the proportion of children and adolescents who are overweight or obese, but the United States has made little progress toward reducing obesity. Statistics demonstrate that childhood obesity has tripled in the past 20 years, affecting 16 percent of children in the United States, according to the Centers for Disease Control and Prevention. Approximately 12% to 18% of 2-19 year old children and adolescents are obese. (defined as having and age and gender specific BMI at or greater than the 95th percentile.) In addition, a recent study of children age 5 to 17 revealed that 70 percent of obese children had at least one risk factor for cardiovascular disease.

Causes of obesity are multi-faceted and complex, and need to be addressed at all levels including: by health providers, within homes, in schools, in businesses, and communities and in the public policy venue.

Finally, all the priority health needs were chosen based on the ability of Mercy Hospital to collaborate, capitalize on existing assets and implement interventions beyond clinical services in addressing these needs in the community.

IDENTIFIED HEALTH NEEDS NOT SELECTED AS PRIORITIES

- Access to care
- Alcohol
- Educational needs
- Healthcare-associated infections
- HIV
- Maternal infant health
- Mental health
- Teen pregnancy prevention
- Tobacco
- Violence

Community Health Dialogues

In spring 2013, Mercy Hospital held a series of meetings designed to solicit feedback from the community on how Mercy Hospital could most effectively address the selected priority issues. These dialogues were facilitated by a community partner and contractor, Wilder Research. The community dialogues were an opportunity for Mercy Hospital to hear from a broader group of community members, identify ideas and strategies to respond to the priority issues, and inform the action-planning phase of the needs assessment.

Invitations were sent via email or in-person by Mercy Hospital's Community Engagement lead to community members including representatives from education, local government, religious, social service and other non-profit organizations in the community. There was intentional outreach to representatives from the medically underserved, low income and minority populations, and populations with chronic disease conditions to ensure vulnerable populations were included. All potential participants were told that their feedback was important in representing the many roles they might play in the community: as a worker, neighbor and citizen. A total of 39 people participated in the two community health dialogues in the Northwest Metro Region.

KEY QUESTIONS

Participants were asked to answer the following questions:

1. What is the impact of each issue in your community?
2. What should be done to address each issue in your community?
3. What is the role for Mercy Hospital, as part of Allina Health, in addressing this issue in your community?

KEY FINDINGS

Chronic disease prevention and management: Dialogue participants felt that Mercy Hospital's role, as part of Allina Health, could help address chronic disease prevention by concentrating on education and awareness, increasing activities/services focused on health and supporting collaborations with the community organizations.

Participants specifically suggested:

- Partnering with the county public health for a wellness at work campaign. Hennepin County has wellness at work resources for companies.
- Expanding the faith community nurse program by providing support and funding for additional participation.
- Continuing to increase the Be Fit program for employees and families.
- Sponsoring low or no cost health screening for parents at local schools.
- Offering free courses to inform people about prevention and treatment of chronic disease.
- Creating more lifestyle choice programs on nutrition, fitness and other activities that promote health.

Childhood obesity: Dialogue participants felt that Mercy Hospital's role, as part of Allina Health, could help address childhood and youth obesity through promoting nutrition and access to healthy foods, creating more opportunities for exercise and physical activity, and increasing collaboration with community organizations.

- Sending nutritionist to schools to help organize healthier school lunch programs. The nutritionists could consult on after-school activities, gardening, cooking and physical activities.
- Collaborating with schools, churches and other organizations that provide healthy lifestyle education. Allina Health could provide funding and staff support for the community organizations that are addressing childhood and youth obesity and related health issues.
- Engaging with the YMCA to connect more youth and families to health programs and exercise.
- Creating a reward program for weight lost by a community or families (e.g., donate playground equipment if a community or families lose "x" pounds).
- Offering free or low cost classes on healthy cooking and eating for families and/or students.
- Hosting free or low cost exercise classes and activities for families.

For a full copy of the report see Appendix H.

Community Assets Inventory

Between the community health dialogues and the action planning phase, the Community Engagement lead for Mercy Hospital developed an inventory of existing programs and services within the region related to the priority areas identified in the needs assessment. The inventory included the location of the program (hospital, clinic or community) as well as the target population and community partners. The purpose of the inventory was to identify:

- Gaps in services and opportunities for new work

- Where and with whom there is a lot of work already being done

- Opportunities for partnership and/or collaboration.

See Appendix I for full inventory of hospital and community-based programs.

Action Planning

The final phase of the CHNA process was to develop the implementation plan for Mercy Hospital. The implementation plan is a set of actions that the hospital will take to respond to the needs identified through the community health needs assessment process. Mercy Hospital used its Community Benefit Advisory Council to engage with internal and external stakeholders, including representatives from Anoka County Public Health, local school districts, the YMCA, community faith organizations, Anoka County Head Start, the Lee Carlson Mental Health Center, the Mercy Hospital Auxiliary, and representatives from our Community Wellness and our Faith Community Nurse programs who met over three meetings to develop the implementation plan for FY 2014–2016.

THE PROCESS INCLUDED FOUR STEPS:

1. Identifying key goals, objectives and indicators related to the priority issues
2. Reviewing Community Health Dialogues report and Community Assets Inventory
3. Selecting evidence-based strategies and programs to address the issues
4. Assigning roles and partners for implementing each strategy.

STEP 1: Identifying key goals, objectives and indicators

Following best practices for community health improvement planning, Mercy Hospital identified key goals and objectives for the implementation plan. These goals and objectives provided structure for the plan elements and helped identify areas for program evaluation and measurement.

Stakeholders also looked at Healthy People 2020 (http://www.healthypeople.gov/2020/default.aspx) for a set of indicators that reflected overall trends related to the priority issues. These indicators will not be used to evaluate the programs, but rather will be used to outline and monitor the issues within a national framework.

STEP 2: Review Community Health Dialogues report and Community Assets Inventory

Stakeholders reviewed the Community Health Dialogues report for ideas and strategies to incorporate into the implementation plan.

In addition, they reviewed the Community Assets Inventory to identify gaps and opportunities for action. The information from these sources served as context as stakeholders moved into the next step of looking at evidence-based strategies.

STEP 3: Selecting evidence-based strategies

Mercy Hospital used Community Anti-Drug Coalitions of America's (CADCA) "Defining the Seven Strategies for Community Change." Evidence shows that a diverse range of strategies and interventions will have a greater impact on community health. Therefore, the CADCA strategies provided the framework to address the priority issues in multiple ways and on multiple levels and the implementation plan includes actions in each strategy area. These strategies are:

1. Providing information
2. Enhancing skills
3. Providing support
4. Enhancing access/reducing barriers
5. Changing consequences
6. Physical design
7. Modifying/changing policies.

For more information on CADCA's strategies see Appendix J.

In choosing evidence-based strategies, Mercy Hospital looked to the What Works for Health through the County Health Rankings and Roadmaps website (http://www.countyhealthrankings.org/roadmaps/what-works-for-health). What Works for Health provides information to help select and implement evidence-informed policies, programs, and system changes to rate the effectiveness of these strategies that affect health through changes to:

- health behaviors
- clinical care
- social and economic factors
- the physical environment.

STEP 4: Assign roles and partners for implementing each strategy

When selecting the strategies, Mercy Hospital identified when the hospital was going to lead the work, support the work or partner on the work. This was important to not only budget accordingly, but to identify and leverage the expertise of the various assets in the community.

Implementation Plan

The implementation plan is a three-year plan depicting the overall work that Mercy Hospital plans to do to address priority issues in the community. Yearly work plans will be developed to provide detailed actions, accountabilities, evaluation measures and timelines.

Chronic disease prevention and management

GOAL: Promote effective strategies for prevention, detection, treatment and management of chronic disease

INDICATORS

- Increase the number of adults who are screened for chronic diseases
- Increase the proportion of adults who meet current physical activity guidelines for aerobic physical activity and muscle-strengthening activity.
- Increase the number of adults who are able to monitor and manage their chronic conditions.

Mercy Hospital will work to improve the health of both the underserved and the older adult population who are affected or potentially affected by chronic disease. Increasing the number of people that are screened and identified as 'at risk' will increase the number who are educated and referred for appropriate health care or services. Partnering with other community organizations will expand the outreach into our community. Planned strategies include:

- Conduct targeted community and population focused screenings. Screenings may be general or disease specific.
- Explore methods to reach older adults, who are isolated, not normally seen by health care providers, and/or are not reached by present outreach efforts.
- Provide health education and information related to disease prevention, self-management, and access to care.
- Inventory, identify, and develop resources that promote healthy lifestyles and address high risk individuals.
- Promote or create public awareness and promote resources, wellness activities, or healthy lifestyles.

Childhood obesity

GOAL: Reduce risk factors for childhood obesity

INDICATOR

- Reduce the prevalence and incidence (new and existing) of overweight and obese children.

Mercy Hospital's strategy to address childhood obesity will focus on the reduction and prevention of childhood obesity and reduction of risk factors known to be contributors to youth obesity. A guiding principle will be the importance of involving parents and entire families in these efforts. Programs will focus on:

Education

- Increasing awareness and education through specific programs and activities such as:
  - Healthy Eating
  - Healthy meal preparation
  - Concept of balanced meals
  - Gardening
- Physical activity
- Community and school health fairs
- Community and school educational programs
- Holistic health focus – physical, mental, social and spiritual
- Stress Reduction and balanced lifestyles

Outreach & Capacity Building

- Improve access by increasing the number of local offerings,
- Coordinate efforts by utilizing existing partners and using a 'train the trainer' model that will expand the impact by reaching more people
- Recruit and develop an advisory team that reflects the targeted community
- Expand the depth of outreach to schools by offering screening, education and follow-up for "at risk" children
- Expand the role of the Faith Community Nurse Program & our Wellness Program to include youth obesity focus

Awareness of Resources

- Improve awareness through health care providers, the Faith Community Nurse Program, the Wellness Program and community partners

Conclusion

As a not-for profit hospital, Mercy Hospital is dedicated to improving the health of the communities it serves. This implementation plan is intended to show that the hospital will partner with and support community and clinical programs that positively impact the identified health needs in 2014–2016. In addition, the hospital will participate in system-wide efforts, as part of Allina Health, that support and impact community health. There are other ways in which Mercy Hospital will indirectly address these priority issues along with other needs, through the provision of charity care, support of Medicare and Medicaid programs, discounts to the uninsured and more. Mercy Hospital will continue to engage with the community to ensure that the work in the plan is relevant, effective and to modify its efforts accordingly.

Allina Health

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Appendix A

Anoka County Profile

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health

MERCY
HOSPITAL

Anoka County
(Twin Cities Region)

CULTURE CARE CONNECTION is an online learning and resource center designed to increase cultural competence of health care providers, administrators, and health care organization staff in serving diverse populations. Simply put, "culture" can refer to a variety of factors, including age, education level, income level, place of birth, length of residency in a country, individual experiences, and identification with community groups; "competence" refers to knowledge that enables a person to effectively communicate; and "care" refers to the ability to provide effective clinical care.

Through Stratis Health's Culture Care Connection Minnesota County Profiles, health care organizations can better understand their geographic service areas by observing the characteristics of the counties, surrounding region, greater Minnesota, and the nation with respect to demographic, socioeconomic, and health status data. The quantitative and qualitative data in this profile can broaden understanding and help users consider actions for responding to the area's most pressing needs.

Apply this information to advance your organization's implementation of the Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards. The 14 CLAS standards serve as guiding principles for ensuring accessibility and appropriateness of health care services delivered to diverse populations. This information is also valuable if your organization is using less formal approaches in providing culturally sensitive services, as well as if you are just interested in learning more about health disparities in your county.

Region is defined as Economic Development Region (EDR), the multi-county groupings established by the Minnesota Department of Employment and Economic Development. The Twin Cities Metropolitan EDR is composed of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.

Careful attention should be paid to identifiers in graphs and narrative, which delineate between county, region, and state level data to prevent inaccurate extrapolation.

Demographics Age • Gender • Race • Foreign Born

Demographic data reveal the following state-level trends:

- Minnesota's population is projected to grow substantially by 2035, with slight growth in the younger age groups and substantial growth in the older age groups. These changes will influence the overall age composition of the state.

- Gender is evenly distributed across age groups, with notable exception in the older age groups which have larger proportions of females.

- Minnesota's population continues to become more diverse. Between 2000 and 2007, the Asian, black, and Hispanic/Latino populations increased at a faster pace than the white population.

StratisHealth

CULTURE CARE CONNECTION

Funding provided by
UCare

Age

Between 2005 and 2035, the population of Minnesotans over age 65 will more than double due to greater longevity. By contrast, the population under age 65 will grow only 10 percent. As a result, the age composition of all parts of the state, including Anoka County, will be much older in 2035.

Population projections:

- 14 and under to rise 5%
- 15 to 24 to rise 6%
- 25 to 44 to rise 4%
- 45 to 64 to rise 29%
- 65 to 84 to rise 213%
- 85 and above to rise 309%

What providers need to know:

The proportion of Minnesota's older population, as well as ethnic and immigrant communities, will grow faster than the rest of the state's population in the next 25 years. Consider whether your organization is prepared to meet the special needs of these populations.

Suggestions:

Become familiar with the needs of older populations, as well as individuals from diverse backgrounds, and develop strategies to accommodate them including: referrals to transportation services, allowing more time for patient encounters, and providing patient education materials in alternative formats.

Gender

In 2015, projections indicate the overall gender distribution for Anoka County to be 49% female, 51% male
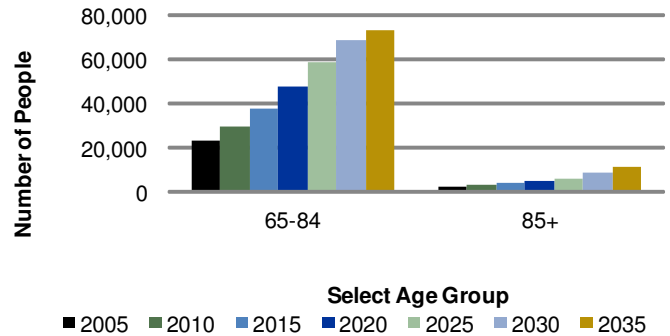
Variations appear when the data are viewed by age range:

- 15 to 24: 47% female, 53% male
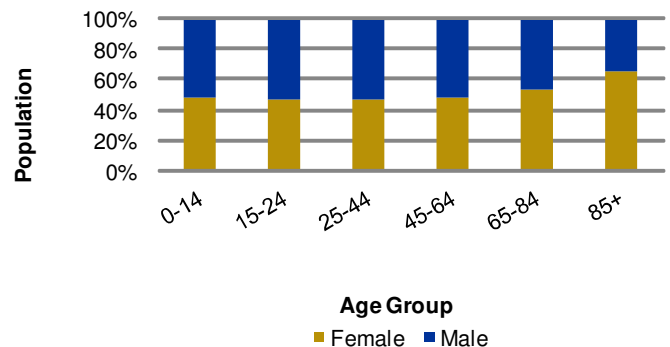- 65 to 84: 54% female, 46% male
- 85 and above: 65% female, 35% male

Projected Population - Anoka County: 2005-2035
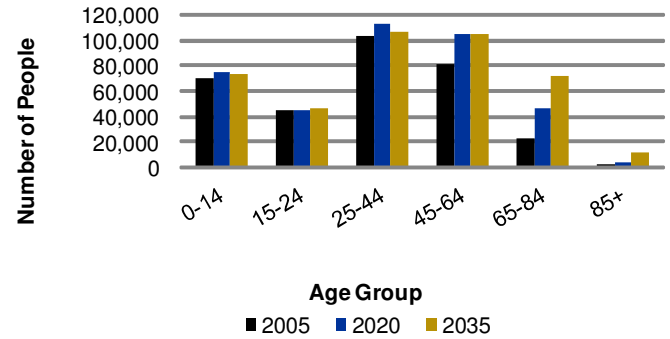
Projected Population - Anoka County: 2005-2035

Projected Gender Distribution - Anoka County: 2015

Race

Minnesota's population is considerably less diverse than the US population. Minnesota's populations of color accounted for 14 percent of the population in 2007 compared to 34 percent of the national population. However, populations of color are growing faster in Minnesota, 28 percent compared to 19 percent nationally.

In the Twin Cities metro area between 2005 and 2015, the population is expected to grow 9 percent. The white population is not expected to change while populations of color are expected to grow 44.5 percent. Growth will be most notable in the Hispanic/Latino population (62.4%). However, growth in populations of color in Anoka County (69%) will exceed the national growth rate of 47.1 percent.

What providers need to know:

The health issues, health-seeking behaviors, cultural norms, and communication preferences of populations of color vary considerably. As Minnesota's population becomes more diverse, patient populations within the state's health care organizations will become more diverse as well.

Suggestions:

Get to know patients and staff on an individual level. Not all patients and staff from diverse populations conform to commonly known culture-specific behaviors, beliefs, and actions. Understanding an individual's practice of cultural norms can allow providers to quickly build rapport and ensure effective health care communication.

Foreign Born

Thirty-six percent of the minority population in Minnesota is foreign born, compared to 2 percent of the white population. In 2007, one-third of Minnesota's foreign born population came from one of four countries: Somalia (13.0%), Thailand (8.7%), Ethiopia (7.0%), and Mexico (4.0%).

What providers need to know:

Important factors to consider in providing care to foreign born populations include: nutritional status, mental health (especially in refugee populations), infectious disease, dental screening, and preventive health measures, including cancer screenings, which are not often available in third world countries. Specific health care screening recommendations depend on an individual's country of origin and immigration status.

Projected Populations of Color - Twin Cities: 2005-2035
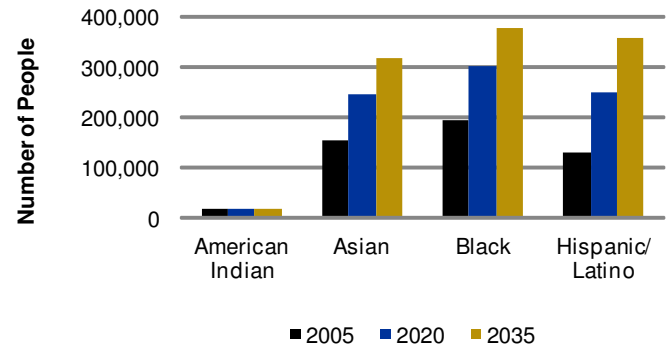
Projected Growth Rates for Populations of Color: 2005-2035
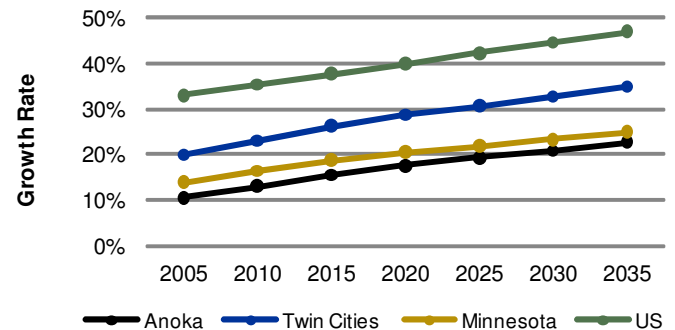
Foreign Born Population by Region of Birth - Minnesota: 2007

- Asia (38%)
- Africa (37%)
- North America (11%)
- Europe (9%)
- South America (5%)
- Other (1%)
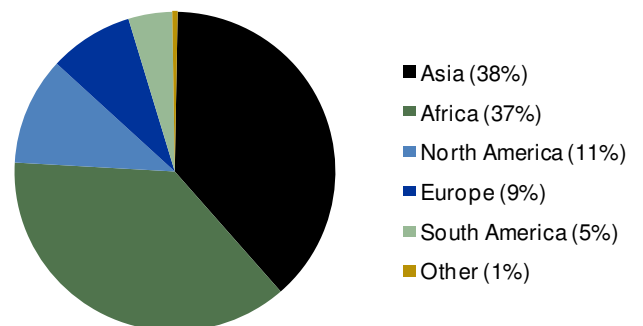
Provide information to patients not familiar with the western medical system, including guidance on obtaining health insurance, setting up initial and follow-up appointments, and practicing preventive health measures.

Socioecomonic Status

Education • Income • Occupation

Socioeconomic status, a measure of an individual's economic and social position relative to others based on income, education, and occupation can provide valuable insights about diverse populations.

- Education influences occupational opportunities and earning potential in addition to providing knowledge and life skills that may promote health.
- Income provides a means for purchasing health care coverage but also may determine eligibility for assistance programs for those who cannot afford coverage.
- Occupation, and whether or not one is employed, may expose an individual to a variety of health risks.

Education

Across Minnesota, high school graduation rates increased between 2005 and 2009. While projections indicate a steady decline for the general population, high school graduation rates in populations of color will increase as much as 40 percent between 2005 and 2015.

In Anoka County, for all races, historic data indicate a higher percentage of individuals receiving at least a high school diploma compared to state level data. Attainment rates of a Bachelor's degree or greater in Anoka County were lower than state level rates .

Income

In Anoka County, the median household income based on 2005-2007 estimates was $67,275. Income level influences an individual's access to health care (as measured by rates of uninsurance) and is used to determine poverty status, which may determine eligibility for various assistance programs.

Rates of uninsured can be difficult to measure. One certainty is that wide variability across racial and ethnic groups exists. Historically, white populations are the least likely to be uninsured in contrast to Hispanic/Latino populations which are the most likely to be uninsured.

Education Attainment: 2005-2007
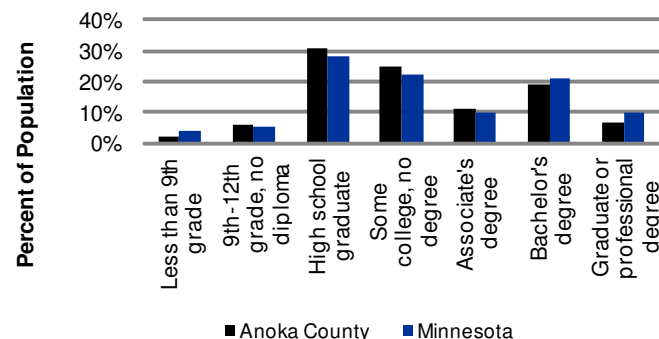
Uninsured by Race - Minnesota: 2001-2007
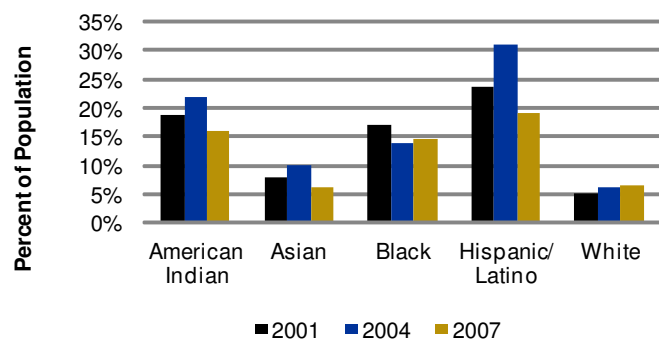
Poverty - All Ages - Minnesota: 2002-2006
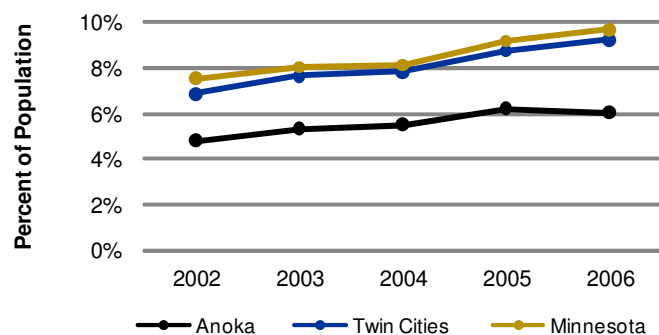
Poverty status, which is based on a minimum level of income necessary to achieve an adequate standard of living, is on the rise in Minnesota. According to federal poverty guidelines this level of income in 2008 equaled $21,200 for a family of four. Families whose income falls near or below this amount may be eligible for medical assistance and other social service programs.

Occupation

According to 2005-2007 estimates, 75.2 percent of the population in Anoka County over 16 years of age were employed. Individuals in office-based occupations are at risk for repetitive stress injuries and musculoskeletal disorders due to the sedentary nature of this work.

For current, quarterly unemployment data, visit the Minnesota Department of Employment and Economic Development. Individuals who are unemployed or experience job insecurity may face health risks such as increased blood pressure and stress.

What providers need to know:

Chronic stress associated with lower socioeconomic status can contribute to morbidity and mortality and is linked to a wide range of health problems including arthritis, cancer, cardiovascular disease, hypertension, and low birthweight.

Suggestions:

Consider how patient's socioeconomic status may affect health risks and ability to follow treatment plans. Become familiar with eligibility requirements and service offerings from local health, housing, and social service programs including medical assistance, food support, and cash assistance. Establish a culturally sensitive plan for identifying and referring patients who may benefit.

Health Status Data   Birth Rate • Morbidity

The health status data concerning birth rates and factors contributing to the incidence of disease revealed the following:

• A need for increased efforts to provide prenatal care in the general population as well as an awareness of birth trends in populations of color.

• Greater potential for engagement in behaviors which increase the burden of poor health in populations of color.

Birth Rate

Anoka County's birth rate of 13.9 per 1,000 population is lower than the regional and state-level rates of 14.7 and 14.2 respectively. In 2007, prenatal care was received in the first trimester for 86.5 percent of cases compared to 86.9 percent in 2003.

Occupations - Anoka County: 2005-2007

Estimated Number of People

(Bar chart showing percentages for occupation categories: Construction, extraction, maintenance & repair ~10.5%; Farming, fishing & forestry ~0%; Management, professional & related ~35%; Production, transportation & material moving ~14.5%; Sales & office ~26.5%; Service ~13%)

Minnesota's teen birth rates reveal marked disparities. Although teen birth rates decreased for African Americans and American Indians over time, the rates remain 3.8 to 5.5 times higher than that for whites. The Asian rate was over 2.5 times the white rate, and the Hispanic/Latino rate is nearly six times the white rate.

Morbidity

Behaviorial risk factors such as use of alcohol and tobacco, diet, exercise, and preventive health practices play an important role in determining a person's overall health status. Control over such factors can decrease a person's risk for adverse health outcomes including illness and premature death.

What providers need to know:

Patients from diverse cultures have varying perceptions of the concepts of disease and preventive care. Help patients understand the reason for their illness and the importance of keeping follow-up appointments and adhering to treatment plans even though they may no longer be feeling symptoms.

Suggestions:

Provide alternative treatment options and acknowledge that patients may use traditional approaches. Use interpreters with patients who do not speak English or who have Limited English Proficiency as a way to encourage them to freely communicate expectations and preferences.

Next Steps CLAS Assessment •
Visit www.culturecareconnection.org

1) Conduct a CLAS (Culturally and Linguistically Appropriate Services) Standards Assessment to identify areas of strength and opportunities for improvement in the services your organization offers to diverse populations. An online assessment which offers customized evaluation and recommendations can be found at: CLAS Standards Assessment.

2) Visit the Culture Care Connection Web site, an online learning and resource center aimed at providing Minnesota health care organizations with actionable tools in support of providing culturally and linguistically appropriate services.

3) Contact Stratis Health to learn more about how we can assist in your organization's efforts to build culturally and linguistically appropriate service offerings.

Birth Rate - All Ages: 2007
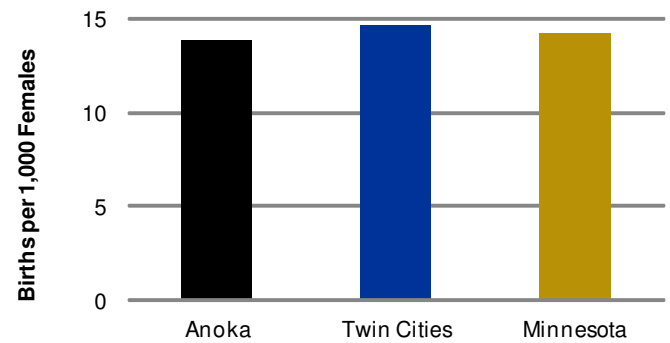
Teen Birth Rate By Race - Minnesota: - Age 15-19: 2007
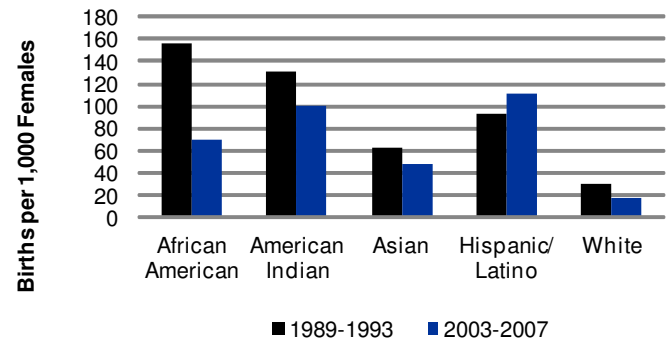
Behavioral Risk Factors: 2007
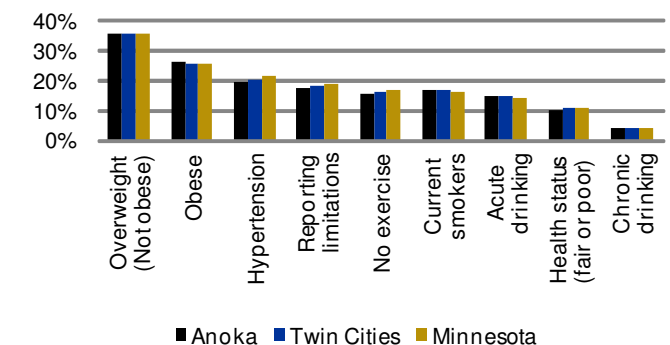
Sources

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"Medical Care for Immigrants and Refugees," Gavagan, T. and Brodyaga, L. *American Family Physician*, 1998.

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Populations of Color in Minnesota Health Status Report Update Summary, Minnesota Department of Health, Center for Health Statistics, 2009.

"Socioeconomic Disparities in Health: Pathways and Policies," Adler, N. and Newman, K. *Health Affairs,* 2002.

Supplemental Table 1. Immigrants Admitted by Country of Birth and Intended State of Residence, Department of Homeland Security and Immigration and Naturalization Services, 2007.

The 2008 HHS Poverty Guidelines, Department of Health and Human Services, (http://aspe.hhs.gov/poverty/08poverty.shtml) viewed on 6/17/09.

Contact us for assistance with your quality improvement and patient safety needs related to reducing health care disparities.

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health works with the health care community as a quality improvement expert, educational consultant, convenor, facilitator, and data resource.

2901 Metro Drive, Suite 400
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Appendix B
Community Partners

Allina Health
MERCY HOSPITAL

Community Health Needs Assessment
and Implementation Plan 2014–2016

Northwest Community Health Council
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Director, Allina Community Benefit
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Appendix C

Full Indicator List

Allina Health
MERCY
HOSPITAL

Community Health Needs Assessment
and Implementation Plan 2014–2016

County- Leading Health Indicators

People and Place

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
People and Place	1. Total population	Census	5,303,925	330,844	508,640	1,152,425
People and Place	2. Population by age and sex	Census	Table I	Table I	Table I	Table I
People and Place	3. Number of females aged 15-44	Census	1,045,681	66,053	110,951	248,159
People and Place	4. Number of births	MDH MCHS	70,617	4,288	7577	16,334
People and Place	5. Birth rate	MDH MCHS	13.4	12.9	15	14.4
People and Place	6. School enrollment for prekindergarten – 12th grade	Census	837,640	63,551	84,542	157,170
People and Place	7. Number and percent of children under age 5	Census	355,504/6.7	22,339/6.8%	35,137/6.9%	76,236/6.6%
People and Place	8. Number and percent of children aged 0-19	Census	1,431,211/26.9	94,222/28.5%	135,728/26.7%	290,665/25.2%
People and Place	9. Child (under 15 years) dependency ratio (per 100 population 15-64)	Census	29.5	29.9	28.4	27.1

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
People and Place	10. Number of households	Census	2,108,843	122,105	209,214	475,913
People and Place	11. Number of deaths	MDH MCHS	37,801	1,538	3,720	7,417
People and Place	12. Total population by race and ethnicity	Census	Table II	Table II	Table II	Table II
People and Place	13. Number of prekindergarten – 12th grade students by race/ethnicity	MDE	Table III	Table III	Table III	Table III
People and Place	14. Percent of prekindergarten – 12th grade students with limited English proficiency	MDE	7.3%	6%	21.5%	12.6%
People and Place	15. Number and percent of people aged 65 years and older	Census	683,121/12.9%	32,232/9.7%	61,181/12%	130,814/11.4%
People and Place	16. Elderly (65+ years) dependency ratio (per 100 population 15-64)	Census	19	13.4	19.8	16.3

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
People and Place/Opportunity for Health	17. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	6.6%	10%	9%
People and Place	18. Arsenic levels in MN	Arsenic MDH	n/a	n/a	n/a	n/a
People and Place	19. Radon levels by zone (low, moderate, high)	US EPA	High/moderate	High	High	High

Opportunity for Health

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Opportunity for Health	20. Four year high school graduation rate	MDE	76.9%	76%	67%	65.7%
Opportunity for Health	21. High school dropout rate	MDE	4.8%	3.8%		5.5%
Opportunity for Health	22. Percent of population aged 25 years and older with less than or equal to high school education or equivalent (e.g. GED)	Census	37.1%	38.6%	34%	28%
Opportunity for Health	23. Percent of prekindergarten – 12th grade students receiving special education	MDE	14.6%	13.7%	15.7%	14.2%
Opportunity for Health	24. 2011 Unemployed rate - annual average	MN DEED	6.6%	8.5%	7.8%	6.6%
Opportunity for Health	25. Total per capita income	Census	$42,953	$38,744	$45,677	$54,008
Opportunity for Health	26. Percent of prekindergarten – 12th grade students eligible for free and reduced meals	MDE	35.5%	30.5%	54%	41.2%
Opportunity for Health	27. Percent of people under 18 years living in poverty	Census	11.4%	7.4%	18.7%	15.7%
Opportunity for Health	28. Percent of all ages living in poverty	Census	11.6%	5.8%	13.5%	11.9%
Opportunity for Health	29. Percent of people of all ages living at or below 200% of poverty	Census 5 yr ACS	25.5%	18.2%	32.4%	25.6%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Opportunity for Health	30. Percent of housing occupied by owner	Census 5 yr ACS	78.1%	85.1%	65.8%	69.3%
Opportunity for Health	31.Percent of births to unmarried mothers	MDH MCHS	33.5%	30.4%	43.6%	34.8%
Opportunity for Health	32. Carbon monoxide poisoning (hospitalizations and ED visits age adjusted rates per 100,000)	MNHDD	6.54/.63	3.9/.6	5/.6	7.5/.9
Opportunity for Health	33. Percent of dwellings built before 1940	Census 2000	3.2%	3.2%	4.9%	21.7%
Opportunity for Health	34. Percent of birth cohort tested with elevated blood lead levels	MDH Lead	.5%	.09%	1.21%	.8%
Opportunity for Health	35. COPD hospitalizations (age adjusted rate per 10,000)	MNHDD	31.5	36	31.5	28.4
Opportunity for Health	36. Percent of children under 18 living in single parent-headed households	Census 5 yr ACS	26.1%	22.2%	34.4%	28.9
Opportunity for Health/People and Place	37. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	6.6%	10%	9%
Opportunity for Health	38. Percent of 9th graders who have changed schools at least once since the beginning of the school year	MSS	5%	4%	7%	6%
Opportunity for Health	39. Number of children under 18 years arrested for violent crimes (Part 1) per 1,000 population 10 - 17 years old	MN DPS	20.5	21.2	32.9	30.1

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Opportunity for Health	40. Percent of 9th graders who skipped school one or more days in the last 30 days due to feeling unsafe at or on the way to school	MSS	5%	5.9%	6%	5%
Opportunity for Health	41. Percent of 9th graders who report that a student kicked, bit, or hit them on school property in the last 12 months	MSS	21%	21%	19%	17%
Opportunity for Health	42. Percent of 9th graders who report that they have hit or beat up another person one or more times in the last 12 months	MSS	22%`	23%	25%	22%
Opportunity for Health/Healthy Living	43. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	6.2	12.6	8.8
Opportunity for Health	44. Number of physicians per 10,000 population	MDH ORHPC	27	13	37	47
Opportunity for Health	45. Number of dentists per 100,000	MDH ORHPC	61.4	134 total	499 total	912 total
Opportunity for Health	46. Percent currently uninsured	MDH MNHAS	9%	9%	12%	10%
Opportunity for Health/Healthy Living	47. Percent of mothers who initiated prenatal care in the 1st trimester	MDH MCHS	85.9%	86.7%	77.9%	85.5%

Healthy Living

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Healthy Living	48. Birth rate per 1,000 population	MDH MCHS	13.4	12.9	15	14.4
Healthy Living	49. Number of births	MDH MCHS	70,617	4,288	7,577	16,334
Healthy Living	50. Percent of births by race/ethnicity of mother	MDH MCHS	Table IV	Table IV	Table IV	Table IV
Healthy Living	60. Percent of mothers who smoked during pregnancy	MDH MCHS	9.8%	8.2%	8.7%	4.7%
Healthy Living	61. Percent of births to unmarried mothers	MDH MCHS	33.5%	30.4%	43.6%	34.8%
Healthy Living/Opportunity for Health	62. Percent of mothers who initiated prenatal care in the 1st trimester	MDH MCHS	85.9 %	86.7%	77.9%	85.5%
Healthy Living	63. Percent of births that were born premature, less than 37 weeks gestation (singleton births)	MDH MCHS	7.8%	7.7%	8%	8.4%
Healthy Living	64. Percent of birth born low birth weight, less than 2,500 grams (singleton births)	MDH MCHS	4.8%	4.7%	5.4%	5.5%
Healthy Living	65. Number of infant deaths	MDH MCHS	429	32	56	110
Healthy Living	66. Percent of 9th and 12th graders who participate in religious activities one or more times per week	MSS	43%/28%	38%/26%	34%/22%	42%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Healthy Living	67. Teen birth rate per 1,000 females aged 15-19 years	MDH MCHS	26.6	22	38	29
Healthy Living/Opportunity for Health	68. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	6.2	12.6	8.8
Healthy Living	69. Percent of 9th graders who ate five or more servings of fruit, fruit juice, or and vegetables yesterday	MSS	18%	16%	18%	20%
Healthy Living	70. Percent of 9th graders who drank three or more glasses of pop or soda yesterday	MSS	14%	16%	15%	11%
Healthy Living	71. Percent of adults who consumed five or more servings of fruits and vegetables per yesterday	Local Surveys		33.4%	38.5%	37.3%
Healthy Living	72. Percent of adults who reported 30+ minutes of moderate physical activity on five or more days per week	Local Surveys		39.4%	44.9%	34.8%
Healthy Living	73. Percent of 9th graders who were physically active for 30 minutes or more on at least five of the last seven days	MSS	56%	51%	48%	56%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Healthy Living	74. Percent of 9th graders who engaged in strenuous exercise for at least 20 minutes on at least three of the last seven days	MSS	71%	67%	65%	72%
Healthy Living	75. Percent of 9th graders who spend six or more hours per week watching TV, DVDs or videos	MSS	44%	45%	41%	42%
Healthy Living	76. Percent of adults who are excessive drinkers (binge/heavy)	Local Surveys	20.2%	21%	20.1%	19%
Healthy Living	77. Percent of 9th graders who engaged in binge drinking in the last two weeks	MSS	10%	10%	10%	8%
Healthy Living	78. Percent of 9th graders who used alcohol one or more times in the last 12 months	MSS	32%	33%	33%	26%
Healthy Living	79. Percent of 9th graders who used alcohol one or more times in the 30 days	MSS	19%	19%	19%	16%
Healthy Living	80. Percent of 9th and 12th graders who drove a motor vehicle after using alcohol or drugs one or more times in the last 12 months	MSS	4%/19%	4%/17%	4%/14%	2%/17%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Healthy Living	81. Percent of 9th graders who rarely or often ride with friends after those friends have been using alcohol or drugs	MSS	17%	18%	19%	14%
Healthy Living	82. Percent of 9th graders who smoked cigarettes during the last 30 days	MSS	9%	10%	10%	6%
Healthy Living	83. Percent of adults who are current smokers	Local Surveys	16.8%	23.3%	15.7%	12.1%
Healthy Living	84. Percent of 9th graders who used chewing tobacco, snuff, or dip during the last 30 days	MSS	5%	4%	3%	3%
Healthy Living	85. Exposure to second hand smoke	Local Surveys	45.6%			
Healthy Living	86. Percent of 9th graders who used marijuana one or more times in the last 12 months	MSS	15%	17%	13%	16%
Healthy Living	87. Percent of 9th graders who used marijuana one or more times in the last 30 days	MSS	10%	11%	3%	10%
Healthy Living	88. Colorectal cancer screening	Local Surveys				
Healthy Living	89. Breast cancer screening	Local Surveys				
Healthy Living	90. Percent of children age 24-35 months up to date with immunizations (vaccine series)	MDH MIIC	58.1%	61.2%	52.4%	55.9%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Healthy Living	91. Percent of 9th and 12th graders who have ever had sexual intercourse	MSS	20%/51%	21%/49%	22%/47%	19%/46%
Healthy Living	92. Among sexually active 9TH and 12th grade students: percent reporting always using a condom	MSS	56%/45%	56%/46%	51%/44%	56%45%
Healthy Living	93. Percent of 9th graders who report always wearing a seatbelt when riding in a car	MSS	66%	68%	66%	71%
Healthy Living	94. Percent of 9th graders who have felt nervous, worried, or upset all or most of the time during the last 30 days	MSS	13%	15%	16%	13%
Healthy Living	95. Percent of 9th graders who feel that people care about them very much or quite a bit (parents, other adult relatives, teacher/other adults, religious or spiritual leaders, other adults in the community, friends)	MSS	Table V	Table V	Table V	Table V
Healthy Living	96. Percent of 9th graders who felt sad all or most of the time in the last month	MSS	14%	15%	16%	13%
Healthy Living	97. Percent of 9th graders who report that a student/students have made fun of or teased them in the last 30 days	MSS	38%	35%	34%	34%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Healthy Living	98. Percent of 9th graders who report that a student pushed, shoved, or grabbed them on school property in the last 12 months	MSS	37%	39%	34%	33%
Healthy Living	99. Percent of 9th graders who report that they have made fun of or teased another student in the last 30 days	MSS	45%	43%	41%	41%
Healthy Living	100. Percent of 9th graders who had suicidal thoughts in last year	MSS	17%	17%	18%	15%
Healthy Living	101. Percent of 9th graders who tried to kill themselves in the last year	MSS	3%	4%	4%	3%

Chronic Diseases and Conditions

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Chronic Dis. and Cond.	102. Percent of 9th graders who are overweight but not obese according to BMI	MSS	13%	14%	14%	12%
Chronic Dis. and Cond.	103. Percent of 9th graders who are obese according to BMI	MSS	9%	10%	11%	8%
Chronic Dis. and Cond.	104. Percent of adults who are overweight according to BMI	Local Surveys	38.1%	38.5%	36.3%	32.8%
Chronic Dis. and Cond.	105. Percent of adults who are obese according to BMI	Local Surveys	24.7%	27.9%	24.4%	20.4%
Chronic Dis. and Cond.	106.Percent of WIC children under aged 2-5 years who are obese according to BMI	MDH WIC	13.1%	11.5%	14.6%	
Chronic Dis. and Cond.	107. Leading causes of death - age adjusted rates per 100,000 (e.g. cancer, heart disease, stroke)	MDH MCHS	Table VI	Table VI	Table VI	Table VI
Chronic Dis. and Cond.	108. Asthma hospitalizations (age adjusted rate per 10,000)	MNHDD	7.5	9	10.6	11.5
Chronic Dis. and Cond.	109. Cancer incidence per 100,000 (all cancer types combined, age adjusted rate per 100,000)	MDH MCSS	474.9	505.9	464.3	470.4
Chronic Dis. and Cond.	110. Breast cancer incidence (age adjusted rate per 100,000)	MDH MCSS	127.3	122	123.4	133.1
Chronic Dis. and Cond.	111. Heart attack hospitalizations (age adjusted rate per 10,000)	MNHDD	27.3	30	28.4	25.7

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Chronic Dis. and Cond.	112. Heart disease prevalence	Local Surveys	4.9%	2.8%	2.3%	2.8%
Chronic Dis. and Cond.	113. Stroke prevalence	Local Surveys	1.8%	2.7%	4.2%	1.3%
Chronic Dis. and Cond.	114. Diabetes prevalence	Local Surveys	6.2%	6.1%	7.5%	5.3%

Infectious Disease

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Infectious Disease	115. STD numbers (e.g. chlamydia, gonorrhea)	MDH IDEPC	Table VII			
Infectious Disease	116. Number of tuberculosis cases	MDH IDEPC	135	3	34	67
Infectious Disease	117. Vector borne diseases (e.g. Lyme disease, West Nile virus)	MDH IDEPC	Table VIII			

Injury and Violence

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Injury and Violence	118. Years of potential life lost before age 65 (e.g. due to injury or violence)	MDH MCHS	30,010	3,045	2,355	6,710
Injury and Violence	119. Unintentional injury death - age adjusted rate per 100,000	MDH MCHS	36	33.4	31	38.7
Injury and Violence	120. Percent of motor vehicle injuries and deaths that are related to alcohol	MN DPS	31.9%/8%	42.9%/6.8%	54.5%/7.6%	26.3%/6.1%
Injury and Violence	121. Percent of 9th graders who report that someone they were going out with has ever hit, hurt, threatened or forced them to have sex	MSS	10%	12%	12%	9%
Injury and Violence	122. Rate of children maltreatment per 1,000 children aged 0-17	MN DHS	17.6	12.5	13.5	18.9
Injury and Violence	123. Suicide deaths	MDH MCHS	599	49	53	122

TABLE I

State-wide

Age Group	Male	Female	Total
0-4	181,342	174,162	355,504
5-9	181,614	173,922	355,536
10-14	180,356	171,986	352,342
15-17	113,281	107,400	220,681
18-19	75,313	71,835	147,148
20-24	180,725	174,926	355,651
25-29	187,562	185,124	372,686
30-34	174,549	168,351	342,900
35-39	165,815	162,375	328,190
40-44	177,234	175,670	352,904
45-49	203,588	202,615	406,203
50-54	200,663	201,032	401,695
55-59	174,321	175,268	349,589
60-64	137,760	142,015	279,775
65-69	97,533	105,037	202,570
70-74	70,840	81,017	151,857
75-79	54,464	67,650	122,114
80-84	40,865	59,051	99,916
85&up	34,307	72,357	106,664
Total	**2,632,132**	**2,671,793**	**5,303,925**

Anoka

Age Group	Male	Female	Total
0-4	11,330	11,009	22,339
5-9	12,079	11,710	23,789
10-14	12,529	11,830	24,359
15-17	8,027	7,517	15,544
18-19	4,250	3,941	8,191
20-24	9,548	8,932	18,480
25-29	10,887	10,692	21,579

30-34	11,177	10,876	22,053
35-39	11,535	11,326	22,861
40-44	12,665	12,769	25,434
45-49	14,722	14,558	29,280
50-54	13,535	13,114	26,649
55-59	10,467	10,703	21,170
60-64	8,138	8,746	16,884
65-69	5,731	6,006	11,737
70-74	3,582	4,237	7,819
75-79	2,557	3,168	5,725
80-84	1,568	2,243	3,811
85&up	1,000	2,140	3,140
Total	**165,327**	**165,517**	**330,844**

Ramsey

Age Group	Male	Female	Total
0-4	17,985	17,152	35,137
5-9	16,346	15,602	31,948
10-14	15,950	15,117	31,067
15-17	10,457	9,884	20,341
18-19	8,583	8,652	17,235
20-24	21,295	22,899	44,194
25-29	20,999	22,037	43,036
30-34	17,129	16,954	34,083
35-39	15,078	15,010	30,088
40-44	15,330	15,515	30,845
45-49	16,987	17,628	34,615
50-54	17,353	18,602	35,955
55-59	15,647	17,061	32,708
60-64	12,456	13,751	26,207
65-69	8,089	9,315	17,404
70-74	5,668	7,279	12,947

75-79	4,513	6,404	10,917
80-84	3,641	5,834	9,475
85&up	3,136	7,302	10,438
Total	246,642	261,998	508,640

Hennepin

Age Group	Male	Female	Total
0-4	38,789	37,447	76,236
5-9	36,731	35,678	72,409
10-14	35,396	33,952	69,348
15-17	22,136	21,216	43,352
18-19	14,851	14,469	29,320
20-24	41,694	42,537	84,231
25-29	50,003	50,910	100,913
30-34	43,947	42,663	86,610
35-39	38,718	37,478	76,196
40-44	39,222	38,886	78,108
45-49	43,045	42,887	85,932
50-54	42,039	43,159	85,198
55-59	36,485	38,368	74,853
60-64	28,188	30,717	58,905
65-69	18,006	20,674	38,680
70-74	12,396	15,440	27,836
75-79	9,653	12,973	22,626
80-84	7,790	12,060	19,850
85&up	7,095	14,727	21,822
Total	566,184	586,241	1,152,425

TABLE II

Total population by race and ethnicity	White	Black/ African American	Amer. Indian/ Alaskan Native	Asian/ Pacific Islander	Two or More Races	Hispanic/ Latino (any race)
State-wide	4,524,062	274,412	60,916	216,390	125,145	250,258
Anoka	287,802	14,503	2,257	12,972	8,521	12,020
Ramsey	356,547	56,170	4,043	59,548	17,556	36,483
Hennepin	856,834	136,262	10,591	72,411	37,499	77,676

TABLE III

Number of prekindergarten – 12th grade students by race/ethnicity	White	African American	American Indian	Asian	Hispanic	Total
State-wide	622,725	83,779	18,486	54,559	58,091	837,640
Anoka	48,745	6,652	919	3,902	3,333	63,551
Ramsey	38,463	17,755	1,175	18,429	8,581	84,403
Hennepin	86,137	37,339	2,859	14,880	16,329	157,544

TABLE IV

Percent of births by race/ethnicity of mother	White	African American	American Indian	Asian	Latina
State-wide	74.5	9.4	2.1	6.9	8.0
Anoka	78.8	8.5	.7	7.2	5.3
Ramsey	50.9	18.2	1.2	20.7	11.3
Hennepin	58.1	20.9	1.5	10.3	10.6

TABLE V

	Percent 9th graders who feel that teachers or other adults at school care about them very much or quite a bit	Percent 9th graders who feel that religious or spiritual leaders care about them very much or quite a bit	Percent 9th graders who feel that other adults in the community care about them very much or quite a bit	Percent 9th graders who feel that other adult relatives care about them very much or quite a bit	Percent 9th graders who feel that their parents care about them very much
State-wide	45	55	42	86	78
Anoka	42	54	40	84	77
Ramsey	42	48	39	81	76
Hennepin	49	57	45	86	80

TABLE VI

Leading causes of death - age adjusted rates per 100,000	Heart Disease	Cancer	Stroke
State-wide	121.81	169.08	34.14
Anoka	92.1	165.77	37.6
Ramsey	104.22	158.8	34
Hennepin	102.1	170.5	35.1

TABLE VII

STD numbers	Chlamydia	Gonorrhea	Primary/Secondary Syphilis	Syphilis - All Stages	HIV
State-wide	15,294	2,119	149	347	331
Anoka	310	87	8	20	11
Ramsey	2,481	339	19	42	55
Hennepin	5,242	1,073	99	213	175

TABLE VIII

Vector borne diseases	Campylo-bacteriosis	Giardiasis	Lyme Disease	Human Anaplasmosis	West Nile	Salmo-nellosis	Shigellosis
State-wide	1,007	846	1293	720	8	695	66
Anoka	38	22	109	34	0	33	2
Ramsey	99	198	85	44	2	99	6
Hennepin	178	141	167	69	2	151	29

Local Surveys

Some Minnesota Counties have conducted local surveys that may provide data for these indicators. Listed below are the local surveys that were most recently conducted along with the counties in which results are available.

Local Survey Websites

> Bridge to Health 2005 and 2010
> Results for Aitkin County, Carlton County, Cook County, City of Duluth, Itasca County, Koochiching County, Lake County, Pine County, St. Louis County, St. Louis County without Duluth
>
> Southwest South Central Adult Health Survey 2010
> Results for Big Stone County, Blue Earth County, Brown County, Chippewa County ,Cottonwood County ,Jackson County, Kandiyohi County, Lac qui Parle County, Le Sueur County, Lincoln County, Lyon County, Murray County, Nicollet County, Pipestone County, Redwood County, Renville County, Swift County, Waseca County, Yellow Medicine County
>
> Metro Adult Health Survey 2010
> Results for Anoka County, Carver County, Dakota County, Ramsey County, Scott County, Washington County
>
> Survey of the Health of All the Population and the Environment (SHAPE) 1998, 2002, 2006, 2010
> Results for Hennepin County
>
> **For Other Counties:** 2010 MCHT, Morbidity and Utilization Tables 11 and 12

If your county is not listed, you can go to the Minnesota County Health Tables (MCHT) website listed above for synthetic estimates of selected risk behaviors. Note that synthetic estimates are statewide estimates (percentages) from the BRFSS that are statistically adjusted using the age and sex distributions for each county. These estimates indicate the percentage of adults at risk for a particular health behavioral risk factor in a county given 1) the statewide percentage for that behavior and 2) that county's age and sex composition. These estimates do not indicate the percentage of adults in that county who actually engage in the risk behavior.

Acronyms

Atlas Online - Minnesota Center for Rural Policy and Development

Census 5 yr ACS - Census 2005-2009 American Community Survey Results

MCHT - Minnesota County Health Tables

MDE - Minnesota Department of Education Data Center

MDH Arsenic - Minnesota Department of Health, Well Management

MDH HEP - Minnesota Department of Health, Health Economics Program

MDH IDEPC - Minnesota Department of Health, Infectious Disease Epidemiology, Prevention and Control

MDH Lead - Minnesota Department of Health, Lead Poisoning Prevention Program

MDH MCHS - Minnesota Department of Health, Minnesota Center for Health Statistics

MDH MCSS - Minnesota Department of Health, Minnesota Cancer Surveillance System

MDH MIIC - Minnesota Department of Health, Minnesota Immunization Information Connection

MDH MNHAS - Minnesota Department of Health, Minnesota Health Access Survey

MDH ORHPC - Minnesota Department of Health, Office of Rural Health and Primary Care

MDH WIC - Minnesota Department of Health, Women, Infants and Children

MN DEED - Minnesota Department of Employment and Economic Development, Local Area Unemployment Statistics

MN DHS - Minnesota Department of Human Services

MN DPS - Minnesota Department of Public Safety

MNHDD - Minnesota Hospital Discharge Data maintained by the Minnesota Hospital Association

MPHDA - Minnesota Public Health Data Access

MSS - Minnesota Student Survey

MSS SY - Minnesota Student Survey Selected Single Year Results by State, County and CHB, 1998-2010

US EPA - US Environmental Protection Agency

VS Trends – Minnesota Vital Statistics State, County and Community Health Board Trend Report

Appendix D

Hanlon Process

Allina Health

MERCY HOSPITAL

Community Health Needs Assessment
and Implementation Plan 2014–2016

First Things First: Prioritizing Health Problems

Introduction
Despite the many accomplishments of local public health, we continue to see emerging population-wide health threats as we forge ahead into to the 21st Century. We are in an economic climate where LHD personnel are facing dire budget cutbacks while simultaneously dealing with issues like H1N1, chronic diseases, and natural disasters. Because LHDs are the backbone of the public health system, the recent movement to establish a national system of accountability for governmental health agencies is particularly timely. The Public Health Accreditation Board (PHAB) is developing a voluntary national accreditation program which is grounded in continuous quality improvement. As LHDs work toward meeting accreditation standards and implementing quality improvement efforts, they are faced with an infinite number of competing health issues to address, while keeping in mind several external considerations such as urgency, cost, impact and feasibility, to name just a few. Fortunately, a number of prioritization methods specifically designed to assist agencies with this very challenge have been developed and widely used in a range of industries including public health. When faced with these tough decisions, employing a defined prioritization technique can provide a structured mechanism for objectively ranking issues and making decisions, while at the same time gathering input from agency-wide staff and taking into consideration all facets of the competing health issues.

This document serves as a guide and provides five widely used options for prioritization including guidance on which technique best fits the needs of your agency, step-by-step instructions for implementation, and practical examples.

Getting Started
Prior to the implementation of any prioritization process, preliminary preparations are necessary to ensure the most appropriate and democratic selection of priority health issues:[i]

1. **Community assessment** – Conducting assessments will determine the current status and detect gaps to focus on as potential priority areas. LHDs engaging in the Public Health Accreditation Board (PHAB) accreditation process must conduct a *community* health assessment (CHA) as a prerequisite for eligibility. A CHA provides data on the overall health of a community and uncovers target priority areas where a population may have increased risk for poor health outcomes.
2. **Agency self-assessment -** As part of the national accreditation process, LHDs must use the PHAB *agency* self-assessment tool to evaluate agency performance against nationally recognized standards. Post-assessment, LHDs can analyze their results and determine strengths and areas for improvement to address through continuous quality improvement efforts. Prioritization methods can be used to help select areas for improvement from a CHA or PHAB self-assessment.
3. **Clarify objectives and processes –** Before beginning the process, LHD leadership must ensure that all team members have a clear understanding of the goals and objectives along with the chosen prioritization process.
4. **Establish criteria -** Selection of appropriate prioritization criteria on which to judge the merit of potential focus areas is important to avoid selection based on bias or hidden agendas and ensure that everyone is 'on the same page.' **Table 1.1** below identifies criteria commonly used in prioritization processes:

Table 1.1: Commonly Used Prioritization Criteria[ii]

Criteria to Identify Priority Problem	Criteria to Identify Intervention for Problem
• Cost and/or return on investment • Availability of solutions • Impact of problem • Availability of resources (staff, time, money, equipment) to solve problem • Urgency of solving problem (H1N1 or air pollution) • Size of problem (e.g. # of individuals affected)	• Expertise to implement solution • Return on investment • Effectiveness of solution • Ease of implementation/maintenance • Potential negative consequences • Legal considerations • Impact on systems or health • Feasibility of intervention

Prioritization in Practice

The following section highlights five prioritization methods:

1. Multi-voting Technique
2. Strategy Grids
3. Nominal Group Technique
4. The Hanlon Method
5. Prioritization Matrix

Each sub-section includes step-by-step instructions on implementation followed by examples illustrating practical application. It is important to remember that no right or wrong method of prioritization exists. Although the provided examples in this document are useful in gaining an understanding of how to use prioritization techniques, they are not meant to be prescriptive but rather, should be tailored to the needs of individual agencies.   Additional information on prioritization processes can be found in the Assessment Protocol for Excellence in Public Health (APEX*PH*).

Multi-voting Technique [iii]

Multi-voting is typically used when a long list of health problems or issues must be narrowed down to a top few. Outcomes of Multi-voting are appealing as this process allows a health problem which may not be a top priority of any individual but is favored by all, to rise to the top. In contrast, a straight voting technique would mask the popularity of this type of health problem making it more difficult to reach a consensus.

Step-by-Step Instructions:

1. **Round 1 vote –** Once a list of health problems has been established, each participant votes for their highest priority items. In this round, participants can vote for as many health problems as desired or, depending on the number of items on the list, a maximum number of votes per participant can be established.
2. **Update list** - Health problems with a vote count equivalent to half the number of participants voting remain on the list and all other health problems are eliminated (e.g. if 20 participants are voting, only health problems receiving 10 or more votes remain).
3. **Round 2 vote** – Each participant votes for their highest priority items of this condensed list. In this round, participants can vote a number of times equivalent to half the number of health problems on the list (e.g. if ten items remain on the list, each participant can cast five votes).

4. **Repeat** – Step 3 should be repeated until the list is narrowed down to the desired number of health priorities.

Multi-voting Example: The following example illustrates how an LHD used the Multi-voting technique to narrow down a list of ten health problems, identified by an agency self-assessment, to one priority focus area for a quality improvement (QI) project. **Table 2.1** illustrates the results of a three-round multi-voting process implemented by a group of 6 project directors using the following steps:

1. **Round-one vote** – On a note card, all participants anonymously voted for as many priority focus areas as desired.
2. **Update list** – All votes were tallied and the six health indicators receiving three or more votes were posted for the group to view.
3. **Round-two vote** – All participants voted up to three times for the remaining health indicators.
4. **Update list** – All votes were re-tallied and the three health indicators receiving less three or more votes were posted for the group to view.
5. **Round-three vote** - All participants voted up to two times and the only item with three or more votes, "Effective Media Strategy," was the chosen focus area for a QI project.

Table 2.1: Three-Round Multi-voting Example
Jane Doe County Health Department wanted to prioritize one health problem to address with funds from a small grant. They began with a list of 12 health problems, which they identified through standards and measures where they scored poorly on PHAB's self-assessment tool. The director convened the management team and implemented the multi-voting method to select the priority area.

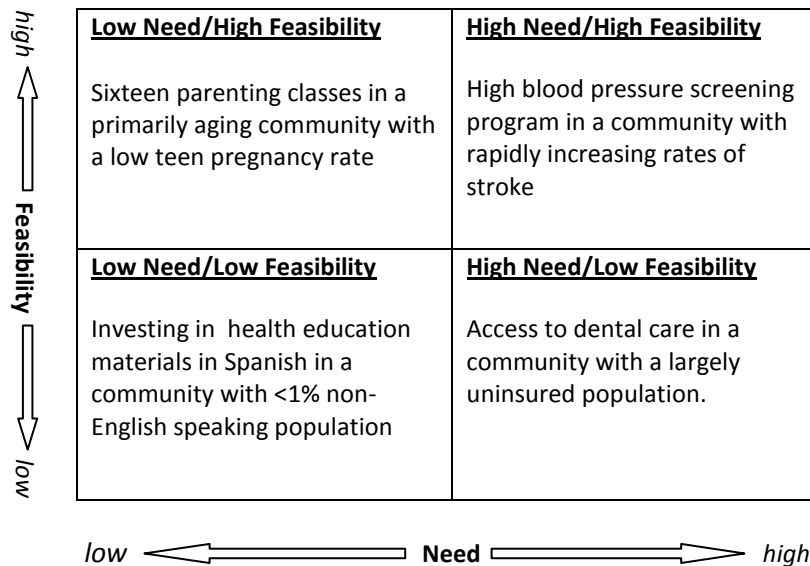| Health Indicator	Round 1 Vote	Round 2 Vote	Round 3 Vote
Collect and maintain reliable, comparable, and valid data	√√√√	√√	
Evaluate public health processes, programs, and interventions.	√√√√√	√√√√	√√√√√
Maintain competent public health workforce	√√		
Implement quality improvement of public health processes, programs, and interventions	√√√√	√√	
Analyze public health data to identify health problems	√√		
Conduct timely investigations of health problems in coordination with other governmental agencies and key stakeholders	√√		
Develop and implement a strategic plan	√√√√√	√√√√	√√
Provide information on public health issues and functions through multiple methods to a variety of audiences	√√		
Identify and use evidence-based and promising practices	√√		
Conduct and monitor enforcement activities for which the agency has the authority	√		
Conduct a comprehensive planning process resulting in a community health improvement plan	√√√√√	√√√√	√√
Identify and implement strategies to improve access	√√√	√√	

Strategy Grids [iv]

Strategy grids facilitate agencies in refocusing efforts by shifting emphasis towards addressing problems that will yield the greatest results. This tool is particularly useful when agencies are limited in capacity and want to focus on areas that provide 'the biggest bang for the buck.' Rather than viewing this challenge through a lens of diminished quality in services, strategy grids can provide a mechanism to take a thoughtful approach to achieving maximum results with limited resources. This tool may assist in transitioning from brainstorming with a large number of options to a more focused plan of action.

The strategy grid below provides an example of an LHD's effort to refocus efforts towards programs that will feasibly result in the greatest impact. Refer to the example strategy grid below while working through the step-by-step instructions.

Step-by-Step Instructions:

1. **Select criteria** – Choose *two* broad criteria that are currently most relevant to the agency (e.g. 'importance/urgency,' 'cost/impact,' 'need/feasibility,' etc.). Competing activities, projects or programs will be evaluated against how well this set of criteria is met. The example strategy grid below uses 'Need' and 'Feasibility' as the criteria.
2. **Create a grid** – Set up a grid with four quadrants and assign one broad criteria to each axis. Create arrows on the axes to indicate 'high' or 'low,' as shown below.
3. **Label quadrants** – Based on the axes, label each quadrant as either 'High Need/High Feasibility,' 'High Need/Low Impact,' 'Low Need/High Feasibility,' 'Low Need/Low Feasibility.'
4. **Categorize & Prioritize -** Place competing activities, projects, or programs in the appropriate quadrant based on the quadrant labels. The example below depicts 'Need' and 'Feasibility' as the criteria and items have been prioritized as follows:

   - *High Need/High Feasibility* – With high demand and high return on investment, these are the highest priority items and should be given sufficient resources to maintain and continuously improve.
   - *Low Need/High Feasibility* – Often politically important and difficult to eliminate*,* these items may need to be re-designed to reduce investment while maintaining impact.
   - *High Need/Low Feasibility* – These are long term projects which have a great deal of potential but will require significant investment. Focusing on too many of these items can overwhelm an agency.
   - *Low Need/Low Feasibility* – With minimal return on investment, these are the lowest priority items and should be phased out allowing for resources to be reallocated to higher priority items.

Strategy Grid

	Low Need	High Need
high (Feasibility)	**Low Need/High Feasibility** Sixteen parenting classes in a primarily aging community with a low teen pregnancy rate	**High Need/High Feasibility** High blood pressure screening program in a community with rapidly increasing rates of stroke
low (Feasibility)	**Low Need/Low Feasibility** Investing in health education materials in Spanish in a community with <1% non-English speaking population	**High Need/Low Feasibility** Access to dental care in a community with a largely uninsured population.

low ⟵ **Need** ⟶ high

Nominal Group Technique [v]

The Nominal Group Technique (NGT) has been widely used in public health as a mechanism for prioritizing health problems through group input and information exchange. **This method is useful in the early phases of prioritization when there exists a need to generate a lot of ideas in a short amount of time and when input from multiple individuals must be taken into consideration.** Often, the Multi-voting Technique is used in conjunction with NGT whereby NGT can be used to brainstorm ideas and create a broad list of possibilities and Multi-voting can be used to narrow down the list to pinpoint the top priorities. One of the greatest advantages of using this technique is that it is a democratic process allowing for equal say among all participants, regardless of position in the agency or community.

Step-by-Step Instructions:

1. **Establish group structure –** Establish a group of, ideally, 6-20 people to participate in the NGT process and designate a moderator to take the lead in implementing the process. The moderator should clarify the objective and the process.
2. **Silent brainstorming –** The moderator should state the subject of the brainstorming and instruct the group to silently generate ideas and list them on a sheet of paper.
3. **Generate list in round-robin fashion –** The moderator should solicit one idea from each participant and list them on a flip chart for the group to view. This process should be repeated until all ideas and recommendations are listed.

4. **Simplify & clarify** –The moderator then reads aloud each item in sequence and the group responds with feedback on how to condense or group items. Participants also provide clarification for any items that others find unclear.
5. **Group discussion –** The moderator facilitates a group discussion on how well each listed item measures up to the criteria that was determined by the team prior to the NGT process.
6. **Anonymous ranking –** On a note card**,** all participants silently rank each listed health problems on a scale from 1 to 10 (can be altered based on needs of agency) and the moderator collects, tallies, and calculates total scores.
7. **Repeat if desired –** Once the results are displayed, the group can vote to repeat the process if items on the list receive tied scores or if the results need to be narrowed down further.

John Doe County Health Department: Nominal Group Technique Example

The John Doe County Health Department (JDCHD) implemented NGT to choose one priority focus area for a QI project. In an effort to remain objective, the process was facilitated by an external consultant and the decision making team was a large group of 27 program and division managers and staff from throughout the agency. The goal of the exercise was to identify a focus area for a QI project based on the following criteria: 1) areas of weakness determined by agency self-assessment results; 2) the degree to which the health department is used for a particular service; and 3) the level of impact the health department can make to bring forth an improvement. In preparation for the exercise, the group was also provided with a detailed report of findings from the agency self-assessment to read prior to the decision-making process.   From this point, the following steps were followed to identify a primary focus area for improvement:

1. **Silent brainstorming –** Two weeks in advance of the meeting**,** team members were provided with results of the self-assessment for review and to individually brainstorm ideas on which health issues should be the focus of a QI project.
2. **Generate list –** At the start of the meeting, the facilitator collected potential health issues from all group members, one by one, and recorded them on a flip chart. The list was simplified by combining and grouping similar items, resulting in the 6 potential health indicators shown in **Table 3.1**.
3. **Group discussion –** The facilitator led a discussion where everyone was given the opportunity to provide input on how each of the 6 priorities measured up against the criteria previously established.
4. **Anonymous voting –** Following the meeting**,** all group members individually completed an on-line ranking for their top three choices by assigning a number of 1-3 next to each option, with 1 being the last choice and 3 being the first choice.
5. **Calculate priority score –** The total priority scores were calculated by adding scores given by every group member for each item on the list **Table 3.1** shows a compilation of the rankings from the 27 group members with improved communication and coordination between divisions and programs within the health department as the top priority:

Table 3.1: Count of Staff Responses to QI Focus Areas

Priority Health Indicator	1st Choice Score = 3	2nd Choice Score = 2	3rd Choice Score = 1	Total Score
Improve communication and coordination between divisions and programs within health	4	6	6	30

department				
Engage policymakers and community to support health department initiatives	1	6	3	18
Promote understanding of public health in general and health department as an organization among stakeholders (may include internal and external stakeholders)	3	1	6	17
Better utilize data and best practices to inform health department program decisions and to generate community support and understanding of the health department's role and contribution to public health	2	4	6	20
Establish a health department presence and recognition at a level comparable to other major City departments	4	5	5	27

The Hanlon Method [vi]

Developed by J.J. Hanlon, the *Hanlon Method for Prioritizing Health Problems* is a well respected technique which objectively takes into consideration explicitly defined criteria and feasibility factors. **Though a complex method, the Hanlon Method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values**.

Step-by-Step Instructions:

1. **Rate against specified criteria** – Once a list of health problems has been identified, on a scale from zero through ten, rate each health problem on the following criteria: *size of health problem, magnitude of health problem, and effectiveness of potential interventions*. It is important to remember that this step requires the collection of baseline data from the community such as from a community health assessment. **Table 4.1** illustrates an example numerical rating system for rating health problems against the criteria.

Table 4.1

The Hanlon Method: Sample Criteria Rating			
Rating	**Size of Health Problem** *(% of population w/health problem)*	**Seriousness of Health Problem**	**Effectiveness of Interventions**
9 or 10	>25% (STDs)	Very serious (e.g. HIV/AIDS)	80% - 100% effective (e.g. vaccination program)
7 or 8	10% - 24.9%	Relatively Serious	60% - 80% effective
5 or 6	1% - 9.9%	Serious	40% - 60% effective
3 or 4	.1% - .9%	Moderately Serious	20% - 40% effective
1 or 2	.01% - .09%	Relatively Not Serious	5% - 20% effective
0	< .01% (Meningococcal Meningitis)	Not Serious (teen acne)	<5% effective (access to care)
Guiding considerations when ranking health problems against the 3 criteria	• Size of health problem should be based on baseline data collected from the individual community.	• Does it require immediate attention? • Is there public demand? • What is the economic impact? • What is the impact on	• Determine upper and low measures for effectiveness and rate health problems relative to those limits. • For more information on assessing effectiveness of

		quality of life? • Is there a high hospitalization rate?	interventions, visit http://www.communityguide.org to view CDC's Guide to *Community Preventive Services.*

*Note: The scales in Table 1 are arbitrary models of how numerical scales are established and are not based on real epidemiological data; LHDs should establish scales that are appropriate for the community being served.

2. **Apply the 'PEARL' test** - Once health problems have been rated by criteria, use the 'PEARL' Test, to screen out health problems based on the following feasibility factors:

   - **P**ropriety – Is a program for the health problem suitable?
   - **E**conomics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
   - **A**cceptability – Will a community accept the program? Is it wanted?
   - **R**esources – Is funding available or potentially available for a program?
   - **L**egality – Do current laws allow program activities to be implemented?

   Eliminate any health problems which receive an answer of "No" to any of the above factors or proceed with corrective action to ensure that potential health priorities meet all five of the feasibility factors.

3. **Calculate priority scores** – Based on the three criteria rankings assigned to each health problem in Step 1 of the Hanlon Method, calculate the priority scores using the following formula:

$$D = [A + (2 \times B)] \times C$$

   Where:
   D = Priority Score
   A = Size of health problem ranking
   B = Seriousness of health problem ranking
   C = Effectiveness of intervention ranking

   *Note: Seriousness of health problem is multiplied by two because according to the Hanlon technique, it is weighted as being twice as important as size of health problem.

4. **Rank the health problems** – Based on the priority scores calculated in Step 3 of the Hanlon Method, assign ranks to the health problems with the highest priority score receiving a rank of '1,' the next high priority score receiving a rank of '2,' and so on.

McLean County Health Department - The Hanlon Method Example:
As a part of the Illinois Project for Local Assessment of Needs (IPLAN), a community health assessment and planning process, the McLean County Health Department (MCHD) used the Hanlon Method to prioritize health problems in the community. After determining the top eight health problems from the community health assessment data, MCHD used the Hanlon Method to establish the top three focus areas the agency should address. The following steps were taken to implement the prioritization process:

1. **Rate against specified criteria** – To rate each health problem, MCHD used the following considerations for each Hanlon criterion. **Table 3.2** illustrates the top three of the eight health problems and corresponding ratings for each criterion.
   - *Size of the problem* – the percentage of the population with the problem, with an emphasis on the percentage of the population at risk for the problem
   - *Seriousness of the problem* – morbidity rates, mortality rates, economic loss, and the degree to which there is an urgency for intervention
   - *Effectiveness of the intervention* – the degree to which an intervention is available to address the health problem

2. **Apply the 'PEARL' test** – After long discussion, all eight health problems passed the 'PEARL' test as the interventions for each problem were judged to be proper, economical, acceptable, feasible based on available resources, and legal.

3. **Calculate the priority scores** – Priority scores were calculated by plugging in the ratings from Columns A through B into the formula in Column D. The calculations of the top three priority scores are illustrated in **Table 3.2**

Table 4.2: MCHD Hanlon Priority Scoring

Health Problem	A Size	B Seriousness	C Effectiveness of Intervention	D Priority Score (A + 2B)C	Rank
Cancer	8	10	6	168	3
Cerebrovascular Disease	7	9	7	175	2
Heart Disease	10	10	7	210	1

Livingston County Department of Health - The 'PEARL' Test Example:

Often, the 'PEARL' component is pulled out of the Hanlon Method and applied on its own or used in conjunction with other prioritization techniques. The following example illustrates how the Livingston County Department of Health (LCDOH) in New York applied the "PEARL" test to assist in the selection of a QI project in preparation for accreditation.

The LCDOH accreditation team was comprised of the agency's center directors and supervising staff and the process was facilitated by an external consultant to ensure objectivity and minimization of bias. Initially, the team completed a scoring matrix to identify areas of weakness and came up with the following focus areas: *engaging in research, connectedness to universities, strategic planning,* and *development and maintenance of an effective performance appraisal system*. Once the team reached a consensus on these potential focus areas, a 'process of elimination' tactic was employed by utilizing the 'PEARL' Test. The facilitator led the group through a discussion allowing all team members to provide input on how well each focus area measured up to the 'PEARL' feasibility criteria. Upon consideration of the criteria, LCDOH initially eliminated engagement in research and connectedness to universities because the group felt that, at that time, any time or resources put into these issues would yield minimal results. Additional focus areas were also eliminated until, ultimately, the group agreed that improving and maintaining an effective performance appraisal system passed all 'PEARL' criteria. Since the previous system lacked basic core competencies, as a part of a QI project, LCDOH went on to

develop a new performance appraisal system which incorporated eight fundamental core competencies which all staff are expected to meet. The new system was tested and changes were made based on feedback provided from the staff. In an effort to continually improve the system, each center is developing more specific competencies for particular job titles.

Prioritization Matrix [iv]

A prioritization matrix is one of the more commonly used tools for prioritization and is ideal when health problems are considered against a large number of criteria or when an agency is restricted to focusing on only one priority health issue.   Although decision matrices are more complex than alternative methods, they provide a visual method for prioritizing and account for criteria with varying degrees of importance.

Step-by-Step Instructions:
The following steps outline the procedure for applying a prioritization matrix to prioritize health issues. While working through each step, refer to **Table 4.1** below for a visual representation:

Table 5.1: Example Prioritization Matrix

	Criterion 1 (Rating X Weight)	Criterion 2 (Rating X Weight)	Criterion 3 (Rating X Weight)	Priority Score
Health Problem A	2 X 0.5 = 1	1 X .25 = .25	3 X .25 = .75	2
Health Problem B	3 X 0.5 = 1.5	2 X .25 = 0.5	2 X .25 = 0.5	2.5
Health Problem C	1 X 0.5 = 0.5	1 X .25 = .25	1 X .25 = .25	1

1. **Create a matrix –** List all health issues vertically down the y-axis (vertical axis) of the matrix and all the criteria horizontally across the x-axis of the matrix so that each row is represented by a health issue and each column is represented by a criterion. Include an additional column for the priority score.
2. **Rate against specified criteria –** Fill in cells of the matrix by rating each health issue against each criterion which should have been established by the team prior to beginning this process. An example of a rating scale can include the following:

> **3 = criterion met well**
> **2 = criterion met**
> **1 = criterion not met**

3. **Weight the criteria –** If each criterion has a differing level of importance, account for the variations by assigning weights to each criterion. For example, if 'Criterion 1' is twice as important as 'Criterion 2' and 'Criterion 3,' the weight of 'Criterion 1' could be .5 and the weight of 'Criterion 2' and 'Criterion 3' could be .25. Multiply the rating established in Step 2 with the weight of the criteria in each cell of the matrix. If the chosen criteria all have an equal level of importance, this step can be skipped.
4. **Calculate priority scores –** Once the cells of the matrix have been filled, calculate the final priority score for each health problem by adding the scores across the row. Assign ranks to the health problems with the highest priority score receiving a rank of '1.'

Lawrence-Douglas County Health Department: Example Prioritization Matrix

Prior to beginning the prioritization process, Lawrence-Douglas County Health Department (LDCHD) developed a decision-making team which was comprised of ten people including directors and coordinators from throughout the department. Next, upon completion of an agency self-assessment, LDCHD identified areas of weakness and created a list of three potential health indicators to improve upon, along with five criteria found to be most relevant in pinpointing which health indicator will prove to have the greatest impact on the needs of Lawrence-Douglas County. Once these variables were determined, the groundwork was in place and LDCHD was ready to use a prioritization matrix to weigh the identified health indicators against each criterion to make a final decision on a focus area for a QI project. The following steps were used to implement the process:

1. **Create a matrix** – LDCHD used the prioritization matrix shown in **Table 4.2**, with the chosen health indicators listed on the Y-axis and each criterion listed across the X-axis:

Table 5.2: LDCHD Prioritization Matrix

	Evaluative Criteria					
Proposed Area for Improvement Based on LHD Self-Assessment	Linkage to Strategic Vision (.25)	Do we need to improve this area? (.25)	What chance is there that changes we put into place will make a difference? (.5)	Likelihood of completion within the timeframe we have (.5)	Importance to Customer (customer is the one who would benefit; could be patient or community) (.75)	**Total Score**
Media strategy & Communications to raise public health awareness	3 X (.25)	4 X (.25)	4 X (.5)	3 X (.5)	3 X (.75)	**7.5**
Work within network of stakeholders to gather and share data and information	2 X (.25)	3 X (.25)	2 X (.5)	1 X (.5)	1 X (.75)	**3.5**
Continuously develop current information on health issues that affect the community	4 X (.25)	2 X (.25)	3 X (.5)	1 X (.5)	2 X (.75)	**5**

Note: The numerical rankings in Table 3.1 are meant to serve as an example and do not reflect the actual rankings from LDCHD's prioritization process.

2. **Rank each health indicator against criteria** – Each member of the decision-making team was given this prioritization matrix and asked to fill it out individually based on the following rating scale:

> **4 = High priority**
> **3 = Moderate priority**
> **2 = Low priority**
> **1 = Not priority**

After completing the matrix, each team member individually discussed with the facilitators of the process the reasoning behind how the health indicators were rated.

3. **Weight the criteria –** Although LDCHD weighted each criterion equally, (i.e. each criterion was assigned a multiplier of 1) the numbers in red provide an arbitrary example of how an agency

could assign weights to the criteria based on perceived importance. In this example, with multipliers of .5, 'Likelihood of making a difference' and 'Completion within timeframe' are weighted as twice as important as 'Linkage to strategic vision' and 'Need for improvement,' with multipliers of .25. With a multiplier of .75, 'Importance to customer' is weighted as three times as important.

4. **Calculate priority scores –** Final priority scores are calculated by adding the weighted scores across the row and recording it in the 'Total Score' column. Since LDCHD had the team complete multiple matrices, the total scores for each health indicator were added together to determine the final priority scores. With 'Media Strategies' receiving the highest priority score of 7.5, it was assigned a rank of '1' and identified as the highest priority health indicator.

Conclusion

In a world with a growing number of health concerns, scarce resources, budget cuts, and conflicting opinions, it is very easy to lose sight of the ultimate goal - improving health outcomes. Often times these external forces drive the decision making process within a health department and make determining where to focus resources and time challenging. Prioritization techniques provide a structured approach to analyze health problems and solutions, relative to all criteria and considerations, and focus on those that will prove to have the greatest impact on the overall health of a community.
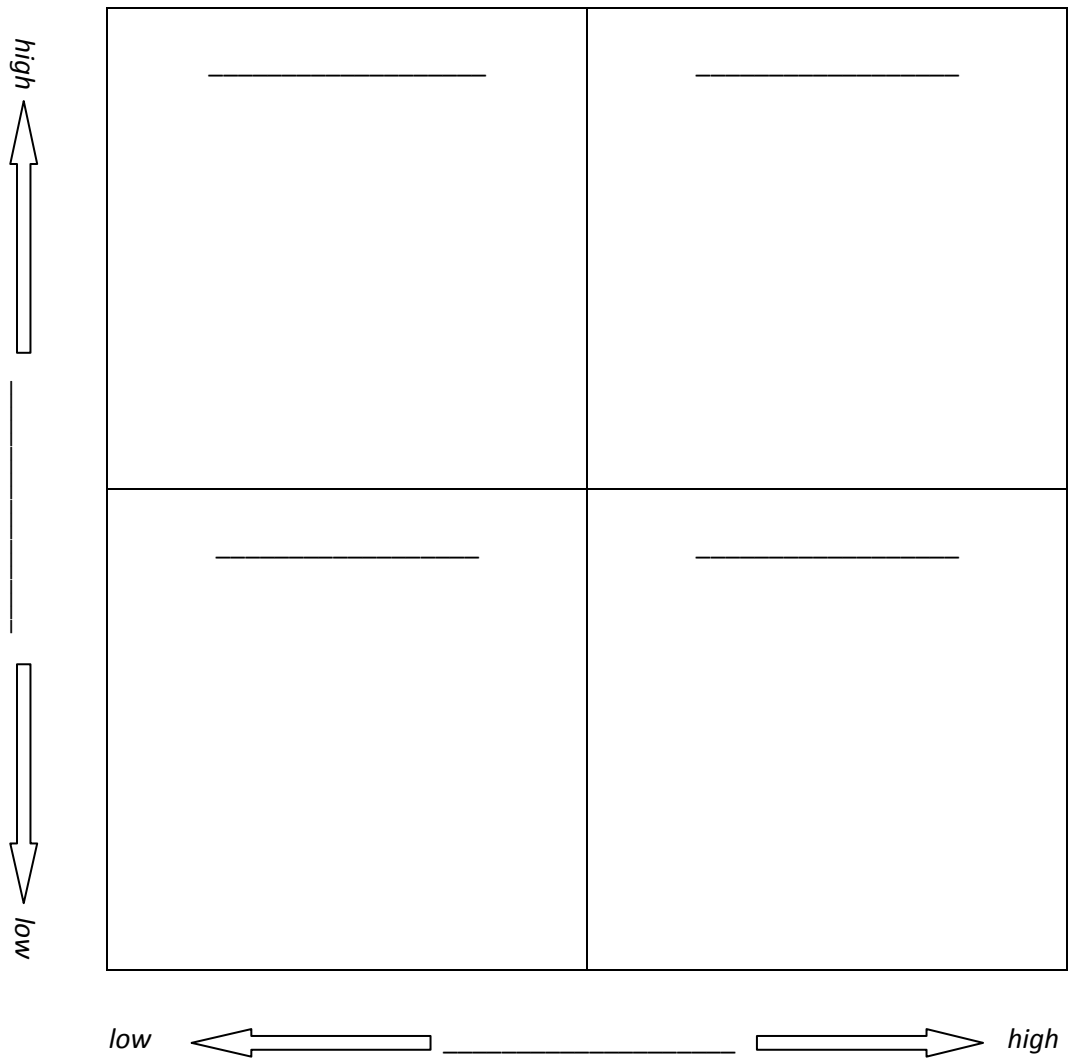
Appendices

3 Round Multi-voting Template

Health Indicator	Round 1 Vote	Round 2 Vote	Round 3 Vote

Instructions:
1. Fill in items to be prioritized under the 'Health Indicator' column
2. Tally votes for each round of voting in the respective column

Strategy Grid

high ↑

_____   _____

_____   _____

low ↓

low ⟵ _____ ⟶ high

Instructions:

1. Fill in the blank spaces on each axis with the desired criteria
2. Label each quadrant according to the axes
3. Place competing programs/activities into the appropriate quadrant

Hanlon Method Worksheet

Health Indicator	A Size	B Seriousness	C Effectiveness of Intervention	D Priority Score (A + 2B)C	Rank

Instructions:

1. Fill in items to be prioritized under the 'Health Indicator' column.
2. Fill in the 'A,' 'B,' and 'C' columns with the assigned ratings for each health indicator with respect to the three criteria.
3. Calculate the priority score using the formula in column 'D.'
4. Rank the health indicators with the highest priority score receiving a rank of '1.'

Prioritization Matrix

Health Indicator	_____	_____	_____	Priority Score

Instructions:
1. Fill in items to be prioritized under the 'Health Indicator' column.
2. Fill in the blank spaces in columns 2, 3 and 4 with the chosen criteria.
3. Fill in the ranks for each health indicator under the appropriate criteria.
4. Calculate the priority score by adding the rankings in each row.

[i] Health People 2010 Toolkit. Setting Health Priorities and Establishing Objectives. Available at http://www.healthypeople.gov/State/toolkit/priorities.htm. Accessed February 9, 2009.

[ii] Public Health Foundation. Priority Setting Matrix. Available at http://www.phf.org/infrastructure/priority-matrix.pdf. Accessed February 9, 2010

[iii] American Society for Quality. Evaluation and Decision Making Tools: Multi-voting. Available at http://www.asq.org/learn-about-quality/decision-making-tools/overview/mutivoting.html. Accessed December 2, 2009.

[iv] Duttweiler, M. 2007. *Priority Setting Tools: Selected Background and Information and Techniques*. Cornell Cooperative Extension.

[v] American Society of Quality. Idea Creation Tools: Nominal Group Technique. Available at http://www.asq.org/learn-about-quality/idea-creation-tools/overview/nominal-group.html. Accessed December 2, 2009.

[vi] National Association of County and City Health Officials. 1996. Assessment Protocol for Excellence in Public Health: Appendix E.

Appendix E
Prioritization Sheet

**Community Health Needs Assessment
and Implementation Plan 2014–2016**

ALLINA HEALTH
MERCY HOSPITAL

NW Metro Prioritization (Hanlon Method)				
Issue	Size	Seriousness	Ability to influence	Priority Score
Obesity	10	10	6	180
Chronic Disease	7	9	7	175
Tobacco Use and Exposure	8	9	6	156
Violence	7	8	6	138
Aging/Service Needs of Elderly	6	8	6	132
Maternal Infant Health	7	6	5	95
Needs of underserved	6	6	5	90
Alcohol Abuse	9	9	3	81
Mental Health	7	6	4	76
Housing	5	7	4	76
Teen Pregnancy	4	6	4	64
Healthcare Associated Infections	4	7	3	54
HIV	3	6	3	45
Educational Needs				0
Transportation (lack of)				0

Appendix F

Justification Sheet

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
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Allina Health 🌿

NW Community Health Council
Wednesday, November 28th, 2012
Mercy Hospital Board Room
Minutes

Attendance:

George Steiner, Chair	Lex Lawson, MD
Gary Alberts	Joel Esmay, MD
Deets Mittelstadt	Barb Hanson
Laurel Hoff	Jerry Maeckelbergh
Chad Lanners	Elaine Voss
Patty Halvorson	Craig Malm, Staff

Community Health Needs Assessment

Craig reviewed the purpose for conducting a CHNA, the background/requirements and Allina's CHNA plan and time line. It was noted that Section 9007 of the Affordable Care Act requires that not for profit hospitals conduct a CHNA every three years; and adopt an implementation strategy to meet the community health needs identified.

Today's meeting will wrap up "Phase 1" of the CHNA, with "Phase 2" to begin in January, 2013. In Phase 2 we will engage in dialog with the community to decide on Allina's approach to each priority issue. We will accomplish this through community meetings (January-February 2013) and facilitated discussion with community members. At these meetings we will present our top 3 regional priorities, and seek input on approaches to addressing these priorities.

The goals of today's meeting are to:
- Complete our prioritization of health issues and selection of final 2-3 priority issues based on the prioritization exercise and our Council's discussion.
- Start thinking about possible community members to participate in the community dialogues in January and February

Craig explained the Hanlon method of prioritization that we would be using to aid our decision making. This method is a data-based way to prioritize health issues through rating:
- Size of health problem
- Seriousness of health problem, and
- Effectiveness of available interventions

The layout of our informational folder was reviewed. Included was:
- Data that Allina had gathered on our chosen 15 priority areas. This data was referenced often during the course of the Councils discussion, as was:
- The "County Leading Health Indicators" data that we had also utilized at our October meeting
- The listing of our 15 priority areas
- The Hanlon scoring explanation and scoring sheet. (See below)

Rating	Size of Health Issue (% of population at risk)	Seriousness of Health Issue	Effectiveness of Intervention
9 or 10	>25%	Very serious	Very effective
7 or 8	10-24.9%	Moderately serious	Moderately effective
5 or 6	1-9.9%	Serious	Effective
3 or 4	.01-.09%	Somewhat serious	Somewhat effective
1 or 2	<.01%	Not very serious	Not very effective

Health Issue	Size of Health Issue	Seriousness of Health Issue	Effectiveness of Intervention
Obesity			
Needs of Underserved (including access to medical care)			
Chronic Disease			
Mental Health			
Maternal Infant Health			
Teen Pregnancy			
Healthcare-Associated Infections			
Alcohol Abuse			
HIV			
Violence			
Educational Needs			
Tobacco Use & Exposure			
Transportation (lack of)			
Aging/Needs of Elderly			
Housing			

Council members discussed in length the scoring process and how we could be as objective as possible for each area: **size**, **seriousness** and **effectiveness of intervention(s).**

It was clarified that **"size"** would be based on the percentage (or number or rate) of the population with the problem or at risk for the problem. For "**seriousness**" the Council would try to review morbidity rates, mortality rates, economic loss, and the degree to which there is an urgency for intervention. There was much ensuing discussion on whether we would rate seriousness of the issue for the population it impacted OR for the overall population of the community. As an example HIV/AIDS is very serious for the population that it impacts, but the seriousness for the entire population is much less significant, than for a more rampant health issue, such as obesity. It was determined that **"seriousness"** would be based on its impact on the general population.

"**Effectiveness of intervention**" is much more difficult to score objectively, and the Council decided that we would rate all of our 15 priority issues for "size" and "seriousness" and then go through each issue to determine the **"Ability to Influence"** rather than effectiveness of the intervention.

An example discussed was that we may be able to rate effectiveness of intervention for "housing needs" as high, but as far as the "ability to influence" this problem, it may not be in the realm of a health care organization, as much as a social service organization.

Questions raised at our previous Council meeting were also brought up, prior to our scoring exercise:
- *What is the sweet spot?*
- *Match with our organization's expertise / Needs to be aligned to our mission*

- *Choose "Win-able battles" a phrase used by the CDC (Center for Disease Control and Prevention) referring to focusing on a limited number of health challenges "to achieve measurable impact quickly in targeted areas."*

Through thorough discussion, utilizing the Hanlon scoring method, the Council came up with the following scores:

NW Metro Prioritization (Hanlon Method)				
Issue	Size	Seriousness	Ability to influence	Priority Score
Obesity	10	10	6	180
Chronic Disease	7	9	7	175
Tobacco Use and Exposure	8	9	6	156
Violence	7	8	6	138
Aging/Service Needs of Elderly	6	8	6	132
Maternal Infant Health	7	6	5	95
Needs of underserved	6	6	5	90
Alcohol Abuse	9	9	3	81
Mental Health	7	6	4	76
Housing	5	7	4	76
Teen Pregnancy	4	6	4	64
Healthcare Associated Infections	4	7	3	54
HIV	3	6	3	45
Educational Needs				0
Transportation (lack of)				0

It was decided that "educational needs" and "transportation" were issues that were very important in our community, but that each could be coupled with other health issues when determining possible interventions. As an example, education may be considered an important element in addressing the issue of AIDS prevention.

The Council decided that it would be very difficult to pick a **top 2-3 issues** for the reasons that all of our minds were "full", that we needed time to step back and, that we needed to give voice to Council members that were not able to make today's meeting. All agreed that the top

4 issues were very relevant to the health of our population and those present "could live" with that top 4. The top four agreed upon are:
1. Obesity
2. Chronic Disease (Prevention)
3. Tobacco Use and Exposure
4. Violence

Craig agreed to send the results of the Hanlon scoring out to the full Council with the request that each Council member would pick their top 3 priority areas, out of today's top 4. Each member would also indicate within each top 3 priorities picked, whether they viewed important issues within that priority as an area of focus. As an example one could indicate that "obesity" was in their top 3, but that they would prefer to focus on "youth obesity" or "addressing nutritional needs of adults and families." This process needs to be completed by the end of the year, so this will be done through email, as opposed to an in-person meeting.

The results were that Obesity was picked as the number one issue by 100% of Council members, with chronic disease prevention being picked as the # 2 issue by 70%. Violence was viewed as a higher priority than tobacco by 70% of Council members, but there were compelling reasoning with each.

It was determined that we limit our priority issues to 2, if at all possible, in terms of when we seek input from the broader community. The following is recommended as we move into 2013:
1) **Our number one issue is obesity, and a focus on childhood and youths seems to be the directive by most. It was commented that we should remain focused and try to build on some of our current good work, such as with the schools and clinics. Also mentioned was taking small steps of change to make gains – becoming more active, eating fruits and vegetables, healthy food policies at worksites, convenience stores.**
2) **Chronic disease prevention is our number 2 issue, but again it's suggested that we try to be focused and not take on too much. Chronic diseases of concern were diabetes, mental health, heart disease and stroke prevention. Tobacco use prevention could easily be tied into this work with areas noted being: worksite policies, education of our youth, & benefit design to provide incentives to be tobacco free.**
3) **Violence would be our number 3 issue, but our role here as a health organization would be not be as clear. It may be that we partner with key organizations to provide education & support policy changes that can impact this issue.**

Appendix G

Framing CHNA
Health Disparities

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
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Framing CHNA's in the Context of Healthcare Equity

"A prerequisite to improving health and reducing inequities is to consider and address social determinants of health, namely the social and physical environments in which people are born, live, learn, work, play, worship and age." (American Public Health Association et al, 2012)

What are health disparities?
Health disparities, or the unequal distribution and prevalence of illness, chronic disease, and death, are ubiquitous at a national, state and local level. Health disparities are connected to a myriad of historical, social, behavioral, environmental and biological factors. An individual's health (physical, mental, emotional, social, cultural and spiritual) is uniquely shaped by a number of factors, including (but not limited to):

- Lifestyle
- Behaviors
- Family History
- Cultural History/Heritage
- Values and Beliefs
- Hopes and Fears
- Life Experience
- Level of Education
- Neighborhood
- Spiritual Beliefs/Practices

- Cultural Group
- Gender
- Language
- Employment Status/Occupation
- Sexual Orientation
- Relationship Status
- Disability Status
- Social, Economic and Environmental Circumstance

An individual's health can be promoted or constrained by these factors, placing specific patients and populations at greater risk for chronic disease and suboptimal health.

What are health*care* disparities?
The care that patients access and receive in the hospital, clinic, community and household setting is also a factor in health disparities. Evidence of disparities within the health care setting has been documented. For example,
- the 2003 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* highlighted racial and ethnic disparities in access to care and also disparities in quality of care for those who had access (IOM, 2012), and
- the most recent *National Healthcare Disparities Report* documents socioeconomic, racial/ethnic and age disparities for a large percentage of quality of care measures they assessed (AHRQ, 2011).

What are a few examples of disparities?
National Level
Health disparities have persisted over time, where minority racial groups such as African Americans and American Indians have higher mortality rates compared to whites (IOM, 2012). Examples include:
- gaps in heart disease and cancer mortality rates between African Americans and whites (even though these mortality rates have declined in both groups, the gap between both racial groups still exists),
- a considerable gap in diabetes-related mortality rates has been present between American Indians and whites since the 1950s, and

- disparities in mortality rates for both African Americans and American Indians compared to whites exist at all age levels (across the life span).

Health disparities have also been documented where racial and ethnic minorities "experience an earlier onset and a greater severity of negative health outcomes" (IOM, 2012). Examples include:
- breast cancer outcomes,
- major depression outcomes, and
- and first birth neonatal mortality.

State Level

Statewide, there are racial/ethnic disparities in the number and magnitude of select health indicators, especially for African Americans and American Indians (MDH, 2009a; MDH, 2009b). Examples include:
- increased incidence of select STDs (HIV, gonorrhea, chlamydia),
- pregnancy and birth disparities (prenatal care, low birth weight, teen births, infant mortality),
- select chronic disease mortality (diabetes, heart disease, cancer, chronic lower respiratory disease), and
- stroke, mortality rates, and homicide.

Disparities are also present among Hispanics, especially with select STDs incidence, pregnancy and birth disparities, and diabetes mortality rates (MDH, 2009a; MDH, 2009b). All of the mentioned racial/ethnic minorities also have higher rates of uninsurance compared to Whites (MDH, 2009b). Evidence also suggests significant disparities for specific health indicators when comparing urban versus rural populations (MDH, 2011). Examples include:
- higher diabetes, stroke, heart disease, pneumonia and influenza mortality rates are some examples of disparities in rural populations compared to urban populations, and
- higher uninsurance, smoking, obesity, and suicide rates and reporting of "fair" or "poor" health are also examples of disparities in rural communities.

Metro Area

In the Metro Area, a study by Wilder Research in 2010 commissioned by the Blue Cross and Blue Shield of Minnesota Foundation identified unequal distribution of health in the Twin Cities based on median area income, education, race and neighborhood conditions (Helmstetter et al, 2010). For example, the report highlights disparities in health outcomes for American Indians residing in the Twin Cities Metro Area, indicating American Indians in the metro area have: the lowest life expectancy (61 years) compared to Asians (83 years) and whites (81 years); the highest mortality rate (3.5 times higher than whites); and the highest diabetes rate (18%) compared with the overall average for Hennepin County (6%).

Hennepin County

In Hennepin County, according to a Survey of the Health of All the Population and the Environment (SHAPE), lesbian, gay, bisexual, and transgender (LGBT) persons have much higher prevalence of poor mental health, including frequent mental distress, depression, anxiety or panic attack, serious psychological distress, and any psychological distress. Smoking, binge drinking, and heavy alcohol use are also higher among LGBTs compared to non-LGBT adults. Rates of LGBTs who currently lack health insurance, or who were not insured at least part of the past year were almost twice as high as those who are not LGBT. Disparities within the healthcare setting are also apparent: "[c]ompared to their non-LGBT peers, LGBT residents are more likely to report experiencing discrimination while seeking health care, have unmet medical care needs and unmet mental health care needs" (SHAPE, 2012).

Allina Health

At Allina Health, preliminary research is beginning to suggest disparities in care and outcomes. For example:

- an internal study by Pamela Jo Johnson, MPH, PhD and her cohorts identified significant disparities in hospital admission rates for potentially-avoidable hospital care for Ambulatory Care Sensitive Conditions (ACSC), especially for chronic conditions. Overall, 10% of 2010 hospital admissions at Abbott Northwestern Hospital were due to diabetes complications and significant disparities by race/ethnicity were noted. Specifically, 36% of Hispanic admissions, 20% of American Indian admissions, and 15% of Black admissions were due to diabetes, compared with only 8% of White admissions (Johnson et al, 2012), and

- preliminary analysis of 2010 optimal diabetes control data from Allina clinics 2010 data by Jennifer Joseph, MPH, and her cohorts show substantial disparities in optimal status by race/ethnicity. Only 37% of Blacks and 37% of American Indians achieved optimal control status compared with 51% of non-Hispanic whites. Analysis indicates that Blacks and American Indians have significantly higher odds of sub-optimal diabetes control compared to non-Hispanic whites (Joseph et al, 2012).

These examples indicate that opportunities may exist for enhanced clinical care and self-management support for chronic disease for some populations to reduce potentially-avoidable hospital care and to improve optimal control of chronic disease, such as diabetes.

What are healthcare systems doing to eliminate healthcare disparities?

Many healthcare systems, including Allina, are working to identify and understand disparities in care and outcomes and to develop and implement evidence-based solutions to promote healthcare equity. Healthcare equity is a key component of our national and local healthcare agenda (U.S. Department of Health and Human Services, 2012; National Prevention Council, 2011). In addition, health equity is inherently related to care quality, and equitable care is one of the six aims for quality improvement identified by the IOM in their groundbreaking report *Crossing the Quality Chasm* (IOM, 2001). Healthcare equity initiatives are expected to:

Improve:
- Quality of Care
- Patient Outcomes
- Patient Safety
- Patient Experience/Satisfaction

Reduce:
- Potentially Preventable Events
- Potentially Preventable Hospital Care
- Readmissions
- Medical Errors
- Overall Healthcare Costs

Identifying Healthcare Disparities within the Hospital and Clinic Setting

Recent improvements in health information technology (HIT) and electronic medical records are helping healthcare systems identify disparities in care, utilization, and outcomes. For example, leading agencies and institutions (such as the National Quality Forum, the Department of Health and Human Services, the IOM, the Joint Commission, the Health Policy Institute, and Minnesota Community Measurement) recommend stratifying hospital quality data/measures by race, ethnicity, and language data to determine whether there are differences in quality of care for different populations. This information can be used to inform specific quality improvement initiatives to reduce disparities and improve outcomes.

Eliminating Healthcare Disparities within the Hospital and Clinic Setting
Central to the goal of eliminating disparities *within* healthcare setting are 1) knowing the unique physical, mental, emotional, social, cultural and spiritual needs of each patient we serve, 2) being aware of the unique resources and barriers to healing that are present in each patient's path to optimal healing and optimal health, and 3) engaging patients as active collaborators in the care of their health. Initiatives in data collection/analysis, patient-centered care, culturally-and linguistically appropriate services, patient engagement, patient-provider communication and shared-decision making are examples of ways that Allina is working toward this goal. In addition, there are a number of evidence-based strategies available to promote healthcare equity within healthcare settings, such as:

- Culturally-Responsive Care
- Cultural Competence Training for Providers
- Interpreter Services (for patients with a primary language other than English)
- Community Health Workers and Promotoras
- Innovative HIT Tools
- Patient-Centered Care
- Patient-Centered Communication
- Bilingual Staff

- Data Collection & Analysis
- Care Management
- Care Navigators
- Coordinated Care
- Prevention and Wellness Initiatives
- Advanced Care Teams
- Meaningful Use
- Patient Materials/Signage in Multiple Languages
- Workforce Diversity

How can Allina's Community Engagement Programs and Projects Such as the CHNA Reduce Disparities?
Allina's community engagement, community benefit, charitable contributions, community health improvement, and public policy initiatives are critical vehicles for reducing disparities and promoting healthcare equity. Since most barriers and resources to health are present within the contexts where patient's carry out their daily lives, the ability to eliminate health disparities from within the walls of hospitals and clinics is limited; conversely, the capacity to capture insights from patient voices and develop solutions within patients and their communities is almost limitless. The IOM, in their groundbreaking report *Unequal Treatment*, explain that racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life (IOM, 2003). So, as Allina works to meet the needs the physical, mental, emotional, social, cultural and spiritual needs of our patients, we have to understand and collaboratively care for our patients in the context of the homes, schools, neighborhoods, communities, and environments where our patients carry out their daily lives.

- For example, community-based efforts, multi-factorial approaches, and HIT are the 'new frontier' for reducing disparities in diabetes, according to leaders in disparities reduction who summarized the latest research in on this topic (Betancourt et al, 2012). What could this mean for Allina? Dialogue and research with patients, providers and community leaders about obstacles to optimal diabetes control at the personal, community, system and policy level may help Allina understand why standard care alone is not successful for some patients/populations. These insights and perspectives could be used to 1) inform quality improvement initiatives in diabetes clinical care delivery, 2) facilitate collaborative bridges between the medical care that is delivered in the clinic setting with additional self-care that is being fostered in the community setting, and 3) improve diabetes control in patients/populations for whom standard care alone is not successful.

Community Health Needs Assessments (CHNA's), as mandated under section 9007 of the Patient Protection and Affordable Care Act and outlined in IRS policy 2011-52, are especially promising for

understanding the specific needs of our patients and informing solutions through patient-centered dialogue in the broader context of the communities we serve. CHNA's will help Allina begin to understand 1) the barriers and resources to health and unmet medical needs of the community, 2) identify actionable opportunities, and 3) implement a community benefit implementation strategy to respond to such needs. To reduce disparities, it is important that Allina understand the needs of our communities overall, and understand the *specific needs of specific patients and populations* within the overall community. In this way, CHNA's present an opportunity for hospitals to maximize community health impact and reduce health disparities by considering social determinants of health and creating strategies to address health inequities (American Public Health Association et al., 2012; Crossley, 2012). CHNA's can be a critical tool to inform prevention, health promotion, quality improvement and healthcare equity initiatives because such assessments "can be considered alongside clinical, utilization, financial and other data to help craft health improvement solutions that take into account both the individual's health and the community context in which they live" (Bilton, 2011; Bilton, 2012).

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Appendix H
Community Dialogue Report

Community Health Needs Assessment
and Implementation Plan 2014–2016

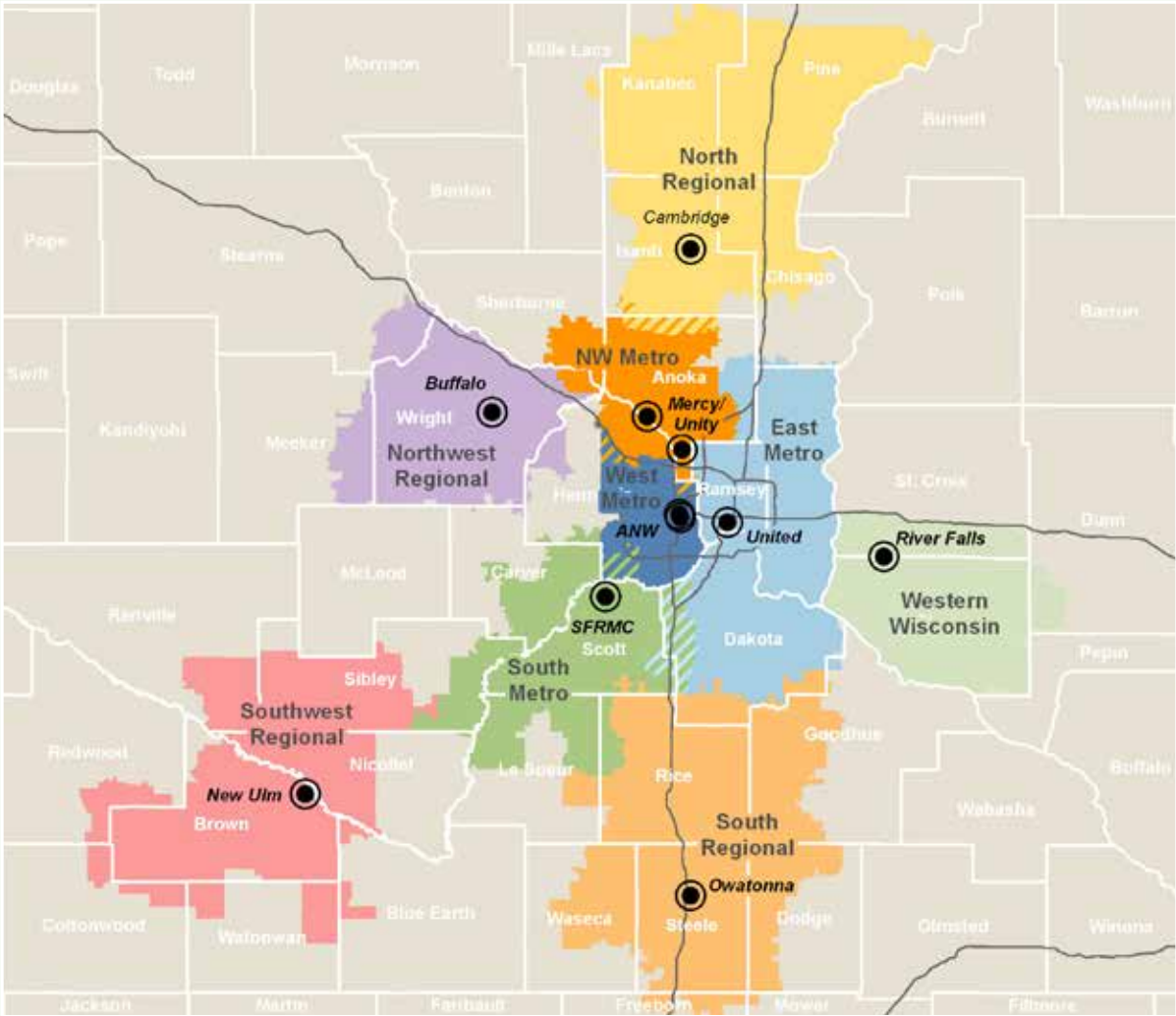**Allina Health**
MERCY HOSPITAL

NORTHWEST METRO

Allina Health

Improving health in our community

Allina Health is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families and communities throughout Minnesota and western Wisconsin.

Allina Health Community Benefit & Engagement Regional Map

Introduction

Allina Health is a not-for-profit organization of clinics, hospitals and other health and wellness services that cares about improving the health of all communities in its service area of Minnesota and Western Wisconsin. Allina Health divides its service area into nine community engagement regions, each with a regional Community Engagement Lead dedicated to working with community partners to develop specific, local plans based on community needs.

To identify and respond to the community needs present in its service area, Allina Health recently conducted a community health needs assessment at an Allina Health hospital in each of the nine community engagement regions.

The needs assessment at Mercy Hospital and Unity Hospital, part of the Northwest Metro Region, identified two priority health issues to focus on from 2014–2016 (see **allinahealth.org** for the full community health needs assessment report). They included:

- **OBESITY (CHILDHOOD/YOUTH),**

- **AND CHRONIC DISEASE PREVENTION.**

As a part of the process, the hospital hosted two community health dialogues with leaders and residents from the region to hear from a broader group of community members, identify ideas and strategies to respond to the priority issues and inform the action-planning phase of the needs assessment. A total of thirty-nine people participated.

This summary highlights the findings from the 2013 dialogues in the Northwest Metro Region, which includes Mercy Hospital and Unity Hospital.

In March 2013, Mercy Hospital, Unity Hospital, and Allina Health convened three Community Dialogues in the Northwest Metro Region.

Participants were asked to share their knowledge about the local health concerns that are most pressing among residents and their ideas about what works and what needs to be done to improve health in their community. Participants engaged in a World Café or participatory dialogue facilitated by members of Wilder Center for Communities. Participants moved through different rounds of conversation focused on obesity (childhood/youth) and chronic disease prevention.

The following summarizes key themes identified through analysis of individual discussion guides, completed by participants prior to engaging in the dialogue. In addition, where possible, themes from the dialogues are also included in the analysis. The information presented in this summary reflects the perspectives of a relatively small number of community members, and may not fully convey the diversity of experiences and opinions of residents who live in the Northwest Metro region. Allina Health believes the community members included in the dialogues conveyed useful information and insight, and they continually seek to develop an understanding of the diverse experiences and opinions of community residents.

COMMUNITY DIALOGUE PARTICIPANTS

Fridley
(March 4 and 19)

Thirteen community members participated in the Fridley community dialogue on March 4 and 19. The majority of participants were between 45 and 64 years of age. Nearly all participants reported living in a suburban community. Over half of the participants indicated representing the healthcare sector. They also cited an array of expertise in health topics including chronic disease management/ treatment/prevention, physical activity, and nutrition. Nearly all participants reported representing and/or working with adults (25-64) and white residents. In addition, several participants indicated working with and/or representing children/youth (6-17), parents of children, and senior citizen (65+).

Coon Rapids
(March 26)

Twenty-six community members participated in the Coon Rapids community dialogue on March 26. Almost half of the participants were between 25 and 44 years of age. The majority of the participants reported living in a suburban community. Many participants indicated representing the education and nonprofit sectors. They also identified an array of expertise in health topics such as nutrition and physical activity. Over three quarters of the participants cited working with and/or representing young children (0-5) and white residents. In addition, several participants noted working with and/or representing parents of children and African-American residents.

Community impact

OBESITY (CHILDHOOD/YOUTH)

Participants were asked to reflect on how childhood and youth obesity impacts people in their community. They noted that childhood and youth obesity could lead to a host of chronic health conditions such as diabetes, as well as elevate the cost of healthcare. Some participants also cited the connection between obesity and children's reduced school performance. When asked about the causes or contributing factors of childhood and youth obesity, participants reported the lack of exercise and physical activity among youth stemming from sedentary lifestyles focused on television, computers, or video games. They also referenced poor family eating habits and a lack of nutrition as a catalyst for obesity. Additionally, many participants highlighted the high cost of nutritious food and limited access to gyms or exercise facilities as major barriers to maintaining a healthy lifestyle.

CHRONIC DISEASE PREVENTION

Participants were asked to reflect on how chronic disease impacts people in their community. They shared that quality of life declines, health care costs increase, people's efficiency at work declines, and families experience elevated levels of financial and emotional stress in contending with chronic diseases. Some participants referenced specific chronic disease present in their community such as heart disease and diabetes. When asked about the causes or contributing factors of chronic disease, participants cited an array of factors such as poor nutrition, a lack of physical activity and exercise, genetic predisposition, and a lack of knowledge and resources about how to prevent chronic diseases.

Addressing health concerns in the community

OBESITY (CHILDHOOD/YOUTH)

Participants were asked to reflect on what should be done to address childhood and youth obesity. They shared a range of ideas, including:

- Having nutrition counseling available in the schools on a weekly basis for individual students
- Hosting more free physical activities and/or lowering gym memberships for families
- Teaching children/youth about gardening and growing their own foods
- Helping parents improve their health by sponsoring cooking classes, exercise activities, and discussion groups that focus on discussing health in the local community
- Creating low cost workout centers along with classes to help people in the community understand proportion sizes and healthy food choices

CHRONIC DISEASE PREVENTION

Participants were asked to reflect on what should be done to address chronic disease prevention. They suggested a variety of approaches, including:

- Creating healthy cooking classes and community programs to encourage exercise
- Emphasizing chronic disease prevention when speaking about health to youth and children, including providing them educational information to bring home to their parents
- Hosting health screenings for children and adults focused on cholesterol, blood pressure, blood glucose, etc.
- Having exercise and physical activity opportunities for families
- Partnering with County Public Health, health organizations, employers, schools and cities to provide education and prioritize ways to address issue and causes of chronic disease

How Allina Health can help address health concerns

OBESITY (CHILDHOOD/YOUTH)

Participants were asked to reflect on how Allina Health could help address childhood and youth obesity. Participants reported that Allina Health could help address childhood and youth obesity through promoting nutrition/access to healthy foods, creating more opportunities for exercise and physical activity, and increasing collaboration with community organizations. Participants specifically recommended:

- Sending nutritionist to schools to help organize healthier school lunch programs. They could consult on after school activities, gardening, cooking, and physical activities.

- Collaborating with schools, churches and other organizations that provide healthy lifestyle education. Allina health could provide funding and staff support for the community organizations that are addressing childhood/youth obesity and health concerns.

- Engaging with the YMCA to connect more youth and families to health programs and exercise.

- Creating a reward program for weight lost by a community or families (e.g., donate playground equipment if a community or families lose "x" pounds).

- Offering free or low cost classes on healthy cooking and eating for families and/or students.

- Hosting free or low cost exercise classes and activities for families.

CHRONIC DISEASE PREVENTION

Participants were asked to reflect on how Allina Health could help address chronic disease prevention. Participants shared that Allina Health could help address chronic disease prevention by concentrating on education and awareness, increasing activities/services that are focused on health, and supporting collaborations with the community organizations. Participants specifically suggested:

- Partnering with the County for a wellness at work campaign. Hennepin County has wellness at work resources for companies.

- Expanding the faith community nurse program by providing support and funding for additional participation.

- Continuing to increase the Be Fit program for employees and families.

- Sponsoring low or no cost health screening for parents at local schools.

- Offering free courses to inform people about prevention and treatment of chronic disease.

- Creating more lifestyle choice programs on nutrition, fitness, and other activities that promote health.

Conclusion

The community dialogues were an opportunity for Mercy Hospital and Unity Hospital to hear from a broader group of community members and identify ideas and strategies to respond to the priority issues to inform the action-planning phase of the needs assessment, and ultimately the action plan for Mercy Hospital and Unity Hospital for FY 2014–2016.

Intersecting social, economic, and cultural barriers impact the health of the community, and by conducting community dialogues, Allina Health gained insight into how to support the community, building on the existing assets, and engage more people in defining the problems, and coming up with appropriate solutions.

Appendix I
Community Inventory

Allina Health
MERCY HOSPITAL

Community Health Needs Assessment
and Implementation Plan 2014–2016

Mercy and Unity Hospitals CHNA Inventory and Implementation Plan 2014-2016

Issues	Key Goals	Objectives/ Indicators	Strategies/ Programs	Target Populations	Hospital Dept.	Current State of Programs (Existing, Enhancement or New)	Allina Health Role (Leader, Supporter, Partner)	Budget Impact (Low, Medium, High)	Partners
Childhood Obesity	Reduction & prevention of childhood obesity in the NW Metro Reduction of risk factors known to be contributors to youth obesity	Healthy weights for youth, Improved BMIs, Weight reduction, Increase awareness of risk factors & improved knowledge of parents and youth of the impact of good nutrition & physical activity	**Focus on:** 1) Outreach 2) Education & Awareness of resources 3) Capacity building **Education:** Increase awareness and education through programs and activities: (Involve Parents) • Cooking • Healthy eating • Gardens • Concept of balanced meals 5-2-1-0 • Physical activity • Community health fairs • Lana programs: school education program **Outreach & Capacity Building:** Build on existing successful programs: Improve access, increase locality of	Youth and Families, Homeless, low-income, diverse populations (Hispanic?) / families youth normally can't access due to fee/transport/ etc Schools, HS has in-road to reach parents M/U Service area (Reaching populations through partners)	Wellness, Faith Community Nurse Program, Community Engagement, others?	Enhancement of existing services such as school screenings and Family Power	Leader & Partner Assistance with outcome measurement	Medium Cost of healthy eating!	Public Health, Schools, Head Start, Churches, YMCA, other non-profits, community centers, Utilize strength of key partnerships (YMCA, schools, Head Start, day care providers, churches, Public Health, SHIP work) School Health Councils in regards to nutritional offerings/ Wellness Committees/ USDA mandated? Head Start mandates for nutrition/high

| | | | offerings, coordinated effort utilizing existing partners, concept of train the trainer to reach more people.

Recruit a team that reflects the targeted community (ie Hispanic community, Spanish speaking)

Expand the depth of outreach to schools (expand on screenings to introduce interventions) churches, YMCA , Community organizations (scouts),

Bring programs to population

Expand role of parish nurses (increase youth focus) , wellness program to include obesity focus

Awareness of Resources:
Improve awarenesss through Providers / PNs / and Wellness referrals to community partners

Notes:
Use logic model to lay out: use as a frame work: what each partner can do

Health Powered Kids | | | | | | caloric foods? |

			& Healthy Home (Y): Bring to others Family Power model move to group based coaching / open up to more people Search Institute data						

Issues	Key Goals	Objectives/ Indicators	Strategies/ Programs	Target Populations	Hospital Dept.	Current State of Programs (Existing, Enhancement or New)	Allina Health Role (Leader, Supporter, Partner)	Budget Impact (Low, Medium, High)	Partners
Chronic Disease Prevention	Improve the health of the underserved and/or seniors in our communities who are affected or potentially affected by chronic disease.	Increase in the number of the target population that is: -screened -educated -identified as at risk -referred or followed up for	**Focus on:** 1) Outreach & Screenings 2) Education 3) Communication & Promotion 4) Follow-up & Resources 5) Evaluation and measurement **Screenings &**	Older Adults At risk populations including: Underserved: Low income, homeless, Underinsured, unsured,	Wellness Faith Comm Nurse Program Community Engagement	Faith Community Nurse Program, Wellness Program and some clinical service lines provide community education, promote	Leader & Partner	Medium	Schools, Head start, churches, Y's Public Health Community Non-Profits, Health Partners, SHIP

		appropriate care or services

We will increase the number of target populations across the age spans (Examples: Youth, Seniors)

We will increase the number of partner community organizations for our work | **outreach:** Conduct community wide and population focused screenings. Screenings may be general or disease specific depending on intent or target population.

Education: Provide health education relative to disease prevention, self management, and accessability (including insurance eligibility). Explore health coaching.

Communication: Promote or create public awareness (visibility) and promote programs, activities & resources. wellness activities or healthy lifestyles

Follow-Up & Resources: Inventory, identify & possibly develop resources that promote healthy lifestyles and address high risk individuals.

Establish structure or protocol for | minorities | | wellness and offer health screenings

Need to expand or enhance | | | |

			follow-up with individuals identified as higher risk through screening activities **Evaluation and measurement:** Examine methods to measure patient outcomes (example: are participants making progress with established program goals such as healthy eating and exercise and weight loss) We are trying to measure more than just numbers here. Can electronic records assist with this? **Notes:** Chronic Disesase Self Management out of Stanford Evaluate data and determine where Allina can make the most impact. Allow for generational and cultural, and economic differences Communication needs to be tailored to targeted						

			population Emphasize exercise/ nutrition / holistic health Prevention work will be focused upstream, but this does not rule out disease specific activities further downstream as well (examples: screenings and education for diabetes, heart, cancer, stoke, tobacco use (high risk habits or lifestyles), vitamin D, etc.)					

Appendix J

CADCA's Seven Strategies
for Community Change

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health

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HOSPITAL

CADCA's National Coalition Institute

Defining the Seven Strategies
for Community Change

1. Providing Information – Educational presentations, workshops or seminars or other presentations of data (e.g., public announcements, brochures, dissemination, billboards, community meetings, forums, web-based communication).

2. Enhancing Skills – Workshops, seminars or other activities designed to increase the skills of participants, members and staff needed to achieve population level outcomes (e.g., training, technical assistance, distance learning, strategic planning retreats, curricula development).

3. Providing Support – Creating opportunities to support people to participate in activities that reduce risk or enhance protection (e.g., providing alternative activities, mentoring, referrals, support groups or clubs).

4. Enhancing Access/Reducing Barriers- Improving systems and processes to increase the ease, ability and opportunity to utilize those systems and services (e.g., assuring healthcare, childcare, transportation, housing, justice, education, safety, special needs, cultural and language sensitivity).

5. Changing Consequences (Incentives/Disincentives) – Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for deserved behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges).

6. Physical Design – Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density).

7. Modifying/Changing Policies – Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).