UNITED HOSPITAL
EAST METRO REGION

Community Health Needs Assessment and Implementation Plan 2014–2016

Allina Health
UNITED HOSPITAL

EAST METRO

Identifying and Responding to Community Needs

UNITED HOSPITAL

333 North Smith Avenue
Saint Paul, MN 55102

United 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. United Hospital is the largest hospital in the Twin Cities east metro area, providing a full range of health care services to more than 200,000 people each year.

United's excellent staff, modern facilities and commitment to providing patients with the best care using state-of-the-art technology has helped the hospital attract some of the most renowned and innovative practitioners in the nation. United's employees and medical staff are committed to place patient needs first and treat all individuals with compassion and respect.

Highly regarded for its clinical care, United Hospital has earned a reputation for supportive, patient-centered care designed to create the most comfortable, stress-free health care experience possible. United Hospital also has a long history of working to improve health in the community it serves through both charitable giving and direct programming efforts which address community health needs and challenges. For example, United Hospital employees partner with the West 7th Community Center to provide health and wellness education and program support as well as with St. Paul Women's Advocates, a shelter for victims of domestic abuse and a wide variety of other non-profit community partners.

LEAD PARTIES ON THE ASSESSMENT

Heather Peterson, director, Community Benefit and Engagement, East Metro Region

Angela Fitzner, coordinator, Community Health Programs, United Hospital

Melissa Hutchison, manager, Community Benefit, System Office, Allina Health

Dimpho Orionzi, project coordinator, System Office, Allina Health

John Salisbury, student intern, System Office, Allina Health

TABLE OF CONTENTS

2012 United Hospital Key Measures

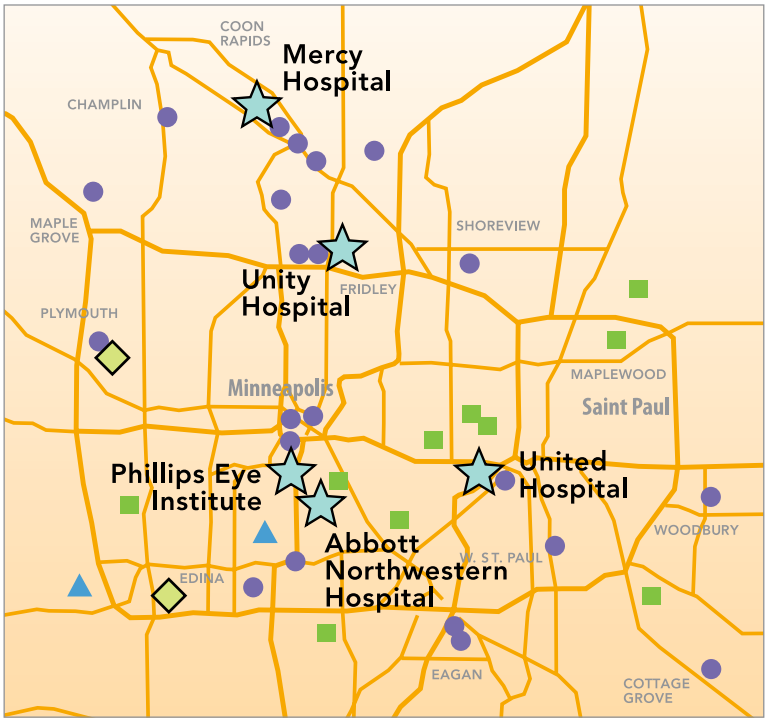
Licensed Beds	546
Staffed Beds	398
Total Operating Revenue	$462,044,540
Total Operating Expense	$430,951,812
Total Admits	24,215
Adjusted Admits	36,023
Total Patient Days	100,572
Total Number of ER Visits	51,834
Total Number of Outpatient Visits	168,352
Total Births	3,505
Number of Full Time Equivalents	2,090.9

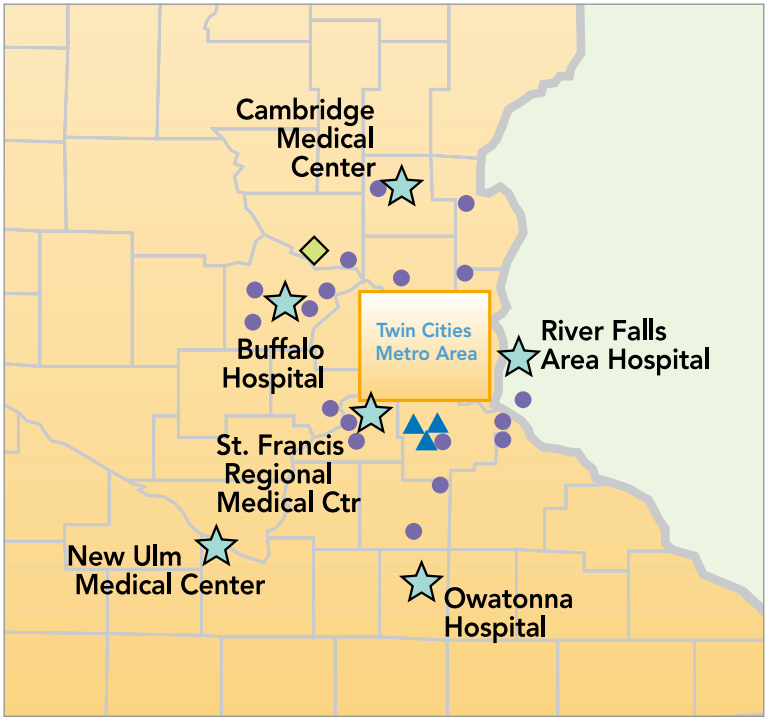
Allina Health and United Hospital Service Area

United 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



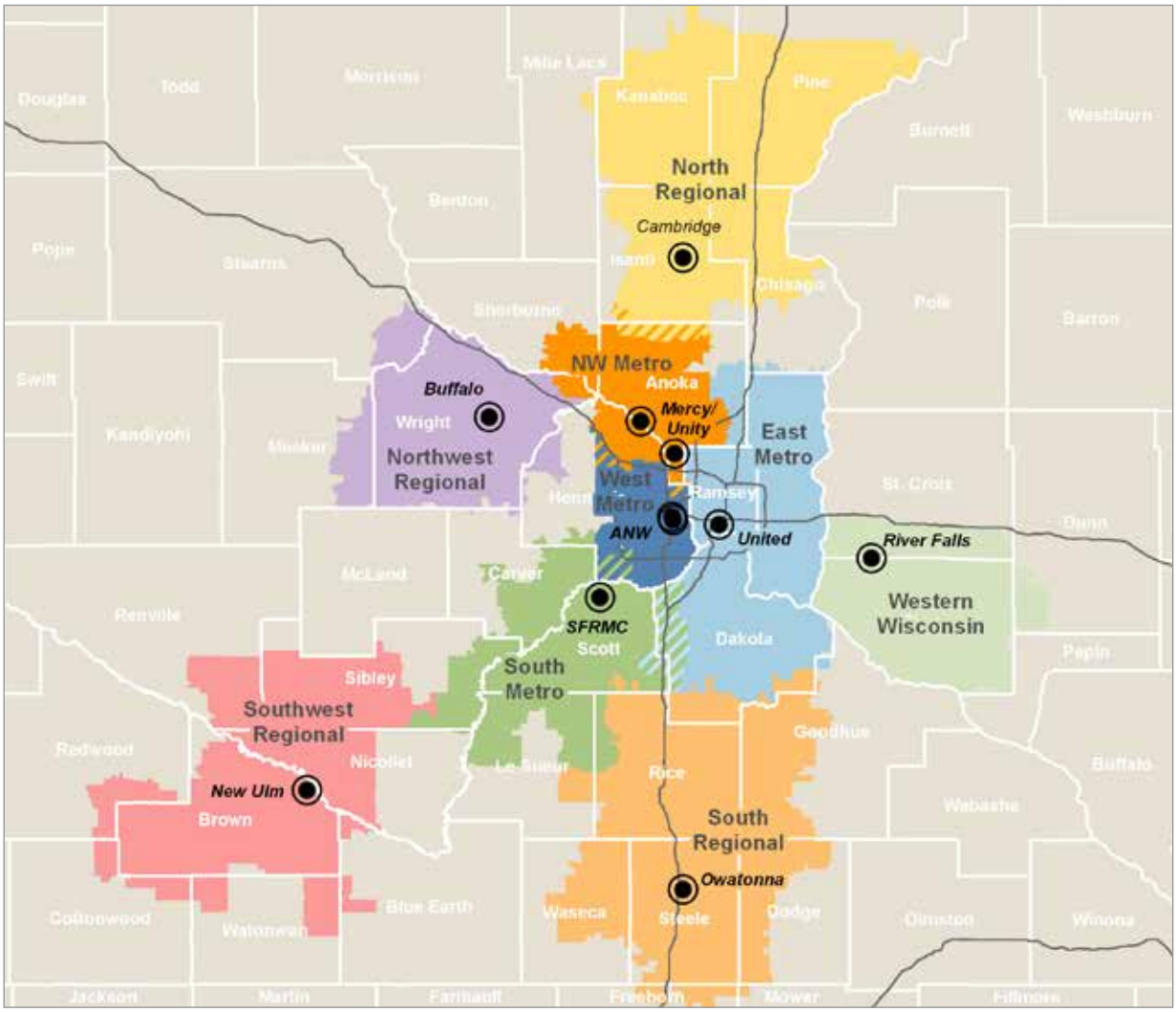


- Allina Health Hospital
- Allina Health Ambulatory Care Center
- Allina Medical Clinic
- Aspen Medical Group
- Quello Clinic

Description of Community Served by United Hospital

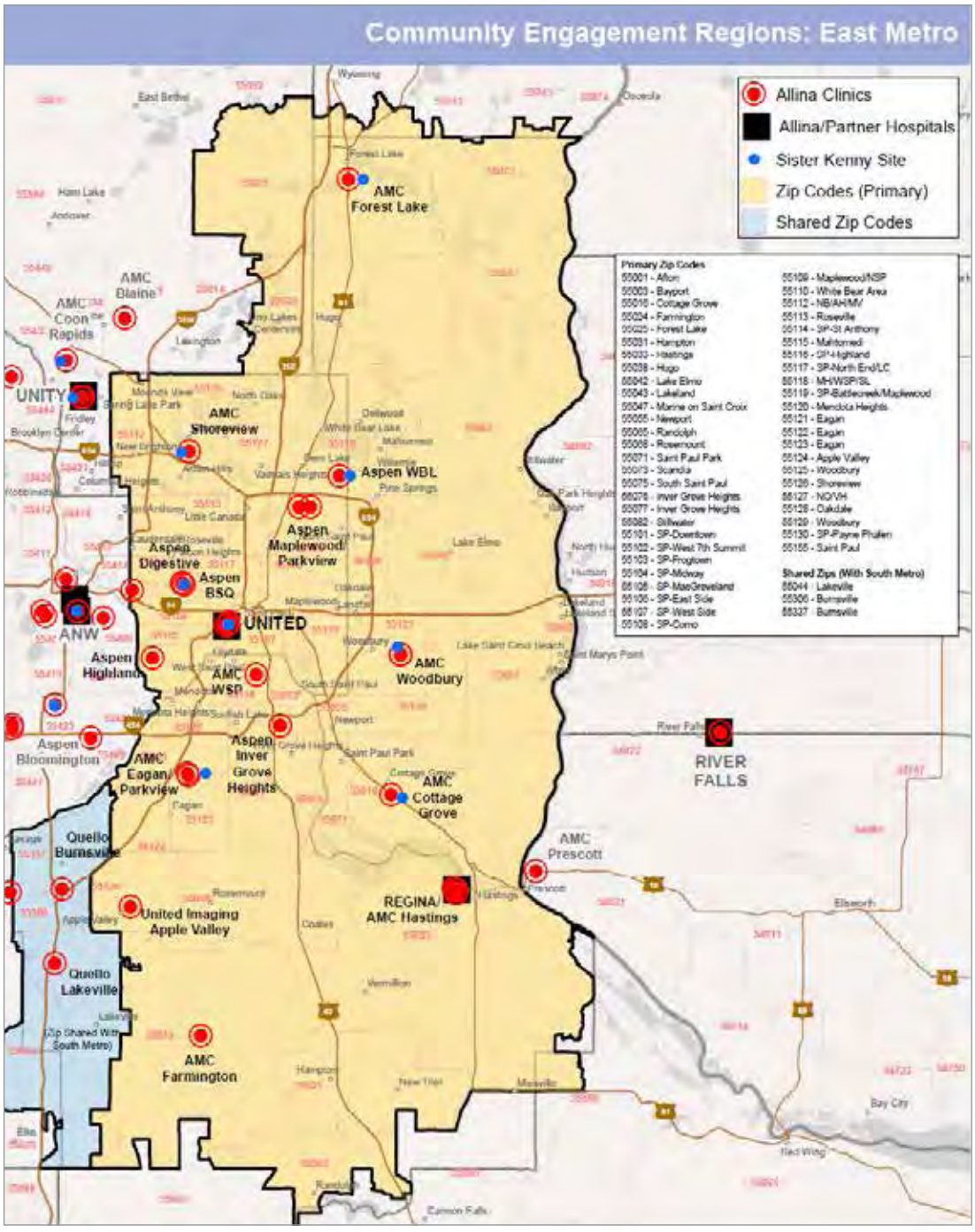
For the purposes of community benefit and engagement, Allina Health divides its service area into nine regions.

FIGURE 1: COMMUNITY BENEFIT & ENGAGEMENT REGIONAL MAP



The region associated with United Hospital is known as the East Metro Region and primarily serves Ramsey County and sections of Dakota and Washington counties in Minnesota. For the East Metro Region Community Health Needs Assessment (CHNA), the focus of inquiry was Ramsey County chosen in part because nearly 50 percent of patients served at United are Ramsey County residents, and generally Ramsey County's socieo-economic and health indicators are among the poorest in the entire Twin Cities metro area. See Appendix A for a detailed report on Ramsey County, prepared by Stratis Health. All appendices can be found on the Allina Health website (**allinahealth.org**).

FIGURE 2: EAST METRO REGION MAP



Assessment Partners

United Hospital's CHNA was conducted in collaboration and partnership with community members, community organizations, stakeholders from local public health and internal stakeholders at United Hospital. These partners assisted in the development of the hospital's priorities as well as in building the implementation plan. In addition, United Hospital partnered with Wilder Research, a branch of the Amherst H. Wilder Foundation, to conduct the community health dialogues in the East 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 East Metro Community Engagement Lead and the Community Health Programs Coordinator guided the effort for United Hospital.

The United 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 the United Hospital Community Benefit Advisory Council and the United Hospital's senior leadership team. 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, United Hospital did not collect primary data, but instead compiled existing public health data to create a set of indicators specific to health in Ramsey 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 Ramsey County and comparison data for other counties in the state.

After the initial review of these three data sources, United's CHNA work group identified additional data points that they wanted to include in the review. They included:

1. The percentage of underinsured and uninsured in Minnesota
2. Data by age, race and income of persons identified with a mental illness in Minnesota

3. Overweight and obesity rates by age in Ramsey County
4. Poverty data in Hennepin County for comparison purposes
5. Household incomes in Ramsey County and state of Minnesota
6. Data about the use of people in poverty's use of technology to access health care

See Appendix D for full set of indicators reviewed.

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

1. Access to care
2. Chronic disease
3. Mental health
4. Obesity/overweight
5. Physical activity
6. Poverty

Prioritization Process

In order to systematically select priorities, United 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, but also to ensure that participants engaged in a deeper discussion about how each issue fit within the United 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 E. 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 F 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? Does Allina Health have the ability to make an impact on 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 G.

Stakeholders were also given a report prepared by the Health Disparities Work Group of Allina Health (see Appendix H). 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, United Hospital determined the following three community health priority needs:

1. Lack of physical activity

Lack of physical activity received the highest score in the Hanlon Prioritization Process. The stakeholders chose this because interventions targeting physical activity have a wide range of effects on other important issues, such as mental health, obesity and chronic disease. Also, United Hospital, as part of Allina Health, has a history of creating effective programs which address this problem in specific populations, such as Health Powered Kids, which encourages physical movement and activity among grade-school aged children. Stakeholders were specifically interested in how United Hospital could address barriers to physical activity, such as environmental design factors that prevent walking and biking, motivation, socioeconomic factors, cultural impediments, and how people with mental health issues can increase their physical activity.

2. Limited access to care

Access to Care received the second-highest score in the Hanlon Prioritization Process. Specifically, stakeholders were interested in United Hospital's role in addressing issues related to affordability and accessibility of health care in the community, including the need for more community-based mental health services. The stakeholders felt that this issue fit well with the mission of United Hospital and Allina Health. Also, as one of the largest health care providers in the community, United Hospital is in a unique position to effectively address this issue.

3. Increasing rates of overweight/obesity

The issue of overweight and obesity was selected primarily due to the large number of people in the community who struggle with this problem. More than two-thirds (68 percent) of American adults are either overweight or obese, and this rate is mirrored in Ramsey County. Obesity is associated with a number of health-related issues with high morbidity and mortality including heart disease, stroke, type 2 diabetes and certain types of cancer these are some of the leading causes of preventable death in our country today. Also, rates of obesity are generally higher in minority and low-income persons, which is an important consideration for Ramsey County in which there is a higher proportion of low-income and minority populations than the rest of the state.

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

IDENTIFIED HEALTH NEEDS NOT SELECTED AS PRIORITIES

Poverty

Poverty was not selected as a priority based on the limited ability of United Hospital to make an impact with this issue. However, stakeholders did note that United Hospital's focus on health care access will assist in addressing outcomes related to poverty such as lack of health insurance and access to health care.

Chronic disease

According to the Centers for Disease Control, more than half of Americans live with chronic disease, many of which are related to underlying, preventable issues such as obesity, poor nutrition and physical inactivity. Chronic disease was not chosen based on the underlying role that obesity plays in increasing an individual's risk of chronic diseases, such as diabetes, heart disease and hypertension. Since obesity was chosen as a priority area for 2014-2016, the stakeholders decided that United Hospital's focus on obesity would serve to address many of the issues related to chronic disease.

Mental health

Even though mental health was not selected as a stand-alone issue, participants felt that issues related to mental health will be an important lens through which United Hospital will address the selected priority issues. For example, United Hospital will look at the connections between regular physical activity and improved mental health and how people with mental health issues face unique challenges in accessing health services. Throughout the discussion, participants raised issues and concerns related to lack of community-based, mental health services and participants frequently commented on how the other health priorities more severely impact people with mental health challenges.

Not only is there a continual need for more mental health services and better access to those services, people with mental health issues are disproportionately affected by the other health priorities and they tend to die earlier from many of these other health issues. United Hospital will continue to look at mental health issues, specifically the effect that mental health has on the priority issues selected.

Community Health Dialogues

In the spring of 2013, United Hospital held a series of meetings which were designed to solicit feedback from the community on how the 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 United 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 United Hospital's Community Health Programs Coordinator 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 22 people participated in the two community health dialogues in the East 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 United Hospital, as part of Allina Health, in addressing this issue in your community?

KEY FINDINGS

Lack of physical activity: Dialogue participants felt that United Hospital's role, as part of Allina Health, would be to increase access to and opportunities for physical activity, to provide education and outreach to community members, to work in the community to identify solutions and support existing activities, and advocate for policy and systems change.
Ideas included:

- Promoting physical activity throughout the community, including schools, medical providers, and employers and sponsor local activities and events, such as run/walks
- Engaging with physicians to include education about the importance of physical activity for routine appointments
- Supporting culturally-specific exercise programs and initiatives
- Influencing public policy at city, regional, state levels to promote positive physical activity efforts
- Investing in local efforts to change the built environment to support physical activity.

Limited access to care: Dialogue participants felt that United Hospital's role, as part of Allina Health, would be to increase access to available providers and clinics, support education and outreach to patients, collaborate with community organizations, and advocate for policy and systems change.
Ideas included:

- Establishing greater access to primary care, including more free or mobile clinics
- Encouraging patients to seek primary care rather than emergency care
- Supporting access to transportation for patients
- Addressing social determinants of health, such as access to healthy foods in disadvantaged neighborhoods
- Offering greater social work support in clinics to help patients address issues beyond health care.

Increasing rates of overweight/obesity: Dialogue participants felt that United Hospital's role, as part of Allina Health, would be to increase access to opportunities for physical activity and healthy eating, support education and outreach about obesity prevention, work with and support community organizations working in obesity prevention, and advocate for policy change. Ideas included:

- Developing or supporting community education classes aimed at healthy eating, meal preparation, etc.
- Supporting community education and outreach efforts to encourage healthy eating and physical activity, including developing materials for community members
- Supporting local community efforts, such as urban gardening
- Encouraging medical providers to offer education classes, or to write "prescriptions" for physical activity or nutrition classes
- Advocating for local and federal policies that support healthy eating and physical activity.

For a full copy of the report see Appendix I.

Community Assets Inventory

Between the community health dialogues and the action planning phase, the Community Engagement Lead and the Community Health Programs Coordinator for United 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 J 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 United 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. United Hospital used its Community Benefit Advisory Council to engage with internal and external stakeholders including Neighborhood House, St. Paul/Ramsey County Public Housing, Keystone Services, People Inc., CommonBond, St. Paul Council on Churches, and many others 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, United 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

United 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 K.

In choosing evidence-based strategies, United 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 and rates 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, United 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 summarizing the overall work that United Hospital plans to do to address its priority issues in the community. Annual work plans will be developed to provide detailed actions, accountabilities, evaluation measures and timelines.

Lack of physical activity

GOAL: Increase physical activity through policy, systems and environmental change

INDICATOR

- Increase the proportion of adults and teens who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity

United Hospital's strategy to encourage physical activity in its community will focus on two key areas, increasing public opportunities for physical activity and increasing the overall amount of physical activity among people in the East Metro Region. Planned programs include:

- Encouraging United Hospital employees to participate in community health education events and develop and expand programs which encourage behaviors shown to increase physical activity. *Partners: community centers, after-school programs, school, community organizations*
- Providing financial and volunteer support to organizations focused on serving low income individuals and individuals with disabilities with the goal of increasing physical activity, improving nutrition and reducing food insecurity. *Partners: public health, community organizations, schools, employers.*
- Actively participating in community-based initiatives focused on serving low-income individuals with the goal of increasing physical activity, improving nutrition and reducing food insecurity. *Partners: public health, community organizations, schools*
- Explore partnering with local organizations to engage in diabetes intervention program. *Partners: health care providers, community organizations, public schools*

Limited access to care

GOAL: Improve access to health care for uninsured and underinsured through education, collaboration and support

INDICATORS

- Increase the proportion of people with health insurance
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.

United Hospital's strategy to improve access to care in its community will focus on two key areas, reducing barriers to care and supporting community partners that provide care to the uninsured and underinsured. Planned programs include:

- Continuing work with health care providers to increase screening and early intervention for chronic disease, optic health and mental illness. *Partners: clinics, hospital doctors, public health, community partners*
- Exploring the possibility of enhancing community-based mental health services. *Partners: local mental health roundtables and community health care providers*
- Improving medical transportation options for seniors and low income individuals. *Partners: community based organizations*
- Supporting community-based health and human services programs designed to help individuals live independently. *Partners: block nursing programs, community service organization, public health*
- Explore convening a workgroup with the goal of developing a community resource network for low-income, under-insured and uninsured individuals. *Partners: public health, health care providers, block nursing programs, community service organizations*
- Supporting programs that provide financial assistance to low-income, under-insured and uninsured individuals. *Partners: community organizations*

Increasing rates of overweight/obesity

GOAL: Decrease obesity through outreach, community partnership and support

INDICATOR

- Reduce proportion of adolescents and adults who are overweight or obese.

United Hospital's strategy to address obesity in its community will focus on two key areas: supporting and implementing programs that encourage healthy eating in the community, and partnering with community organizations that support healthy living. Planned programs include:

- Explore partnering with local organizations to engage in diabetes intervention programs. *Partners: health care providers, community organizations, public schools*
- Utilizing United Hospital employees to participate in community health education opportunities and develop and expand programs which encourage behaviors shown to reduce obesity. *Partners: community centers, after-school programs, schools, community organizations*
- Providing financial and volunteer support to organizations focused on serving low-income individuals and individuals with disabilities with the goal of increasing physical activity, improving nutrition and reducing food insecurity. *Partners: public health, community organizations, schools, employers*
- Actively participating in community-based initiatives focused on serving low-income individuals with the goal of increasing physical activity, improving nutrition and reducing food insecurity. *Partners: public health, community organizations, schools*

Conclusion

As a not-for profit hospital, United 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 United Hospital will indirectly address these priority issues along with other needs, such as through the provision of charity care, support of Medicare and Medicaid programs, discounts to the uninsured and more. United 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.

333 North Smith Avenue
St. Paul, MN 55102
651-241-8000

unitedhospital.com

UNITED HOSPITAL
EAST METRO REGION

Appendix A

Ramsey County Profile

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
UNITED HOSPITAL

Ramsey 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

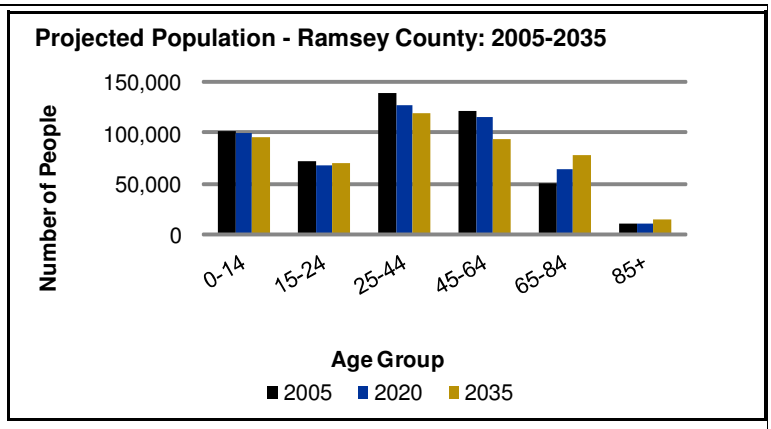
Funding provided by UCare

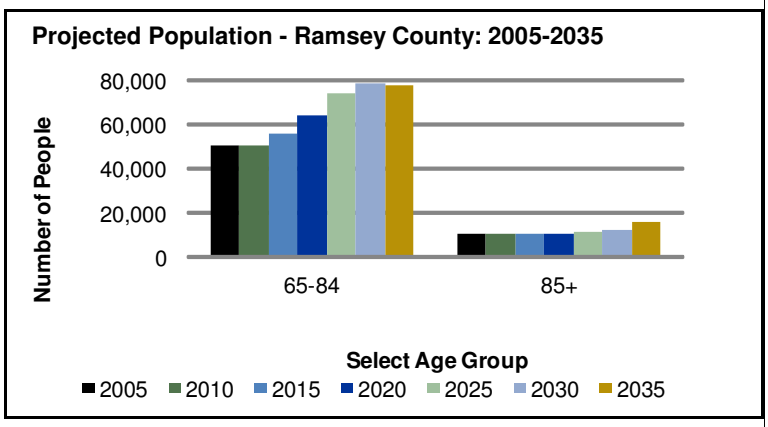
Age

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 Ramsey County, will be much older in 2035.

Population projections:

- 14 and under to fall 6%
- 15 to 24 to fall 3%
- 25 to 44 to fall 14%
- 45 to 64 to fall 22%
- 65 to 84 to rise 55%
- 85 and above to rise 52%





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:

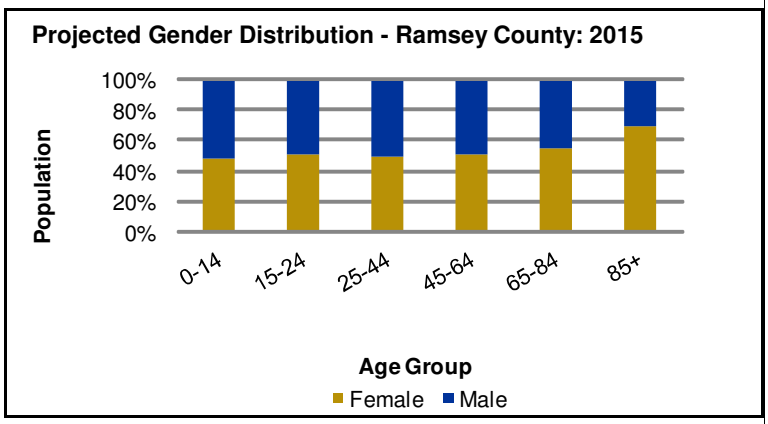
Become familiar with the needs of older populations, as well as individuals from diverse backgrounds, and develop strategies to accommodate them including: referrals to transportation services, allowing more time for patient encounters, and providing patient education materials in alternative formats.

Gender

In 2015, projections indicate the overall gender distribution for Ramsey County to be 51% female, 49% male

Variations appear when the data are viewed by age range:

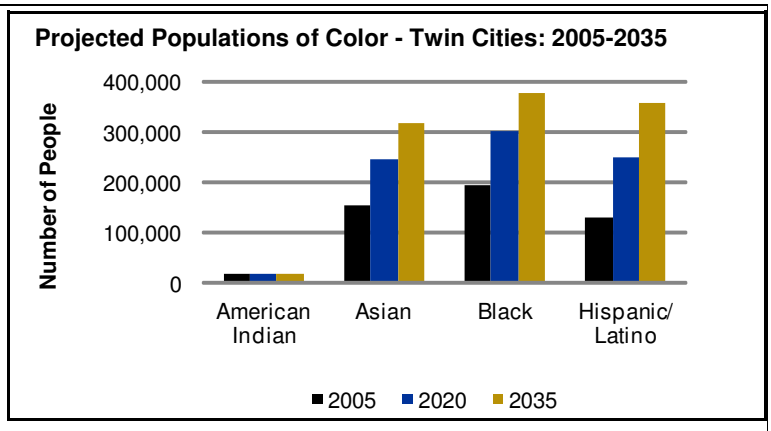
- 15 to 24: 51% female, 49% male
- 65 to 84: 56% female, 44% male
- 85 and above: 69% female, 31% male

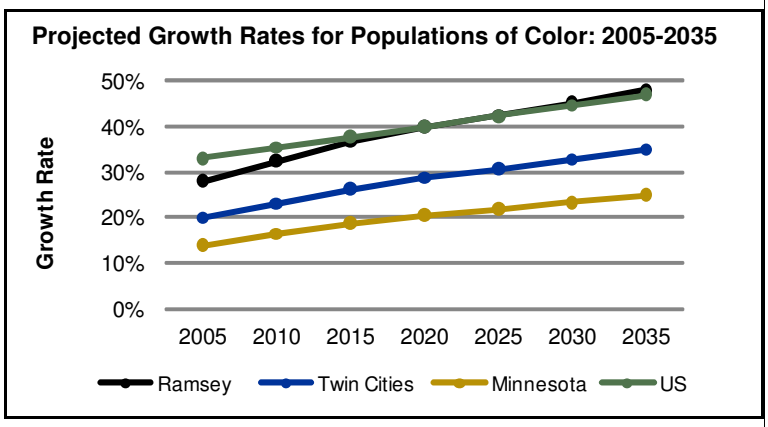


Race

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 Ramsey County (28.5%) will still lag behind 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:

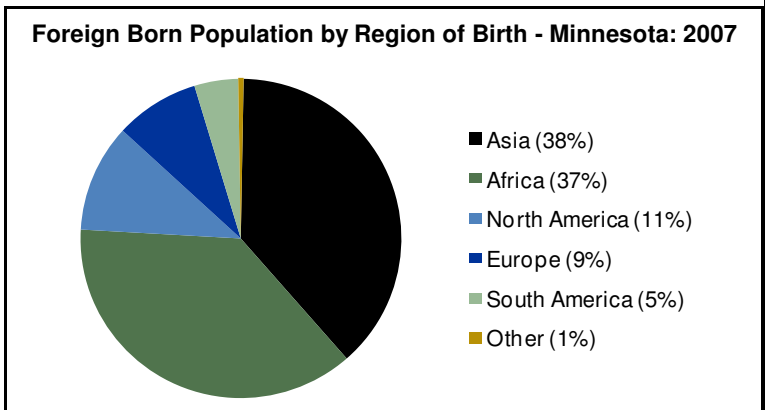
Get to know patients and staff on an individual level. Not all patients and staff from diverse populations conform to commonly known culture-specific behaviors, beliefs, and actions. Understanding an individual's practice of cultural norms can allow providers to quickly build rapport and ensure effective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



Suggestions:

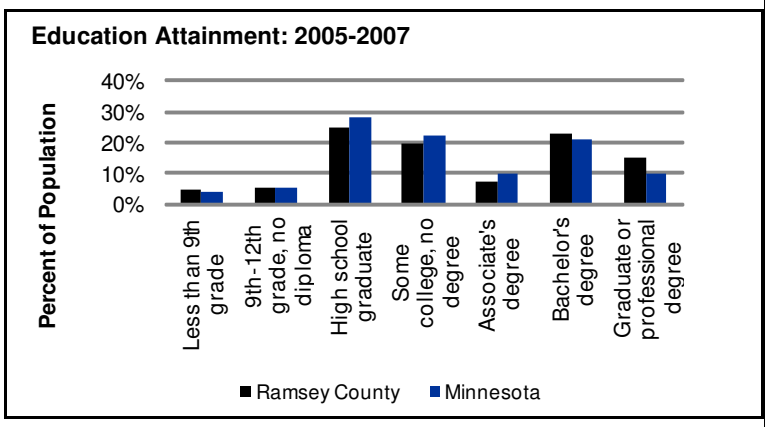
Provide information to patients not familiar with the western medical system, including guidance on obtaining health insurance, setting up initial and follow-up appointments, and practicing preventive health measures.

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.

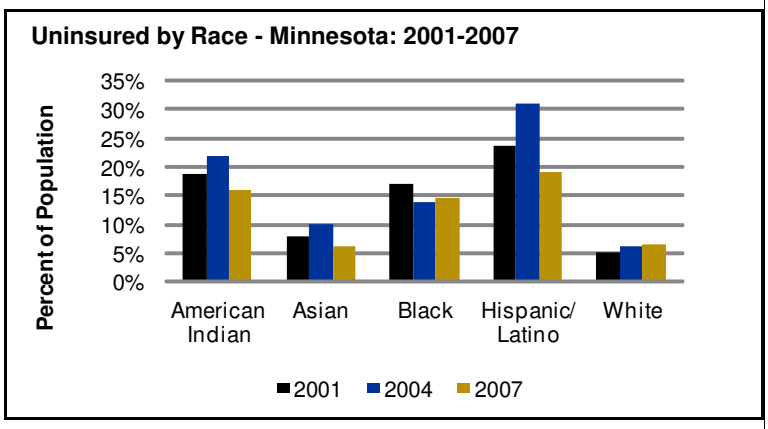
- Education influences occupational opportunities and earning potential in addition to providing knowledge and life skills that may promote health.
- Income provides a means for purchasing health care coverage but also may determine eligibility for assistance programs for those who cannot afford coverage.
- 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.

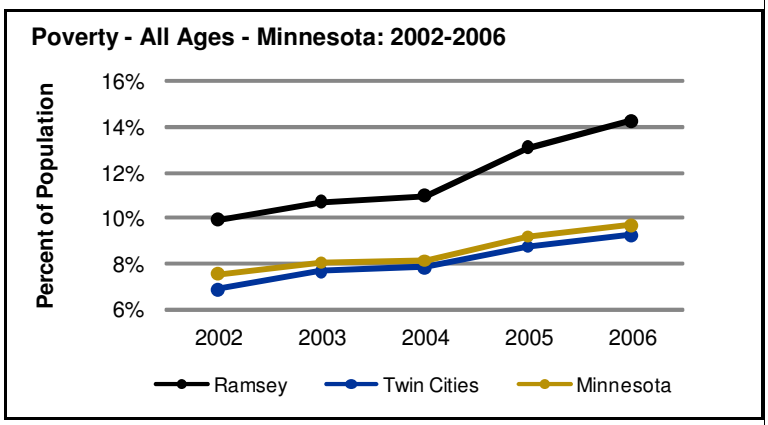
In Ramsey County, for all races, historic data indicate a lower percentage of individuals receiving at least a high school diploma compared to state level data. Attainment rates of a Bachelor's degree or greater in Ramsey County were higher than state level rates.



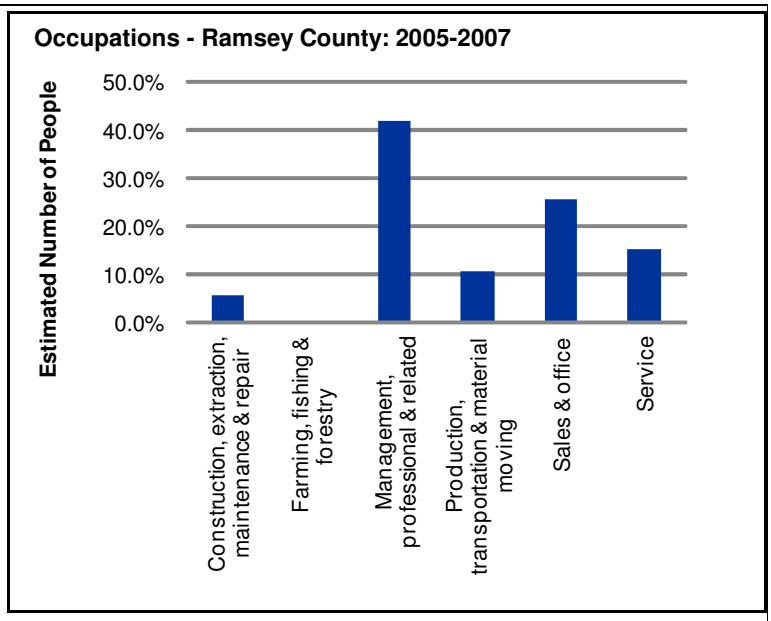
Income

In Ramsey County, the median household income based on 2005-2007 estimates was $51,862. 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.



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, 68.8 percent of the population in Ramsey 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

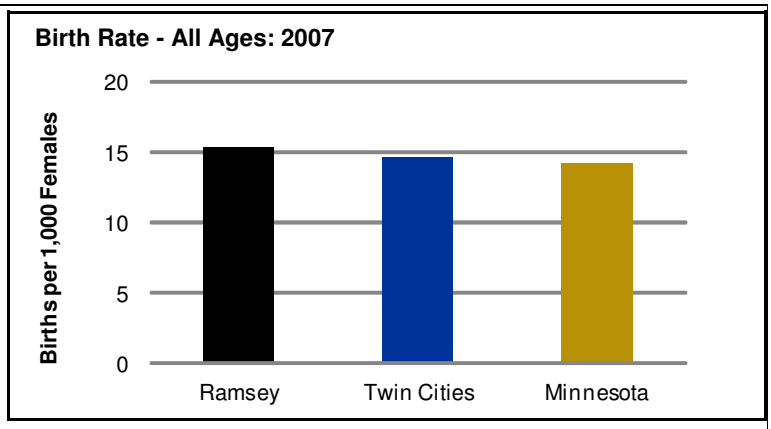
The health status data concerning birth rates and factors contributing to the incidence of disease revealed the following:

- 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

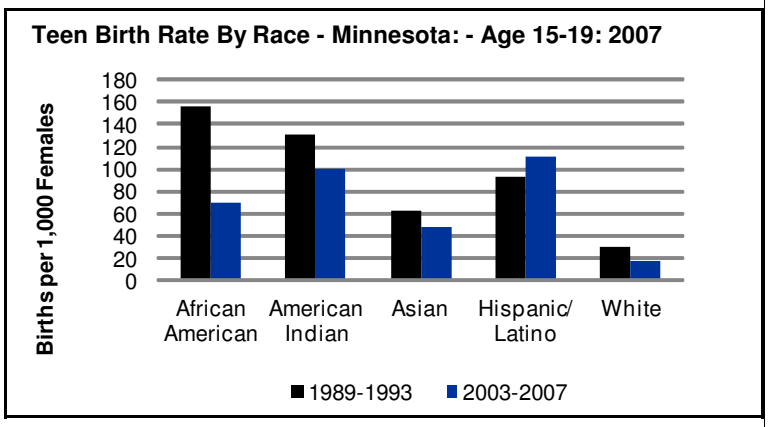
Ramsey County's birth rate of 15.4 per 1,000 population is higher than the regional and state-level rates of 14.7 and 14.2 respectively. In 2007, prenatal care was received in the first trimester for 82.2 percent of cases compared to 80.4 percent in 2003.

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.

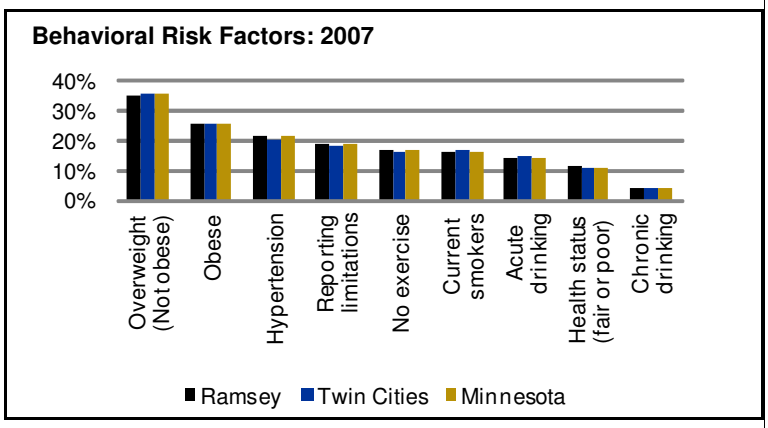


What providers need to know:

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.

Sources

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Minnesota Population Projections 2005 – 2035, Minnesota State Demographic Center, 2007.

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
Bloomington, MN 55425-1525

(952) 854-3306 telephone

(952) 853-8503 fax

1-877-STRATIS (1-877-787-2847) toll-free

info@stratishealth.org

UNITED HOSPITAL
EAST METRO REGION

Appendix B

Community Partners

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
UNITED HOSPITAL

Data Review and Prioritization Meeting at monthly East Metro Community Engagement committee meeting on September 11, 2012

Marge Avoles, Physician Services Manager at United Hospital

Joan Bjorklund, Patient Registration/Scheduler at Allina Medical Clinic – West St. Paul

Kris Coleman, ExerCare and Cardiac Rehab Manager at United Hospital

Angela Fitzner, Community Health Programs Manager at United Hospital (Meeting Recorder)

Susan Hylton, Patient Registration/Scheduler at Allina Medical Clinic – Shoreview.

Steve Horstmann, Emergency Department Director at United Hospital

Heather Peterson, Community Engagement and Benefits Director for the East Metro region of Allina Health (Facilitator)

Tanya Schally, Marketing/Communications at United Hospital

Data Review and Prioritization Meetings with external community partners

Meeting 1: Data Review on September 28, 2012
Meeting 2: Prioritization on October 31, 2012

Allina Health Staff
Angela Fitzner, Community Health Programs Manager at United Hospital (Meeting Recorder)

Heather Peterson, Community Engagement and Benefits Director for the East Metro region of Allina Health (Facilitator)

PARTICIPANTS INCLUDED:

Marge Avoles, Physician Services Manager at United Hospital

Marge organizes community health education fairs, creates partnerships with community organizations, and sits on the internal east metro community engagement team.

Helene Freint, Director of Health Care for the Homeless and HouseCalls, West Side Community Health Services

West Side Community Health Services (WSCHS) is a Federally Qualified Health Center that provides comprehensive health care and social services with bilingual/bicultural staff on a sliding fee scale. Services include primary, specialty, preventive, urgent care, complementary,

pharmacy, dental, OB/GYN, mental health, social and wrap-around services such as child care, transportation and assistance with health plan enrollment.

They serve over 35,000 patients each year from the diverse St. Paul metro area community – particularly the Latino and Hmong populations, St. Paul public housing residents, people in the homeless population, and adolescents in a service area that includes a significant portion of the City of St. Paul and Ramsey County.

Jessie Hendel, Director of Family Programs, CommondBond

CommonBond Communities, the Midwest's largest nonprofit provider of affordable housing with services, has served the region for over 40 years. CommonBond develops, owns or manages 5,200 affordable rental apartments and townhomes throughout 44 cities in Minnesota, Wisconsin and Iowa.

Participants are low-income families, seniors and people with disabilities and other barriers. In 2011, 23% of participants were African American, less than 1% American Indian, 2% Asian Pacific Islander, 25% Caucasian, 2% Latino, and 47% Unknown. On average, resident household income is $17,000 a year.

Eric Jayne, Lead Community Social Worker, Keystone Community Services

Keystone Community Services is a community-based human service organization in St. Paul, Minnesota, offering a variety of human service programs for all ages across their service area at multiple sites. Programs include three food shelves and emergency assistance; a comprehensive seniors program that provides Meals on Wheels, peer counseling and programs for active seniors; case management for seniors, the disabled and at-risk families; and a support program for Hmong youth and their families. Their service area includes the St. Paul Midway area, the North End of St. Paul, and the communities of north suburban Ramsey County.

Sharon Romano, Director of the Department of Indian Work, St. Paul Area Council Churches

The Department of Indian Work (DIW) addresses socioeconomic needs and health issues in the American Indian community, respecting the cultural and spiritual diversity of the people it serves. DIW develops and coordinates programs which empower American Indian people toward self-determination.

Ying Lee, Coordinator of Youth Programs; Ann Schulte, Director of Fitness; and Chue Xiong, Director at Emma B. Howe, St. Paul Eastside YMCA

The Eastside YMCA *is an inclusive nonprofit dedicated to strengthening communities through youth development, healthy living and social responsibility.* Populations served in the Eastside neighborhoods have incomes at or less than 200% of the federal poverty level; the median household income is under $35,000. More than 50% are single-parent households. About 25% of the families in these neighborhoods are immigrants or refugees who speak a language other than English. For these families, linguistic and culture differences can lead to a sense of isolation and lack of connection to the larger community. Many families in the neighborhoods lack access to appropriate housing, affordable childcare, living wage jobs and primary health care. They face food insecurity and related health problems like poor nutrition and obesity. Because of their lack of access to health care and other community resources, household members often have unresolved mental, physical and chemical health problems

Alicia Huckleby, Program Coordinator/HR Program Manager; and Teresa Vaplon, Program Manager, St. Paul Public Housing

St. Paul Public Housing Agency helps families and individuals with low incomes achieve greater stability and self-reliance by providing safe, affordable, quality housing, and links to community services. In 2011, the racial makeup of Ramsey County was 32% Caucasian, 36% African American, 1% Native American, and 31% Asian. 4% of the population is Hispanic or Latino of any race. The median income of participants was $14,336.

Cindi Yang, Programs Director, Neighborhood House

Neighborhood House is a multicultural settlement house originally founded in 1897. It supports families from over 50 cultural and ethnic populations in times of transition or need, drawing people from diverse communities throughout Saint Paul and beyond. The Neighborhood House mission is to help people, families and organizations develop the skills, knowledge and confidence to thrive in diverse communities.

Participants are low-income families, refugees and immigrants, and long-time residents in challenging situations. Of the nearly 15,000 individuals served annually, 65% live at or below the poverty level, over 90% are persons of color, and 70% speak a language other than English at home. In 2011, 8% of participants were African, 15% African American, 1% American Indian, 34% Asian Pacific Islander, 7% Caucasian, 26% Latino, 4% multi-racial, 1% Other, and 4% Unknown.

Diane Holmgren, Administration Manager; and Julianne Seiber, Chronic Disease Prevention Coordinator, Ramsey County Public Health

Ramsey County Public Health provides a diverse range of services as it carries out its mission to improve, protect and promote public health.

As of the census of 2011, there were 514,696 people residing in 203,382 households in the county. The racial makeup of the county was 72.6% White, 11.2% Black or African American, 1% Native American, 12% Asian, 0.1% Pacific Islander, and 3.2% from two or more races. 7.2% of the population was Hispanic or Latino of any race. The median income for a household in the county was $51,915, and 15.8% of the population was below the poverty line.

Julie Murphy, Director of Family and Youth Programs, West 7th Community Center

The West 7th Community Center, located in the heart of this urban Saint Paul community, offers a variety of human service programs that empower people of all ages to be both self-sufficient and connected with their neighbors and community.

Programs include kids after school and free summer lunch program for community youth; Fare for All Food assistance for adults; community health fairs; and a comprehensive seniors program that provides Meals on Wheels, peer counseling and programs for active seniors.

Jennifer Weigelt, Director of Treatment Services, People Inc.

People Incorporated Mental Health Services is a Twin Cities-based nonprofit providing a spectrum of services through more than 60 programs in the greater metro area. *Promoting and securing independence for people with mental illness* is their mission and they provide people with mental illness with the help they need to avoid hospitalization and institutionalization and live hopeful, meaningful lives in the community.

Programs inclue a continuum of support services to help clients stabilize their mental illnesses, improve or regain their independent living skills and realize a better quality of life. Services are provided under seven divisions: Homeless Services, Residential Services, Treatment Services, Case Management Services, Community Support Services, Clinical Services, Children and Family Services, acquired from the behavioral health services unit of Children's Home Society and Family Services. They are recognized throughout the state as a leader in providing innovative programming that responds to the needs of their clients and the community.

Mary Yackley, Supervisor of Student Health and Wellness, St. Paul Public Schools

With approximately 39,000 students, Saint Paul Public Schools is Minnesota's second largest school district. In 2011, 29.4% of students were African American, 1.7% American Indian, 31.2% Asian Pacific Islander, 24.2% Caucasian, and 13.5% Latino. 72% of students are eligible for free or reduced-price lunch.

UNITED HOSPITAL
EAST METRO REGION

Appendix C

Full Indicator List

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
UNITED HOSPITAL

County- Leading Health Indicators

People and Place

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
People and Place	1. Total population	Census	5,303,925	508,640	398,552	238.136
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	110,951	80,452	45,676
People and Place	4. Number of births	MDH MCHS	70,617	7577	5453	2,781
People and Place	5. Birth rate	MDH MCHS	13.4	15	13.8	12
People and Place	6. School enrollment for prekindergarten – 12th grade	Census	837,640	84,542	73,792	38,681
People and Place	7. Number and percent of children under age 5	Census	355,504/6.7	35,137/6.9%	27,871/6.9%	15,345/6.4%
People and Place	8. Number and percent of children aged 0-19	Census	1,431,211/26.9	135,728/26.7%	113,912/28.5%	68,825/28.9%
People and Place	9. Child (under 15 years) dependency ratio (per 100 population 15-64)	Census	29.5	28.4	30.6	31.6
People and Place	10. Number of households	Census	2,108,843	209,214	152,997	88,120
People and Place	11. Number of deaths	MDH MCHS	37,801	3,720	2045	1,274

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
People and Place	12. Total population by race and ethnicity	Census	Table II			
People and Place	13. Number of prekindergarten – 12th grade students by race/ethnicity	MDE	Table III			
People and Place	14. Percent of prekindergarten – 12th grade students with limited English proficiency	MDE	7.3%	21.5%	6.2%	3.1%
People and Place	15. Number and percent of people aged 65 years and older	Census	683,121/12.9%	61,181/12%	39,816/10%	24,984/10.5%
People and Place	16. Elderly (65+ years) dependency ratio (per 100 population 15-64)	Census	19	19.8	12.9	13.7
People and Place/Opportunity for Health	17. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	10%	7.4%	7.2%
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	Ramsey	Dakota	Washington
Opportunity for Health	20. Four year high school graduation rate	MDE	76.9%	67%	82%	88%
Opportunity for Health	21. High school dropout rate	MDE	4.8%			
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%	34%	28.8%	28.5%
Opportunity for Health	23. Percent of prekindergarten – 12th grade students receiving special education	MDE	14.6%	15.7%	14.7%	12%
Opportunity for Health	24. 2011 Unemployed rate - annual average	MN DEED	6.6%	7.8%	7.3%	6.9%
Opportunity for Health	25. Total per capita income	Census	$42,953	$45,677	$46,357	$48,617
Opportunity for Health	26. Percent of prekindergarten – 12th grade students eligible for free and reduced meals	MDE	35.5%	54%	22.7%	16.3%
Opportunity for Health	27. Percent of people under 18 years living in poverty	Census	11.4%	18.7%	5.5%	4.7%
Opportunity for Health	28. Percent of all ages living in poverty	Census	11.6%	13.5%	4.6%	4.5%
Opportunity for Health	29. Percent of people of all ages living at or below 200% of poverty	Census 5 yr ACS	25.5%	32.4%	16.2%	13.4%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
Opportunity for Health	30. Percent of housing occupied by owner	Census 5 yr ACS	78.1%	65.8%	81.8%	87.5%
Opportunity for Health	31.Percent of births to unmarried mothers	MDH MCHS	33.5%	43.6%	27.1%	24.3%
Opportunity for Health	32. Carbon monoxide poisoning (hospitalizations and ED visits age adjusted rates per 100,000)	MNHDD	6.54/.63	5/.6	3/.9	4.3/.3
Opportunity for Health	33. Percent of dwellings built before 1940	Census 2000	3.2%	4.9%	4.9%	8.6%
Opportunity for Health	34. Percent of birth cohort tested with elevated blood lead levels	MDH Lead	.5%	1.21%	.07%	.05%
Opportunity for Health	35. COPD hospitalizations (age adjusted rate per 10,000)	MNHDD	31.5	31.5	29.2	31.6%
Opportunity for Health	36. Percent of children under 18 living in single parent-headed households	Census 5 yr ACS	26.1%	34.4%	21.3	18.3%
Opportunity for Health/People and Place	37. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	10%	7.4%	7.2%
Opportunity for Health	38. Percent of 9th graders who have changed schools at least once since the beginning of the school year	MSS	5%	7%	4%	4%
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	32.9	20.6	10.8

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
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%	6%	6%	4%
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%	19%	31%	18%
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%`	25%	21%	21%
Opportunity for Health/Healthy Living	43. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	12.6	3.4	3.1
Opportunity for Health	44. Number of physicians per 10,000 population	MDH ORHPC	27	37	13	22
Opportunity for Health	45. Number of dentists per 100,000	MDH ORHPC	61.4			
Opportunity for Health	46. Percent currently uninsured	MDH MNHAS	9%	12%	9%	7%
Opportunity for Health/Healthy Living	47. Percent of mothers who initiated prenatal care in the 1st trimester	MDH MCHS	85.9%	77.9%	87.4%	90.6%

Healthy Living

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
Healthy Living	48. Birth rate per 1,000 population	MDH MCHS	13.4	15	13.8	12
Healthy Living	49. Number of births	MDH MCHS	70,617	7,577	5443	2781
Healthy Living	50. Percent of births by race/ethnicity of mother	MDH MCHS	Table IV			
Healthy Living	60. Percent of mothers who smoked during pregnancy	MDH MCHS				
Healthy Living	61. Percent of births to unmarried mothers	MDH MCHS	33.5%	43.6%	27.1%	24.3%
Healthy Living/Opportunity for Health	62. Percent of mothers who initiated prenatal care in the 1st trimester	MDH MCHS	85.9 %	77.9%	87.4%	90.6%
Healthy Living	63. Percent of births that were born premature, less than 37 weeks gestation (singleton births)	MDH MCHS	7.8%	8%	7.2%	7.2%
Healthy Living	64. Percent of birth born low birth weight, less than 2,500 grams (singleton births)	MDH MCHS	4.8%	5.4%	4.8%	4.4%
Healthy Living	65. Number of infant deaths	MDH MCHS	429	56	27	18
Healthy Living	66. Percent of 9th and 12th graders who participate in religious activities one or more times per week	MSS	43%/28%	34%/22%	45%/29%	42%/25%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
Healthy Living	67. Teen birth rate per 1,000 females aged 15-19 years	MDH MCHS	26.6	38	19.4	14.9
Healthy Living/Opportunity for Health	68. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	12.6	3.4	3.1
Healthy Living	69. Percent of 9th graders who ate five or more servings of fruit, fruit juice, or and vegetables yesterday	MSS	18%	18%	20%	19%
Healthy Living	70. Percent of 9th graders who drank three or more glasses of pop or soda yesterday	MSS	14%	15%	13%	14%
Healthy Living	71. Percent of adults who consumed five or more servings of fruits and vegetables per yesterday	Local Surveys		38.5%	40.8%	37%
Healthy Living	72. Percent of adults who reported 30+ minutes of moderate physical activity on five or more days per week	Local Surveys		44.9%	45%	43.5%
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%	48%	56%	58%
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%	65%	73%	72%
Healthy Living	75. Percent of 9th graders who spend six or more hours per week watching TV, DVDs or videos	MSS	44%	41%	44%	44%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
Healthy Living	76. Percent of adults who are excessive drinkers (binge/heavy)	Local Surveys	20.2%	20.1%	18%	20%
Healthy Living	77. Percent of 9th graders who engaged in binge drinking in the last two weeks	MSS	10%	10%	9%	9%
Healthy Living	78. Percent of 9th graders who used alcohol one or more times in the last 12 months	MSS	32%	33%	31%	33%
Healthy Living	79. Percent of 9th graders who used alcohol one or more times in the 30 days	MSS	19%	19%	18%	19%
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%/14%	3%/19%	3%/18%
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%	19%	14%	15%
Healthy Living	82. Percent of 9th graders who smoked cigarettes during the last 30 days	MSS	9%	10%	8%	9%
Healthy Living	83. Percent of adults who are current smokers	Local Surveys	16.8%	15.7%	12.5%	10.7%
Healthy Living	84. Percent of 9th graders who used chewing tobacco, snuff, or dip during the last 30 days	MSS	5%	3%	3%	5%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
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%	13%	15%	15%
Healthy Living	87. Percent of 9th graders who used marijuana one or more times in the last 30 days	MSS	10%	3%	10%	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%	52.4%	55.3%	57.1%
Healthy Living	91. Percent of 9th and 12th graders who have ever had sexual intercourse	MSS	20%/51%	22%/47%	18%/52%	18%/42%
Healthy Living	92. Among sexually active 9TH and 12th grade students: percent reporting always using a condom	MSS	56%/45%	51%/44%	67%65%	63%/48%
Healthy Living	93. Percent of 9th graders who report always wearing a seatbelt when riding in a car	MSS	66%	66%	71%	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%	16%	14%	11%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
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			
Healthy Living	96. Percent of 9th graders who felt sad all or most of the time in the last month	MSS	14%	16%	13%	11%
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%	34%	37%	32%
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%	34%	35%	32%
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%	41%	44%	41%
Healthy Living	100. Percent of 9th graders who had suicidal thoughts in last year	MSS	17%	18%	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	Ramsey	Dakota	Washington
Chronic Dis. and Cond.	102. Percent of 9th graders who are overweight but not obese according to BMI	MSS	13%	14%	12%	11%
Chronic Dis. and Cond.	103. Percent of 9th graders who are obese according to BMI	MSS	9%	11%	7%	6%
Chronic Dis. and Cond.	104. Percent of adults who are overweight according to BMI	Local Surveys	38.1%	36.3%	34%	35%
Chronic Dis. and Cond.	105. Percent of adults who are obese according to BMI	Local Surveys	24.7%	24.4%	25.8%	26%
Chronic Dis. and Cond.	106.Percent of WIC children under aged 2-5 years who are obese according to BMI	MDH WIC	13.1%	14.6%	12.9%	10.8%
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			
Chronic Dis. and Cond.	108. Asthma hospitalizations (age adjusted rate per 10,000)	MNHDD	7.5	10.6	7.3	6.1
Chronic Dis. and Cond.	109. Cancer incidence per 100,000 (all cancer types combined, age adjusted rate per 100,000)	MDH MCSS	474.9	464.3	490.5	502.5
Chronic Dis. and Cond.	110. Breast cancer incidence (age adjusted rate per 100,000)	MDH MCSS	127.3	123.4	134.4	138.2
Chronic Dis. and Cond.	111. Heart attack hospitalizations (age adjusted rate per 10,000)	MNHDD	27.3	28.4	32.4	34.8
Chronic Dis. and Cond.	112. Heart disease prevalence	Local Surveys	4.9%	2.3%	3.1%	2.7%
Chronic Dis. and Cond.	113. Stroke prevalence	Local Surveys	1.8%	4.2%	1.8%	2.1%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
Chronic Dis. and Cond.	114. Diabetes prevalence	Local Surveys	6.2%	7.5%	7.8%	6.6%

Infectious Disease

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Ramsey	Dakota	Washington
Infectious Disease	115. STD numbers (e.g. chlamydia, gonorrhea)	MDH IDEPC	Table VII			
Infectious Disease	116. Number of tuberculosis cases	MDH IDEPC	135	34	5	3
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	Ramsey	Dakota	Washington
Injury and Violence	118. Years of potential life lost before age 65 (e.g. due to injury or violence)	MDH MCHS	30,010	2,355	1,805	898
Injury and Violence	119. Unintentional injury death - age adjusted rate per 100,000	MDH MCHS	36	31	35	31.5
Injury and Violence	120. Percent of motor vehicle injuries and deaths that are related to alcohol	MN DPS	31.9%/8%	54.5%/7.6%	14.3%/7%	27.3%/9.5%
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%	10%	9%
Injury and Violence	122. Rate of children maltreatment per 1,000 children aged 0-17	MN DHS	17.6	13.5	15.2	9
Injury and Violence	123. Suicide deaths	MDH MCHS	599	53	41	22

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**

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**

Dakota

Age Group	Male	Female	Total
0-4	14,175	13,696	27,871
5-9	14,738	14,209	28,947
10-14	15,285	14,508	29,793
15-17	9,563	8,886	18,449
18-19	4,663	4,189	8,852
20-24	11,006	10,833	21,839
25-29	13,360	13,982	27,342
30-34	13,355	13,582	26,937
35-39	13,283	13,779	27,062
40-44	14,649	15,201	29,850
45-49	16,603	17,594	34,197
50-54	15,770	16,367	32,137
55-59	12,431	13,229	25,660

60-64	9,560	10,240	19,800
65-69	6,289	7,076	13,365
70-74	4,100	4,968	9,068
75-79	3,103	3,907	7,010
80-84	2,116	3,189	5,305
85&up	1,612	3,456	5,068
Total	**195,661**	**202,891**	**398,552**

Washington

Age Group	Male	Female	Total
0-4	7,852	7,493	15,345
5-9	9,096	8,771	17,867
10-14	9,492	9,338	18,830
15-17	5,897	5,659	11,556
18-19	2,835	2,392	5,227
20-24	6,123	5,697	11,820
25-29	7,364	7,266	14,630
30-34	7,056	7,178	14,234
35-39	7,770	7,906	15,676
40-44	8,989	9,578	18,567
45-49	10,142	10,594	20,736
50-54	9,760	9,916	19,676
55-59	7,870	8,219	16,089
60-64	6,358	6,541	12,899
65-69	4,189	4,355	8,544
70-74	2,733	3,163	5,896
75-79	1,950	2,356	4,306
80-84	1,317	1,842	3,159
85&up	1,011	2,068	3,079
Total	**117,804**	**120,332**	**238,136**

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
Ramsey	356,547	56,170	4,043	59,548	17,556	36,483
Dakota	339,499	18,709	1,647	17,677	11,474	23,966
Washington	209,012	8,579	1,088	12,148	5,009	8,127

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
Ramsey	38,463	17,755	1,175	18,429	8,581	84,403
Dakota	55,655	6,727	593	4,730	6,087	73,792
Washington	32,538	1,874	208	3,158	1,496	39,274

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
Ramsey	50.9	18.2	1.2	20.7	11.3
Dakota	75.2	8.7	.6	7.4	9.1
Washington	81.3	5.5	.5	9.5	4.2

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
Ramsey	42	48	39	81	76
Dakota	46	55	43	87	80
Washington	45	55	43	87	79

TABLE VI

Leading causes of death - age adjusted rates per 100,000	Heart Disease	Cancer	Stroke
State-wide	121.81	169.08	34.14
Ramsey	104.22	158.8	34
Dakota	119.69	167.58	36.98
Washington	114.28	187.09	31.16

TABLE VII

STD numbers	Chlamydia	Gonorrhea	Primary/Secondary Syphilis	Syphilis - All Stages	HIV
State-wide	15,294	2,119	149	347	331
Ramsey	2,481	339	19	42	55
Dakota	949	89	7	18	22
Washington	390	30	3	6	12

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
Ramsey	99	198	85	44	2	99	6
Dakota	62	31	69	16	0	32	4
Washington	31	25	69	11	0	26	1

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

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EAST METRO REGION

Appendix D

Additional Data Sources

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
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2010 Income Distribution of Households State of Minnesota vs Ramsey County

STATE OF MINNESOTA

INCOME AND BENEFITS (IN 2010 INFLATION-ADJUSTED DOLLARS)		
Total households	2,091,548	2,091,548
Less than $10,000	123,174	5.90%
$10,000 to $14,999	106,991	5.10%
$15,000 to $24,999	211,450	10.10%
$25,000 to $34,999	210,268	10.10%
$35,000 to $49,999	290,148	13.90%
$50,000 to $74,999	412,685	19.70%
$75,000 to $99,999	289,660	13.80%
$100,000 to $149,999	278,005	13.30%
$150,000 to $199,999	93,242	4.50%
$200,000 or more	75,925	3.60%
Median household income (dollars)	55,459	(X)
Mean household income (dollars)	71,345	(X)

RAMSEY COUNTY

NCOME AND BENEFITS (IN 2010 INFLATION-ADJUSTED DOLLARS)		
Total households	203,382	203,382
Less than $10,000	15,297	7.50%
$10,000 to $14,999	10,218	5.00%
$15,000 to $24,999	20,952	10.30%
$25,000 to $34,999	22,029	10.80%
$35,000 to $49,999	29,537	14.50%
$50,000 to $74,999	37,592	18.50%
$75,000 to $99,999	25,210	12.40%
$100,000 to $149,999	25,328	12.50%
$150,000 to $199,999	8,968	4.40%
$200,000 or more	8,251	4.10%
Median household income (dollars)	51,915	(X)
Mean household income (dollars)	70,090	(X)

Source: 2010 American Community Survey, U.S. Census Bureau,http:\factfinder.census.gov.

Demographics of internet users in 2000 and 2011

% of each group of American adults who use the internet. For instance, 76% of women use the internet as of August 2011.

	% of adults who use the internet	
	June 2000	August 2011
All adults (age 18+)	**47%**	**78%**
Men	50	80
Women	45	76
Race/ethnicity		
White, Non-Hispanic	49	80
Black, Non-Hispanic	35	71
Hispanic^	40	68
Age		
18-29	61	94
30-49	57	87
50-64	41	74
65+	12	41
Household income		
Less than $30,000/yr	28	62
$30,000-$49,999	50	83
$50,000-$74,999	67	90
$75,000+	79	97
Educational attainment		
No high school diploma	16	43
High school grad	33	71
Some College	62	88
College +	76	94

^ Note: In the 2000 survey, this included only English-speaking Hispanics. In the 2011 survey, this included both English- and Spanish-speaking Hispanics.

All differences are statistically significant except for those between blacks and Hispanics in 2011.

Sources: The Pew Research Center's Internet & American Life Project's May 2000 Tracking Survey conducted May 19-June 21, 2000. N=2,117adults age 18 and older. Interviews were conducted in English. // The Pew Research Center's Internet & American Life Project's August Tracking Survey conducted July 25-August 26, 2011. N=2,260 adults age 18 and older, including 916 interviews conducted by cell phone. Interviews were conducted in both English and Spanish.

More: http://pewinternet.org/Static-Pages/Trend-Data/Whos-Online.aspx

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EAST METRO REGION

Appendix E

Hanlon Process

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
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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~~	√√√	√√	

~~to healthcare services~~			

Red = Round 1 Elimination Green = Round 2 Elimination Blue = Round 3 Elimination

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.

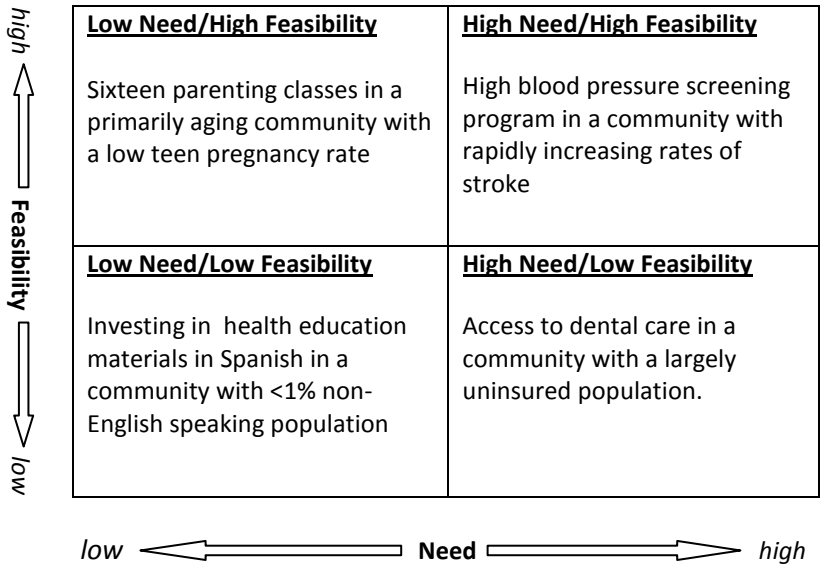
The strategy grid below provides an example of an LHD's effort to refocus efforts towards programs that will feasibly result in the greatest impact. Refer to the example strategy grid below while working through the step-by-step instructions.

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



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 x B)] x 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.

<u>McLean County Health Department - The Hanlon Method Example:</u>
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.

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Appendices

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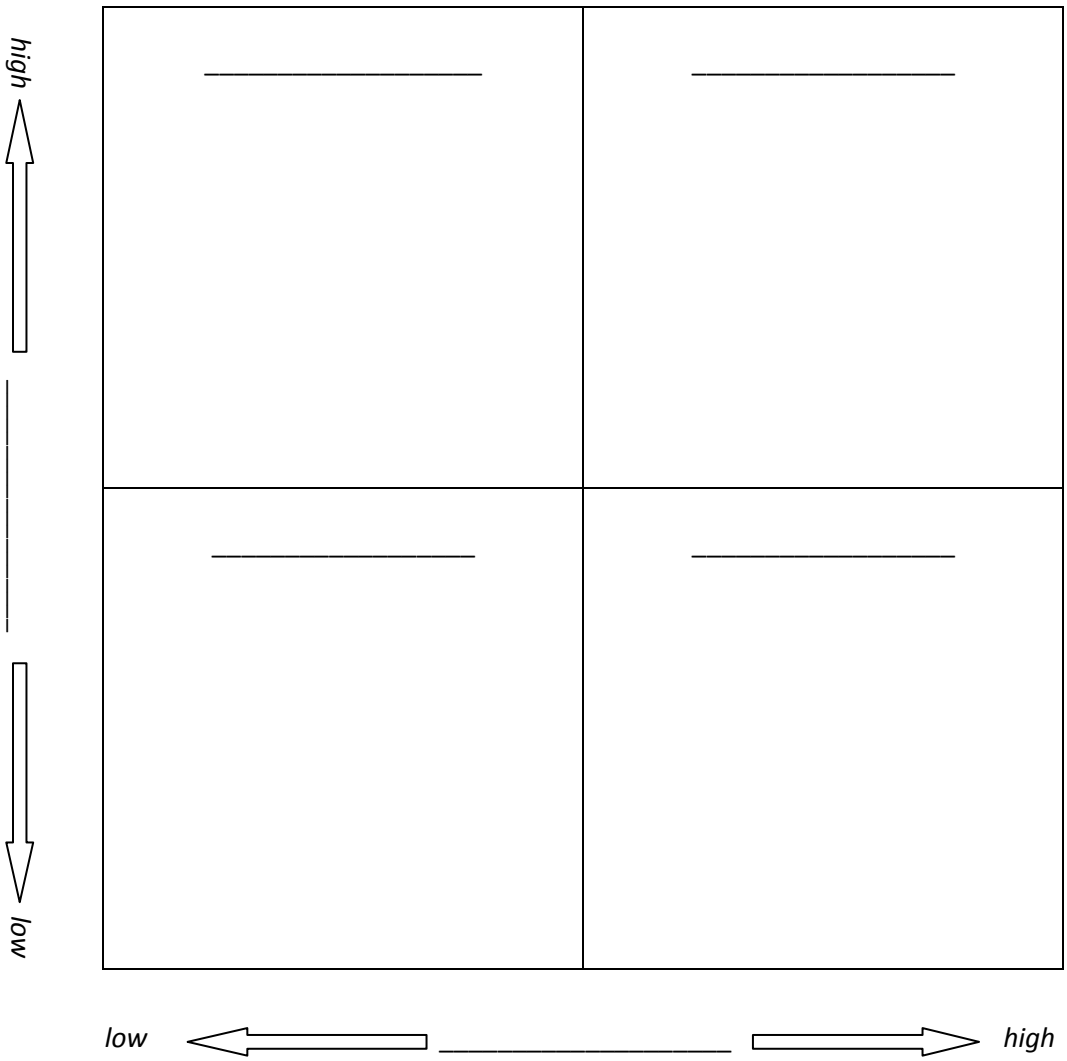
3 Round Multi-voting Template

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



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

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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.

UNITED HOSPITAL
EAST METRO REGION

Appendix F

Prioritization Sheet

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
UNITED HOSPITAL

East Metro

Access to Care	Size	Seriousness	Effectiveness	Priority Score
Group 1	7	9	8	
Group 2	7	7	4	
Group 3	7	8	4	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	7	8	5.333333333	**122.6666667**

Chronic Disease	Size	Seriousness	Effectiveness	Priority Score
Group 1	9	8	6	
Group 2	9	8	3	
Group 3	9	9	3	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	9	8.333333333	4	**102.6666667**

Mental Health	Size	Seriousness	Effectiveness	Priority Score
Group 1	8	9	5	
Group 2	8	9	3	
Group 3	8	9	2	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	8	9	3.333333333	**86.66666667**

Overweight & Obesity	Size	Seriousness	Effectiveness	Priority Score
Group 1	10	9	5	
Group 2	10	8	2	
Group 3	10	10	4	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	10	9	3.666666667	**102.6666667**

Physical Activity	Size	Seriousness	Effectiveness	Priority Score
Group 1	10	9	7	
Group 2	10	6	5	
Group 3	10	8	3	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	10	7.666666667	5	**126.6666667**

Poverty	Size	Seriousness	Effectiveness	Priority Score
Group 1	7	10	3	
Group 2	7	10	1	
Group 3	7	10	4	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	7	10	2.666666667	**72**

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Appendix G

Justification Sheet

Community Health Needs Assessment
and Implementation Plan 2014–2016

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East Metro Regional External Stakeholders
2-3 Priorities

Priority	**Ranked Score**
Physical Activity	127

Barriers to physical activity: environmental factors that prevent walking and biking, motivation, socioeconomic factors, cultural, etc.

Access to Care 123
Affordability and accessibility of health care.

Overweight/Obesity 103
More than two-thirds (68%) of American adults are either overweight or obese.

Chronic Disease 103

***Mental Health** 87

Physical Activity, Access to Care and Overweight/Obesity were chosen based on the Allina Health's ability to collaborate among many stakeholders, utilize assets and implement interventions beyond clinical services. These health issues each received an average effectiveness rating of 4 or 5.

NOTE: Even though Mental Health was not ultimately rated among the top three health priorities, issues and concerns related to lack of community-based, mental health services continually surfaced throughout the small- and large-group discussions and consideration of the indicators of health, and participants frequently commented on how the other health priorities more severely impact people with mental health challenges. Not only is there a continual need for more mental health services and better access to those services, people with mental health issues are disproportionately affected by the other health priorities and they tend to die earlier from many of these other health issues.

Unselected Issues

Chronic Disease	103
Poverty	72

Chronic disease was not chosen based on the underlying role that obesity plays in increasing an individual's risk of chronic diseases, such as diabetes, heart disease and hypertension.

According to the CDC, more than half of Americans live with chronic disease, many of which are related to underlying, preventable issues such as obesity, poor nutrition and physical inactivity.

Poverty was not chosen based on the Allina Health's limited ability to impact the health issue.

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Appendix H

Framing CHNA Health Disparities

Community Health Needs Assessment
and Implementation Plan 2014–2016

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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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UNITED HOSPITAL
EAST METRO REGION

Appendix I

Community Dialogue Report

Community Health Needs Assessment
and Implementation Plan 2014–2016

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ALLINA HEALTH COMMUNITY DIALOGUE

EAST METRO

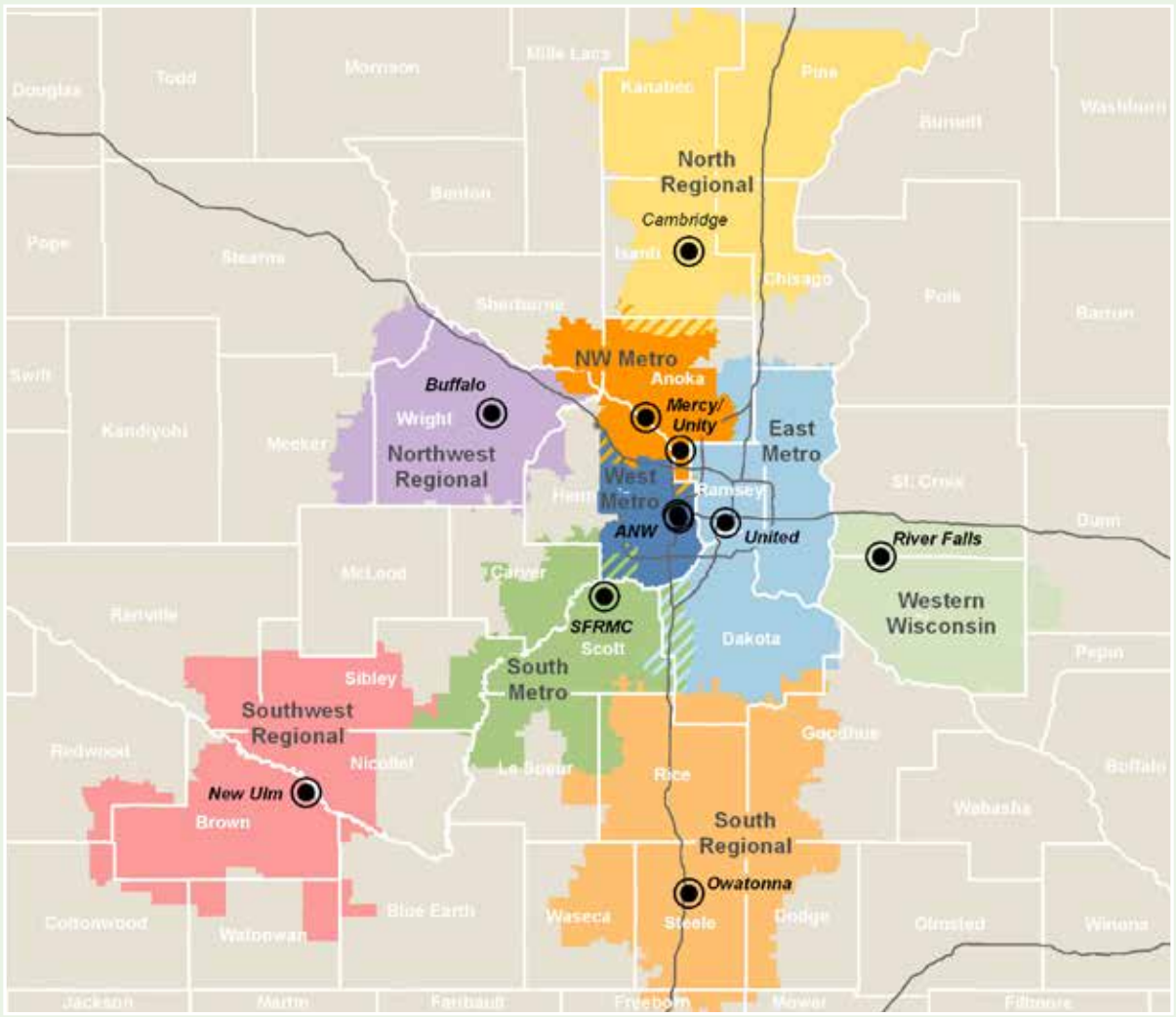
APRIL 2013

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 United Hospital, part of the East Metro Region, identified three priority health issues to focus on from 2014–2016 (see **allinahealth.org** for the full community health needs assessment report). They included:

- LACK OF PHYSICAL ACTIVITY,
- ACCESS TO CARE,
- AND OBESITY.

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 twenty-two people participated.

This summary highlights the findings from the 2013 dialogues in the East Metro region, which includes United Hospital.

In February 2013, United Hospital and Allina Health convened two Community Dialogues in the East 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, lack of physical activity, and access to health care.

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 East 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

Saint Paul #1

Ten community members participated in the first east metro community dialogue. Most were 45 years old or older. Half of the participants reported living in a metropolitan community; others noted living in a large town or suburban community. Participants represented healthcare, faith-based organizations, and information technology. Seven reported that they were currently retired. They also cited an array of expertise in health topics including: nutrition, physical activity, and mental health. Most participants reported representing and/or working with adults and white residents. In addition, many participants indicated working with and/or representing older adults, parents of children, and individuals with physical disabilities.

Saint Paul #2

Twelve community members participated in the second east metro community dialogue. More than half of the participants were between 45 and 64 years of age. Many participants indicated representing the heath care and non-profit sectors. They also identified an array of expertise in health topics, such as: obesity prevention, nutrition, and chronic disease management and prevention. Several participants also cited working with and/or representing adults (25-64) and older adults (65+).

Community impact

LACK OF PHYSICAL ACTIVITY

Participants were asked to reflect on how lack of physical activity impacts people in their community. They noted a lack of physical activity can lead to physical and mental health problems, and difficulty in individuals managing their weight. Participants acknowledged that physical activity can be challenging for busy families, that many in the community lack access to safe and affordable exercise opportunities, and that there is a lack of programs specific to cultural groups, including older adults. Participants highlighted the availability of Saint Paul parks and recreation centers, and an emphasis on biking and walking in the community as key community assets.

ACCESS TO CARE

Participants were asked to reflect on how access to care impacts people in their community. Participants reported that community members may have limited awareness of or knowledge about available resources. In addition, access to resources may be limited due to concerns about cost of services, lack of insurance and/or concerns about copays, in addition to transportation to existing services. Some participants also discussed cultural concerns, and concerns related to stigma that prevents some in the community from accessing needed services. Finally, a few participants noted a need for increased availability of services.

OBESITY

Participants were asked to reflect on how obesity impacts people in their community. Participants reported the obesity leads to health-related concerns, including chronic disease. Participants identified limited access to healthy foods and ready access to less-healthy foods, limited physical activity, and lack of knowledge of how to maintain health as contributing factors. In addition, participants expressed concern that children and families had limited access to healthy activities in the community.

Addressing health concerns in the community

LACK OF PHYSICAL ACTIVITY

Participants were asked to reflect on what should be done to address a lack of physical activity. Participants shared a range of ideas to increase physical activity in the community, including the following:

- Increasing access to existing opportunities for physical activity
- Developing new, culturally appropriate activities
- Increasing collaboration between community partners to maximize existing resources
- Improving access to existing services and resources.

Specific examples included:

- Workplace promotion of physical activity
- Development of public education campaigns
- Offering of exercise classes in parks or easily accessible community centers
- Encouragement of more community-wide physical activity
- Improving access to existing resources by ensuring existing public transportation is available to all

ACCESS TO CARE

Participants were asked to reflect on what should be done to address access to care. Participants suggested a variety of approaches to addressing access to care, including:

- Outreach and education about existing services and resources where community residents can receive information
- Increase the availability of services by expanding clinics or adding clinics
- Increase medical provider competencies for working cross-culturally
- Collaborate with community organizations and community leaders to find solutions within the community

OBESITY

Participants were asked to reflect on what should be done to address obesity. Participants shared the importance of increasing access to and opportunities for physical activity and healthy foods. Several participants felt it especially important to focus efforts on children and families, to start good habits early. Participants also highlighted the importance of analyzing the food and physical activity environments of community residents, to identify ways in which the environment could be modified to promote good nutrition and physical activity, such as modifying vending machine contents or increasing fresh fruits and vegetables at local stores. Finally, participants felt it important that community leaders and members were engaged in identifying solutions.

How Allina Health can help address health concerns

LACK OF PHYSICAL ACTIVITY

Participants were asked to reflect on how Allina Health could help address a lack of physical activity. Participants reported that Allina Health could help address physical activity through increasing access to and opportunities for activity, providing education and outreach to community members, working in community to identify solutions and support existing activities, and advocate for policy and systems change. Participants specifically suggested:

- Promoting physical activity throughout the community, including schools, medical providers, and employers and sponsor local activities and events, such as run/walks
- Engaging with physicians to include education about the importance of physical activity for routine appointments
- Supporting culturally-specific exercise programs and initiatives
- Influencing public policy at city, regional, state levels to promote positive physical activity efforts
- Investing in local efforts to change the built environment to support physical activity

ACCESS TO CARE

Participants were asked to reflect on how Allina Health could help address access to care. Participants shared that Allina Health could help improve access to care by increasing access to available providers and clinics, supporting education and outreach to patients, collaborating with community organizations, and advocate for policy and systems change. Participants specifically noted:

- Establishing greater access to primary care, including more free or mobile clinics
- Encouraging patients to seek primary care rather than emergency care
- Supporting access to transportation for patients
- Addressing social determinants of health, such as access to healthy foods in disadvantaged neighborhoods
- Offering greater social work support in clinics to help patients address issues beyond health care

OBESITY

Participants were asked to reflect on how Allina Health could help address obesity. Participants indicated that Allina Health could help address obesity by increasing access to opportunities for physical activity and healthy eating, supporting education and outreach about obesity prevention, work with and support community organizations working in obesity prevention, and advocate for policy change. Participants specifically referenced:

- Developing or supporting community education classes aimed at healthy eating, meal preparation, etc.
- Supporting community education and outreach efforts to encourage healthy eating and physical activity, including developing materials for community members
- Supporting local community efforts, such as urban gardening
- Encouraging medical providers to offer education classes, or to write "prescriptions" for physical activity, nutrition classes
- Advocating for local and federal policies that support healthy eating and physical activity

Conclusion

The community dialogues were an opportunity for United 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 implementation plan for United 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.

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Appendix J

Community Assets Inventory

Community Health Needs Assessment
and Implementation Plan 2014–2016

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UNITED HOSPITAL/EAST METRO
COMMUNITY HEALTH NEEDS ASSESSMENT
REGIONAL INVENTORY

Priority Area #1: Physical Activity (selected by community-based data review workshops hosted by United)

Program/Service Name	Program/Service Description	Location of Activity	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
The Trust for Public Land	Green Line Parks and Commons Initiative	Community	All ages		
Community Health Fairs	United employees promoting physical activity throughout the community.	Community	All ages	Angela Fitzner	A variety of community-based organizations
Neighborhood Health Connection	An Allina Health program that offers grants to community members and organizations to build connections and increase healthful activities. The program includes: • Free health screenings • Pedometer Fitness Challenge • Grant opportunities	Community	All ages	Heather Peterson	A variety of community-based organizations and individuals
School Health Connection	An Allina Health program that gives educators tools and services to encourage healthy lifestyles in students, teachers and families. Ten schools were chosen through a competitive application process. More than 80 schools submitted	Elementary Schools	Youth and families	Heather Peterson	East metro elementary schools

Program/Service Name	Program/Service Description	Location of Activity	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
	applications to receive the health expertise of the Allina Health medical community, plus: • Grant dollars to promote healthy activities in schools; • Online learning tools and teacher trainings; and • A health fair for the entire school community.				
Free Bikes 4 Kidz	An Allina Health partnership that helps kids ride into a happier, healthier childhood by providing bikes to those most in need.	-Hospital -Clinic -Community	Youth and families	Heather Peterson	A variety of community-based organizations, schools and families
Community Health Education	Presentations, lectures and workshops by United employees that promote physical activity.	Community-based organizations	-Low-income -Community members -Businesses	-Marge Avoles -Jodi Denker -Angela Fitzner -Heather Peterson	A variety of community-based organizations
Health Powered Kids	An Allina Health program that provides schools and families fun, easy-to-use information about health and wellness. It empowers children and teens to make healthy choices about what to eat, how to stay active and manage stress.	-Schools -Community-based organizations	Youth and families	Heather Peterson	-East Metro area schools -Community-based nonprofit organizations

Program/Service Name	Program/Service Description	Location of Activity	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
	Health Powered Kids™ includes: • school-based lessons and activities on nutrition, physical fitness and mind-body balance • activities for families • workshops and events for children, teens, teachers and parents that focus on healthful activities, such as meal planning, illness prevention, exercising and health screenings • mind-body activities for stress-reduction and relaxation • health-incentive tools, such as pedometers, jump ropes and water bottles • health and wellness information available through the internet and printed materials				

Program/Service Name	Program/Service Description	Location of Activity	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
Active Living Ramsey Communities	Encourages healthy lifestyles by bringing people and resources together to build more active, bikeable, and walkable communities.	Community	All ages	Heather Peterson	-Ramsey County Public Health -City planners -Transportation organizations
Ramsey County Community Health Services Advisory Committee	Advises, consults with, and makes recommendations to the Commissioner of Health on matters relating to the development, funding, and evaluation of community health services in Minnesota.	Community	All ages	Heather Peterson	-MN Dept. of Health -Community members -Public Health
Allina Health Charitable Contribution	Community walks, runs, and rides focused on physical activities.	Community	All ages	Heather Peterson	-Ramsey County Library -Hastings YMCA Fun Run -Pinewood School 5K
Allina Health Charitable Contribution	The Learn to Ride program teaches adults who haven't had the chance to learn to ride a bike.	Community	Adults	Heather Peterson	Cycles for Change
Allina Health Charitable Contribution	Ski programs offered in Battle Creek park to youth and adults.	Community	Adults	Heather Peterson	SISU Foundation
Allina Health Charitable Contribution	Fitness boot camp designed for teens in St. Paul's West 7th neighborhood.	Community	Adults	Heather Peterson	SOKOL
Allina Health Charitable Contribution	20 toolkits with physical activity equipment to enhance or expand physical education.	Schools	Youth	Heather Peterson	St. Paul Public Schools
Allina Health	Tennis programs in schools	Community	All ages	Heather Peterson	United States Tennis

Program/Service Name	Program/Service Description	Location of Activity	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
Charitable Contribution	and urban environments for youth.				Association
Allina Health Charitable Contribution	Support of community gardens that provide access to good nutrition and physical activity.	Community	All ages	Heather Peterson	-Sholom Homes -West 7th Community Center
Allina Health Charitable Contribution	Support of bike kiosks in St. Paul.	Community	Adults	Heather Peterson	Nice Ride MN
Allina Health Charitable Contribution	Support for the purchase of new badminton racquets for teens.	School	Teens	Heather Peterson	Harding High Badminton Team
Allina Health Charitable Contribution	Partnerships with non-profit organizations that provide programs that promote physical activities.	Community	All ages	Heather Peterson	-Camp Fire USA -YMCA Eastside -St. Paul YWCA
Access to Places for Physical Activity	Partnerships with neighborhood associations, municipalities, and parks and recreation to improve access to built environments for physical activity.	Community	All ages	Heather Peterson	-Community-based organizations -Green Lines Parks and Commons Initiative
United's Employee Health & Wellness	Internal employee health & wellness events encouraging physical activity.	Hospital	Employees	Jodi Denker	-United States Tennis Association - Nice Ride MN
Mission Matters – Walks, Runs & Rides	An Allina Health program that rewards employees' participation in charitable events.	Community	Employees	Angela Fitzner	A variety of community-based organizations

Priority Area #2: Access to Care (selected by community-based data review workshops hosted by United)

Program/Service Name	Program/Service Description	Location of Activity	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
United's Public Program Enrollment	Public program enrollment assistance for patients.	Hospital	Low-income		MedEligible Services
Greater MN Ride Service	A United program that provides free transportation for patients whose destination is United or a clinic with physicians on the United Hospital Medical Staff.	Hospital	Low-income	Marge Avoles	Allina EMS
Portico Healthnet	Nonprofit health and human services organization that helps uninsured Minnesotans access affordable health coverage and care.	-Clinics -Hospital	Low-income and vulnerable populations		
United Family Medicine	An independent, nonprofit provider of primary health care, physician training, health promotion and outreach services.	Federally Qualified Health Center (FQHC)	-Low income -All ages	-Alison Peterson, MD - Heather Peterson	Healthy West 7th! initiative
Community Health Screenings	Free community health screenings conducted by United employees	Community	-Low-income -Adults	-Jodi Denker	A variety of community-based organizations

HealthEast Pre-Diabetes Prevention, a community partner	A HealthEast community health initiative focuses resources, partnerships and established diabetes education for individuals at risk for diabetes	Community	-Low-income -Adults		A variety of community-based organizations
Anchor Institutions	Hospitals, universities, colleges and clinics collaborating in economic development and community revitalization initiatives.	Community	-Low-income -All ages	-Jim McGlade -Heather Peterson	Community-based foundations and organizations
Allina Health Charitable Contribution	Community partners dedicated to the needs of homeless youth and/or adults.	Community	Low-income and vulnerable populations	-Face-to-Face Board of Directors: Terri Dresen -Many hospital employee groups provide volunteer hours	-Face-To-Face -Listening House -St. Paul Women's Advocates
Allina Health Charitable Contribution	Support of an Alliance whose goal is to ensure that adults experiencing mental health crises receive timely, high quality integrated services in the least restrictive setting—regardless of ability to pay or county of residence.	Community	Low-income and vulnerable adults	Heather Peterson	-East Metro Mental Health Alliance -A variety of community-based organizations
Allina Health Charitable Contribution	Support of a program that provides free or low-cost medications, provided by pharmaceutical companies, to patients.	Community	Low-income and vulnerable populations	Heather Peterson	-Mental Health Drug Assistance Program -A variety of community-based organizations
Allina Health	Health Care for the Homeless	Community	Low-income and	Heather Peterson	West Side Community

Charitable Contribution	and Project Homeless Connect event support.		vulnerable populations		Health, a FQHC
Allina Health Charitable Contribution	Support of neighborhood block nurse programs	Community	Seniors	Heather Peterson	-MacGroveland Block Nurse program -St. Anthony Block Nurse program
East Metro Health Project MN Alliance of Community Health Workers (CHW)	Supporting local efforts to incorporate the role of the CHW in the health and social service sectors to decrease health disparities by reducing the social economic risk factors for the underserved population in Minnesota.	Community	Low-income and vulnerable populations	Heather Peterson	A variety of community-based organizations
Mission Matters	An Allina Health program that supports employee volunteerism, service may include organizations that address social determinants of health	Community	Low-income and vulnerable populations	Heather Peterson	A variety of community-based organizations

Priority Area #3: Overweight/Obesity (selected by community-based data review workshops hosted by United)

Program/Service Name	Program/Service Description	Location of Activity • hospital • clinic • community	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
Health Powered Kids	An Allina Health program that provides schools and families fun, easy-to-use information about health and wellness. And, it empowers children and	-Schools -Community	Youth and families		-East Metro area schools -Community-based organizations

Program/Service Name	Program/Service Description	Location of Activity • hospital • clinic • community	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
	teens to make healthy choices about what to eat, how to stay active and manage stress.				
yumPower, a community partner	A HealthPartners initiative to promote and educate the public about healthier food choices.	-Schools -Community	Youth and families		A variety of community-based organizations
Community Health Fairs	United employees promoting healthy eating and nutrition throughout the community	Community	-Low-income -All ages	-Marge Avoles -Jodi Denker -Angela Fitzner	A variety of community-based organizations
Community Health Education	Presentations, lectures and workshops by United employees to encourage health eating	Community	-Low-income -All ages	-Marge Avoles -Jodi Denker -Angela Fitzner	A variety of community-based organizations
Neighborhood Health Connection	An Allina Health program that offers grants to community members to build connections and increase healthful activities.	Community	All ages	Heather Peterson	A variety of community-based organizations
School Health Connection	An Allina Health program that gives educators tools and services to encourage healthy lifestyles in students, teachers and families.	Elementary Schools	Youth and families	Heather Peterson	Selected schools
Free Bikes 4 Kidz	An Allina Health partnership that helps kids ride into a happier, healthier childhood by providing bikes to those most in need.	-Hospital -Clinic -Community	Youth and families	Angela Fitzner	A variety of community-based organizations

Program/Service Name	Program/Service Description	Location of Activity • hospital • clinic • community	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
Ramsey County Nutrition Commission	A forum for public and private stakeholders to assess how local food systems are operating and suggest policies, share information and plan for increased access to safe, affordable and nutritious foods.	Community	All ages	Heather Peterson	A variety of community-based organizations
UMN "Simply Good Eating" Program, a community program	This University of MN program provides hands-on nutrition education classes, promotion of healthy school environments, and continuing education for community professionals.	Community	All ages		A variety of community-based organizations
East Metro Prosperity Campaign	Supporting local efforts by participating with organizations and residents whose vision is an engaged, powerful and equitable East Side, including a Health and Wellness committee.	Community	All ages	Angela Fitzner	A variety of community-based organizations
Mobile Food Truck	Exploring opportunities to support local efforts to increase access to healthy foods.	Community	-Low income -All ages	Heather Peterson	-Emergency Food Shelf Network -Mississippi Market
Allina Health Charitable Contribution	Supporting local farm to table efforts by nonprofits focused on youth initiatives and	Community	Youth and families	Board of Directors: Jim MCGlade -Angela Fitzner	-Community Design Center of MN -Roots for the Home

Program/Service Name	Program/Service Description	Location of Activity • hospital • clinic • community	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
	educational programs on eating healthier.			-Heather Peterson	Team
Allina Health Charitable Contribution	Supporting local efforts by improving the health and wellness of Saint Paul's West End through education and sponsorships of community gardens	Community	All ages	-Angela Fitzner -Heather Peterson	Healthy West 7th!
Allina Health Charitable Contribution	Support of community gardens that provide access to good nutrition and physical activity	Community	All ages	Heather Peterson	Farmington Community Education
Allina Health Charitable Contribution	Support of nutrition programs for people with developmental disabilities	Community	All ages	Heather Peterson	-Highland Friendship Club -Lifeworks
Allina Health Charitable Contribution	Support for providing healthy food for community meetings	Community	Adults	Heather Peterson	St. Paul District Councils
Allina Health Charitable Contribution	Support of scholarships for a youth obesity program	Community	Teens	Heather Peterson	-Allina Medical Clinic – Hastings -Hastings YMCA
Breastfeeding Resource Center	United educational program that offers support and professional advice for women who choose to breastfeed their babies.	Hospital	Women	Birth Center	
Allina Health's Healthy Lifestyle Programs	Offering employees worksite weight management meetings and webinars	Hospital	Adults		-Lifetime Fitness -Weight Watchers

Program/Service Name	Program/Service Description	Location of Activity • hospital • clinic • community	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
Allina Health ‘s Wellness Rewards Program	The 2013 Wellness Rewards Program, featuring myHealthCheck, is designed to encourage and incent employees and their medical enrolled spouse/partner to achieve or maintain good health	Hospital	Adults	Human Resources	Lifetime Fitness
Allina Health's Healthy Food Initiative	Allina Health provides employees information and choices to support healthy eating	Hospital	Employees		

UNITED HOSPITAL
EAST METRO REGION

Appendix K

CADCA's Seven Strategies for Community Change

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
UNITED 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).