

NEW ULM MEDICAL CENTER
SOUTHWEST REGIONAL

Community Health Needs Assessment and Implementation Plan 2014–2016

SOUTHWEST REGIONAL

Identifying and Responding to Community Needs

NEW ULM MEDICAL CENTER

1324 Fifth North Street

New Ulm, MN 56073

New Ulm Medical Center 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. New Ulm Medical Center serves the Brown County and sections of Sibley and Nicollet counties in south central Minnesota. New Ulm Medical Center offers an extensive range of care options with more than 30 affiliated physicians and a full complement of visiting specialists. New Ulm Medical Center is accredited by the Joint Commission. New Ulm Medical Center is an integrated health care organization, the result of a merger between Sioux Valley Hospital and the New Ulm Medical Clinic in 1996. This integration culminated many years of close cooperation between the two facilities, which had been operating on the same campus since 1991, when physicians built a new clinic adjacent to the hospital. The same year, the two organizations merged laboratory, radiology and medical records departments. Today, primary care services are provided to residents in a 25-mile radius around New Ulm, including the communities of Sleepy Eye, Searles, Courtland, Nicollet, Klossner, Lafayette and Winthrop. Many patients drive 60 to 80 miles to receive specialty services as orthopedics, general surgery, obstetrics and gynecology, psychiatry and pediatrics.

New Ulm Medical Center also has a long history of working to improve health in the community it serves through both charitable giving by the New Ulm Medical Center Foundation and direct programming efforts which address health needs in the community.

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For example, the Children’s Health Initiative programming is focused on preventing and/or decreasing the incidence of childhood obesity, the Heart of New Ulm program is aimed at decreasing heart attacks in New Ulm and the Heart Safe Community program, which places AEDs in public locations, is making the community a safer place to live, work and play by being prepared to reduce the number of deaths and disabilities associated with sudden cardiac arrest.

2012 New Ulm Medical Center Key Measures

Licensed Beds.....	62
Staffed Beds.....	35
Total Operating Revenue	\$79,969,987
Total Operating Expense.....	\$68,905,070
Total Admits.....	2,494
Adjusted Admits.....	10,821
Total Patient Days	7,390
Total Number of ER Visits.....	11,286
Total Number of Outpatient Visits	109,040
Total Births	319
Number of Full Time Equivalents	359.1

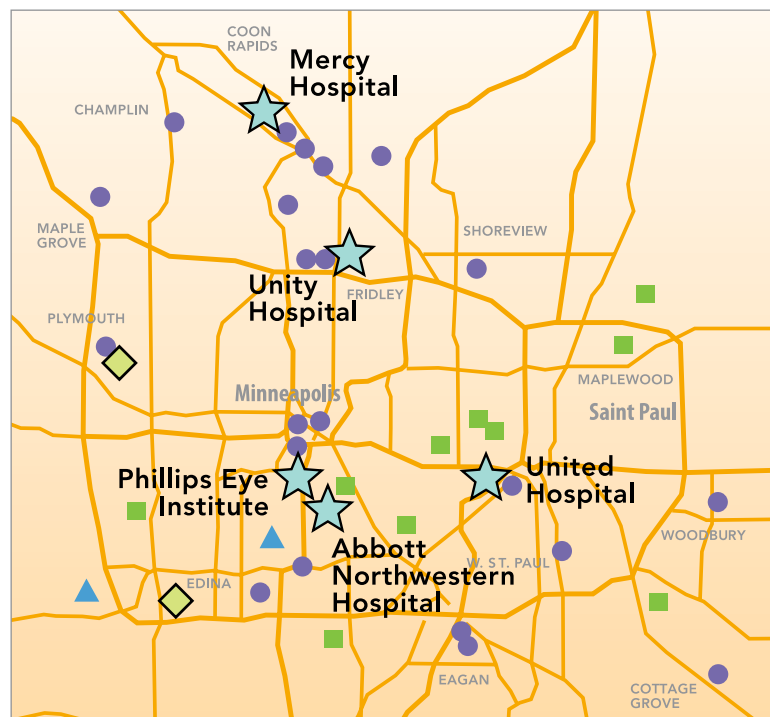
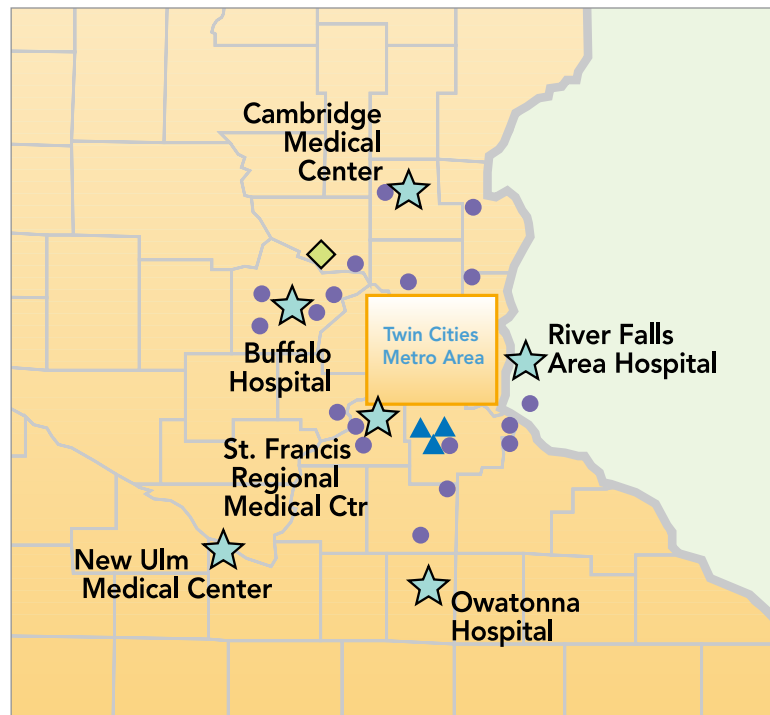
Allina Health and New Ulm Medical Center Service Area

New Ulm Medical Center 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

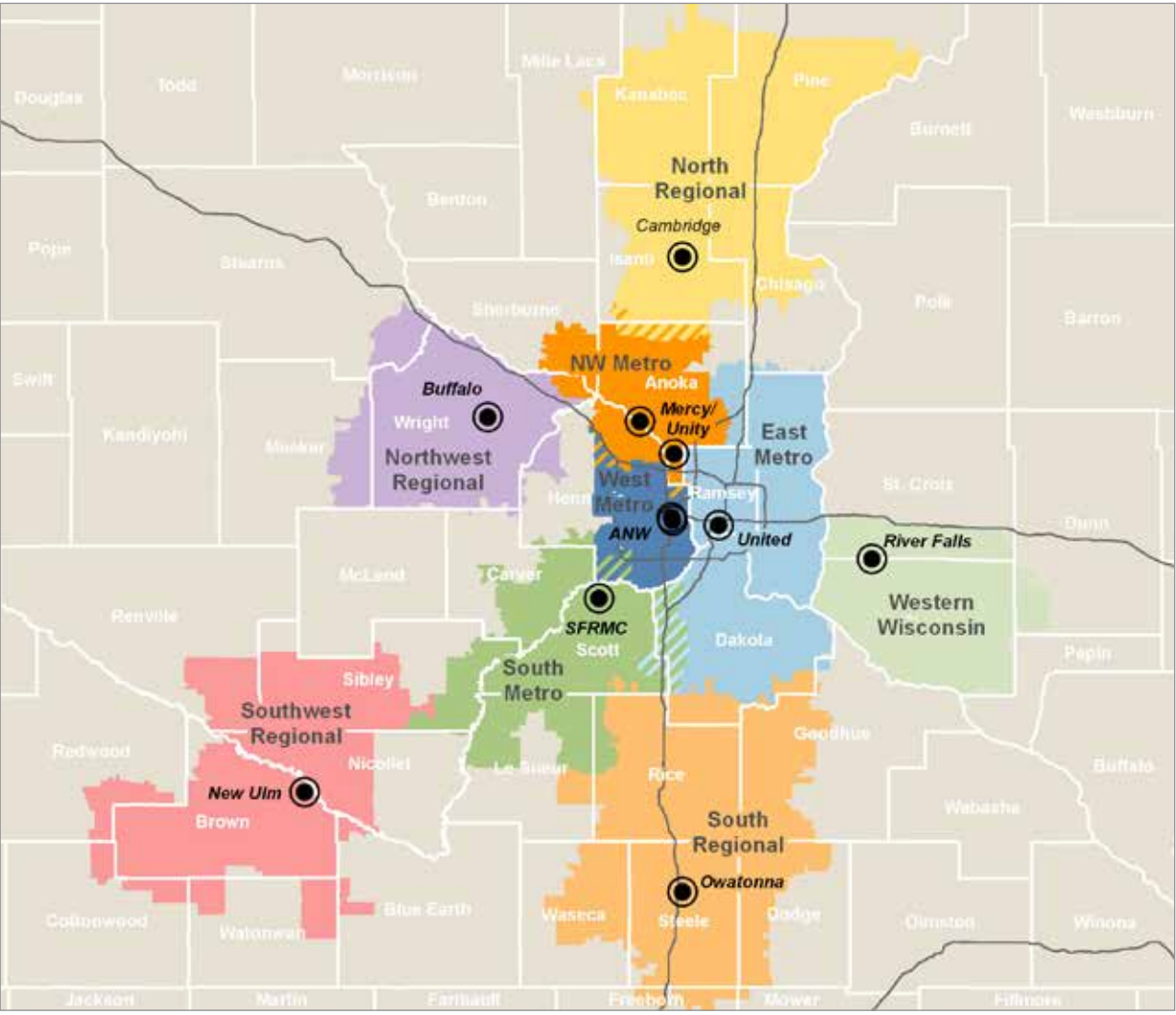
- ★ Allina Health Hospital
- ◇ Allina Health Ambulatory Care Center
- Allina Medical Clinic
- Aspen Medical Group
- ▲ Quello Clinic



Description of Community Served by New Ulm Medical Center

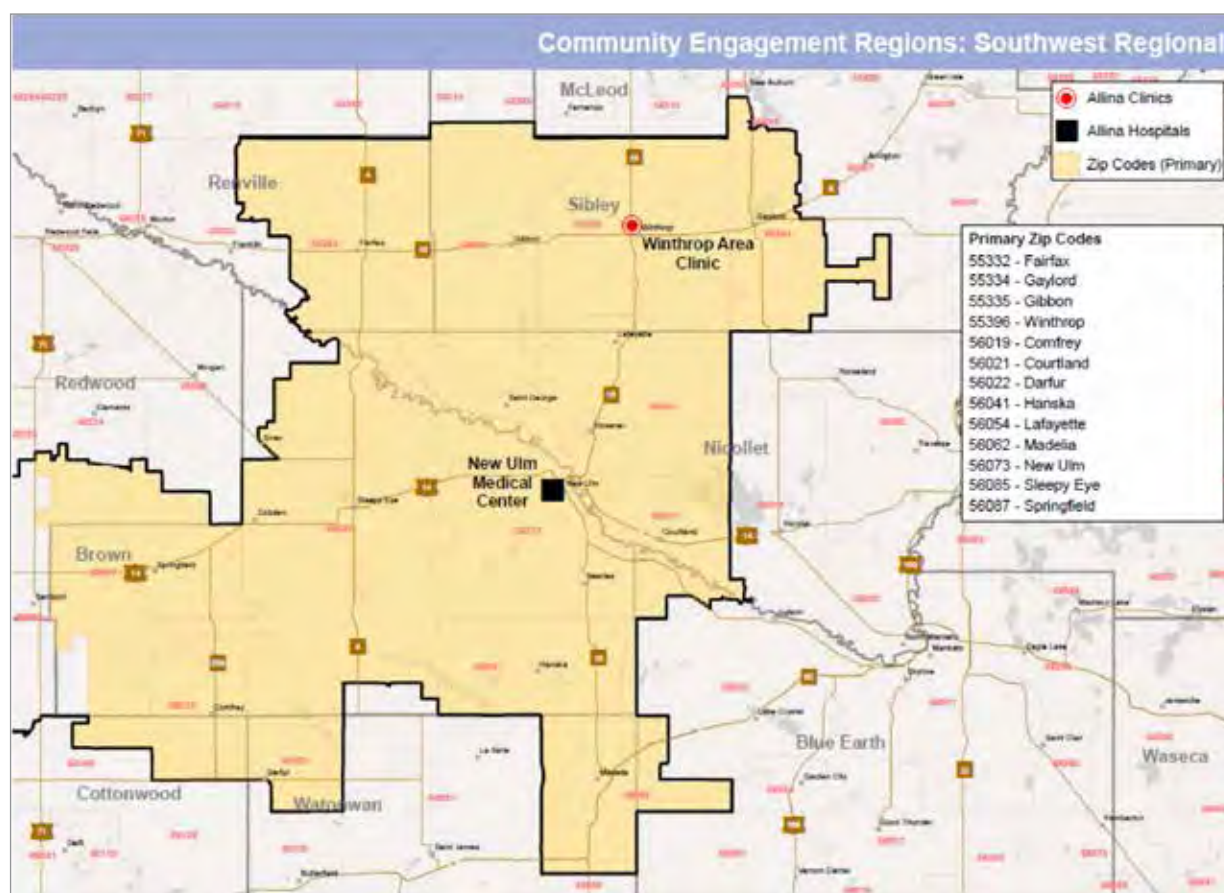
For the purposes of community benefit and engagement, Allina Health divides its service area into nine regions.

FIGURE 1: COMMUNITY BENEFIT & ENGAGEMENT REGIONAL MAP



The region associated with the New Ulm Medical Center is known as the Southwest Region and primarily covers Brown County and sections of Sibley and Nicollet counties in Minnesota. For the Southwest Region community health needs assessment (CHNA), the focus of inquiry was Brown County, which is the primary service area for New Ulm Medical Center. See Appendix A for a detailed report on Brown County, prepared by Stratis Health. All appendices can be found on the Allina Health website (allinahealth.org).

FIGURE 2: SOUTHWEST REGIONAL MAP



Assessment Partners

New Ulm Medical Center's CHNA was conducted in collaboration and partnership with community members, community organizations, stakeholders from local public health and internal stakeholders. These partners assisted in the development of the hospital's priorities as well as in building the implementation plan. In addition, New Ulm Medical Center partnered with Wilder Research, a branch of the Amherst H. Wilder Foundation, to conduct the community health dialogues in the Southwest 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 Southwest Region Community Engagement Lead guided the effort for New Ulm Medical Center.

The New Ulm Medical Center 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 New Ulm Medical Center Community Benefit Advisory Council and the New Ulm Medical Center Board of Trustees. The following is a description of the assessment steps and timeline.

PHASE 1	DATA REVIEW AND PRIORITY-SETTING
MAY – JULY 2012	<ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> ○ DATA REVIEW Reviewed data packets with stakeholders, selected initial list of regional health-related needs and priorities, identified additional data needs
OCTOBER 2012	<ul style="list-style-type: none"> ○ ISSUE PRIORITIZATION Reviewed revised data packet and completed formal prioritization process with stakeholders

PHASE 2	COMMUNITY HEALTH DIALOGUES
FEBRUARY – MARCH 2013	<ul style="list-style-type: none"> ○ DATA COLLECTION Conducted community health dialogues related to priority areas identified in the data review and prioritization process
APRIL 2013	<ul style="list-style-type: none"> ○ REPORT PRODUCTION Developed report of findings from needs assessment and community dialogues

PHASE 3	ACTION PLANNING
APRIL – JUNE 2013	<ul style="list-style-type: none"> ○ IMPLEMENTATION/PLAN Internal and external stakeholders reviewed report and developed strategies to address health needs
AUGUST – DECEMBER 2013	<ul style="list-style-type: none"> ○ 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, New Ulm Medical Center did not collect primary data, but instead compiled existing public health data to create a set of indicators specific to health in Brown 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 data sets 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 Brown County and comparison data for other counties in the state.

Based on the review of data over the course of these meetings, New Ulm Medical Center's community health assessment group identified eleven issues to be considered in the next step of the prioritization process.

1. Aging population
2. Asthma
3. Dental care
4. Education
5. Maltreatment of children
6. Mental health
7. Per capita income
8. Premature and low weight births
9. Overweight/obesity
10. Substance abuse
11. Tobacco use.

Prioritization Process

In order to systematically select priorities, New Ulm Medical Center 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 New Ulm Medical Center mission and role in the community as a health care provider.

THE HANLON METHOD

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

- to allow decision-makers to identify explicit factors to be considered in setting priorities
- to organize the factors into groups that are weighted relative to each other
- to allow the factors to be modified as needed and scored individually.

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

Component A = Size of the problem

Component B = Seriousness of the problem

Component C = Estimated effectiveness of the solution

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

DISCUSSION QUESTIONS

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

- Does work on this issue fit within the Allina Health mission? Does this fit within work we're already doing?
- What is the role for Allina Health? Leader, partner or supporter? What are the opportunities for collaboration?
- What's the economic impact of the issue? What's the cost to address the problem? What are the costs associated with not doing anything?
- Will the community accept and support Allina Health efforts on this issue?
- Does work on this issue provide an opportunity to address the health needs of vulnerable populations? Can Allina Health impact barriers to health for groups around this issue?
- Are there legal implications involved in addressing the health issue? (e.g., HIPAA privacy concerns, the need for consent for minors, undocumented citizens, etc.)

Notes from this discussion can be found in Appendix F.

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

Priority Health Needs for 2014–2016

Upon completion of the prioritization process, New Ulm Medical Center determined the following three community health priority needs:

1. Obesity

Obesity was chosen as a priority issue because of both rising rates of obesity among adults and children and the effect that obesity can have on lifespan and quality of life. Stakeholders were particularly concerned about the following indicators:

- The Centers for Disease Control reports that, for the first time in 100 years, children's life expectancy is projected to decline mainly due to poor lifestyle choices around inactivity, nutrition and overweight.
- Childhood obesity has more than tripled in the U.S. in the past 30 years.
- At least 24 percent of female children and 27 percent male children ages 9-18 living in New Ulm are overweight or obese.
- MDH reports that 35-45 percent of the children ages 2-5 in the WIC program in Brown County are overweight or obese.
- 72 percent of adults screened through the Heart of New Ulm project were overweight or obese.

2. Substance abuse

Substance abuse was chosen due to the effect that it has on the health and safety of people in the community. For example:

- Minnesota Department of Public Safety reported that half of the motor vehicle injuries and deaths in Brown County are related to alcohol.
- 21 percent of Brown County adults are excessive drinkers.
- In the last year 30 percent of high school students reported that they have drove a motor vehicle after using alcohol or drugs.
- 43 percent of ninth graders have used alcohol one or more times in the last year.
- In the last year 18 percent of ninth graders have used marijuana

3. Mental health

Mental health was chosen as a priority issue by stakeholders. Stakeholders felt that mental health and mental illness is a national challenge, and it should be effectively addressed on a variety of levels, including intervention from local hospitals and community.

- 14.5 percent of residents 65 and over are living alone.
- In the last 30 days, 50 percent of ninth graders reported that a student has made fun of or teased them.
- In the last month 17 percent of ninth graders stated they have felt sad all or most of the time.
- The number of ninth graders in Brown County who have tried to kill themselves in the last 12 months is double the state-wide average of 3 percent.

In summary, all the priority health needs were chosen based on the ability of New Ulm Medical Center to collaborate, capitalize on existing assets and implement interventions beyond clinical services in addressing these needs in the community.

IDENTIFIED HEALTH NEEDS NOT SELECTED AS PRIORITIES

Although the following issues were identified in the needs assessment, they were not selected as priority needs for FY 2014–2016. The need to focus efforts, limited capacity, community resources already working on the issues, and/or the issues were outside of the hospital's core competencies were the reasons these needs were not selected.

- Aging population
- Asthma
- Dental care
- Education
- Maltreatment of children
- Per capita income
- Premature and low weight births
- Tobacco use

Community Health Dialogues

In spring 2013, New Ulm Medical Center held a series of meetings designed to solicit feedback from the community on how New Ulm Medical Center 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 New Ulm Medical Center 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 New Ulm Medical Center's Community Engagement lead to community members including representatives from education, local government, religious, social service and other nonprofit 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 44 people participated in the two community health dialogues in the Southwest 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 New Ulm Medical Center, as part of Allina Health, in addressing this issue in your community?

KEY FINDINGS

Obesity: Dialogue participants felt that New Ulm Medical Center's, a part of Allina Health, could help address obesity through increasing opportunities and education focused on physical activity, nutrition and healthy living, and by growing community partnerships to draw on local assets. Participants specifically suggested:

- Increasing counseling for children and adults who are overweight
- Providing incentives for daycare homes and centers to buy and serve fresh fruits and vegetables
- Supporting community gardens for low income people
- Offering discounted rates for memberships at health clubs
- Giving financial rewards for losing and keeping off weight
- Extending the Heart of New Ulm's work to youth
- Offering free, individualized nutrition counseling.

Substance abuse: Dialogue participants felt that New Ulm Medical Center, as part of Allina Health, could help address substance abuse by increasing awareness and education, access to services and leverage community partnerships. Participants specifically referenced:

- Sponsoring alcohol and drug free celebrations (e.g. having the 4th of July as an alcohol and drug free event)
- Partnering with schools to offer supports for students after treatment
- Expanding education regarding expired or unused medicine drop-off sites
- Improving access to those seeking help with their addictions.

Mental health: Dialogue participants felt that New Ulm Medical Center, a part of Allina Health, could help address mental health through increased education and access to services. Participants specifically noted:

- Providing mental health trainings on how to identify the symptoms of mental illnesses
- Promoting Allina Health mental health programs and providing more outpatient treatment programs
- Creating support groups for parents of children with autism, ADHD and depression
- Increasing mental health screenings at worksites and schools
- Extending the Heart of New Ulm model to mental health
- Educating providers who work with seniors about what to look for and what steps to take in regards to depression.

For a full copy of the report see Appendix H.

Community Assets Inventory

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

- Gaps in services and opportunities for new work
- Where and with whom there is a lot of work already being done
- Opportunities for partnership and/or collaboration.

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

Action Planning

The final phase of the CHNA process was to develop the implementation plan for New Ulm Medical Center. 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. New Ulm Medical Center used its Community Benefit Advisory Council to engage with internal and external stakeholders including representatives from Brown County Public Health, New Ulm Park and Recreation, United Way of Brown County, New Ulm Medical Center employees and physicians whose work relates to these priorities, New Ulm Medical Center Foundation, and the New Ulm Medical Center Board of Trustees 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, New Ulm Medical Center 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

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

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

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

In choosing evidence-based strategies, New Ulm Medical Center 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, New Ulm Medical Center identified when the hospital was going to lead the work, support the work or partner on the work. This was important to budget accordingly, and to identify and leverage the expertise of the various assets in the community.

Implementation Plan

The implementation plan is a three-year plan depicting the overall work that New Ulm Medical Center 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.

Obesity

GOAL: Reduce obesity and increase physical activity

INDICATOR

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

New Ulm Medical Center's strategy to address obesity and encourage physical activity in its community will focus on two key areas: education around the risks of obesity, and providing programs that reduce obesity and increase physical activity in the community by encouraging and motivating people to take actions to improve their overall health. Planned programs include:

- Continuing partnerships through the Heart of New Ulm on programs designed to reduce obesity, such as expanding access to healthy foods, health screenings, healthy cooking classes and policy improvements that support healthy living. *Partners: public health, local restaurants, farmers markets, community co-ops, local community groups, employers, Minneapolis Heart Institute Foundation*
- Continuing partnership with the University of Minnesota for developing and implementing programs that support family-based and design approaches to addressing obesity in the community. *Partners: University of Minnesota, community groups*
- Creating and supporting programming that combines educational, environmental and behavioral activities at worksites and community centers. *Partners: Senior centers, community fitness centers, clinics, employers*
- Enhancing and expanding options for physical activity and nutrition education using the Health Powered Kids developed by Allina Health. *Partners: Clinics, local school districts, community*

programs targeting children.

- Facilitating and promoting nutritional coaching and groups targeting families and children. *Partners: Schools, community centers, community programs*
- Providing motivational talks in the community encouraging healthy changes in behavior. *Partners: Providers, clinics, public health, local health and wellness groups and organizations.*

Substance abuse

GOAL: Support programs and provide education in the community addressing substance abuse

INDICATORS

- Increase the proportion of adolescents who perceive great risk associated with substance abuse
- Reduce the proportion of persons engaging in binge drinking of alcoholic beverages
- Reduce the past-year nonmedical use of prescription drugs.

New Ulm Medical Center's strategy to address substance abuse in its community will focus on two key areas: supporting programs in the community which focus on the prevention and treatment related to substance abuse and providing community education designed to help prevent substance abuse. Planned programs include:

- Support and promote resources for prescription drugs drop-off and disposal site. *Partners: Clinics, hospital doctors, public health*
- Providing education to providers and community members around substance abuse identifying the signs of substance abuse in individuals. *Partners: Clinics, hospital doctors, public health, employers*
- Offering integrative workshops for parents and educators on how to discuss issues related to substance abuse with children and adolescents. *Partners: Public health, employers, schools*
- Adding substance abuse and recovery resources to the Heart of New Ulm's after-screening resource guide. *Partners: Heart of New Ulm partnership*

Mental health

GOAL: Improve access to mental health-related resources in the community and address stigma related to mental health

INDICATORS

- Increase the proportion of adults and children with mental health disorders who receive treatment
- Reduce stigma around mental health issues.

New Ulm Medical Center's strategy to address mental health in its community will focus on two key areas, reducing the stigma around mental health conditions and treatment and providing and facilitating education and programming around mental health both to members of the community and to health care providers. Planned programs include:

- Partnering with community partners to host depression screenings at community events, workplaces and schools. *Partners: Clinics, hospital doctors, public health, employers, schools*
- Supporting and developing programs that provide individuals with the tools to improve mental wellness and life-balance. *Partners: Clinics, public health, employers, schools*
- Developing and offering classes to the community focused on recognizing the symptoms related to mental illness, and providing people with the resources and knowledge to help individuals in crisis connect with appropriate professional, peer, social and self-help care. *Partners: Clinics, hospital doctors, public health, mental health advocacy organizations*
- Actively engaging providers in public discussions around mental health and mental illness with the goal of decreasing stigma. *Partners: Clinics, hospital doctors, public health, employers, schools*

Conclusion

As a not-for-profit hospital, New Ulm Medical Center is dedicated to improving the health of the communities it serves. This implementation plan is intended to show that the medical center 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 New Ulm Medical Center will indirectly address these priority issues along with other needs, through the provision of charity care, support of Medicare and Medicaid programs, discounts to the uninsured, among others. New Ulm Medical Center will continue to engage with the community to ensure that the work in the plan is relevant, effective and to modify its efforts accordingly.



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NEW ULM MEDICAL CENTER
SOUTHWEST REGIONAL

Appendix A

Brown County Profile

Community Health Needs Assessment
and Implementation Plan 2014–2016



Brown County

(South Central 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 South Central EDR is composed of Blue Earth, Brown, Faribault, Le Sueur, Martin, Nicollet, Sibley, Watonwan, and Waseca 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.



CULTURE CARE CONNECTION

Funding provided by



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 Brown County, will be much older in 2035.

Population projections:

- 14 and under to fall 2%
- 15 to 24 to fall 22%
- 25 to 44 to fall 6%
- 45 to 64 to fall 14%
- 65 to 84 to rise 63%
- 85 and above to rise 56%

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.

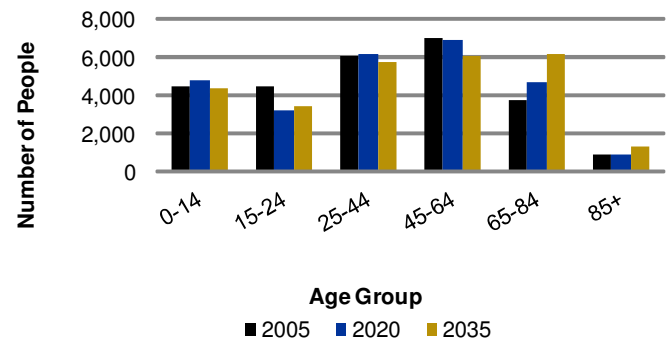
Gender

In 2015, projections indicate the overall gender distribution for Brown County to be 50% female, 50% male

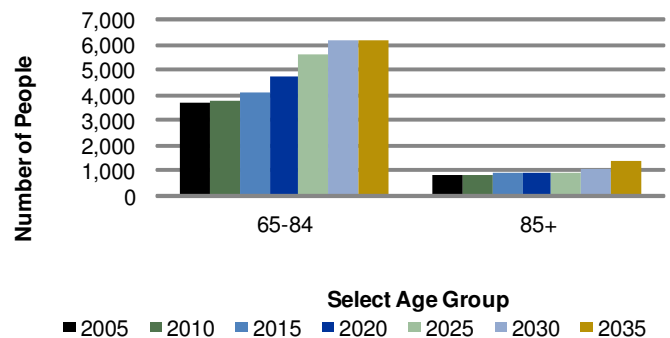
Variations appear when the data are viewed by age range:

- 15 to 24: 47% female, 53% male
- 65 to 84: 54% female, 46% male
- 85 and above: 66% female, 34% male

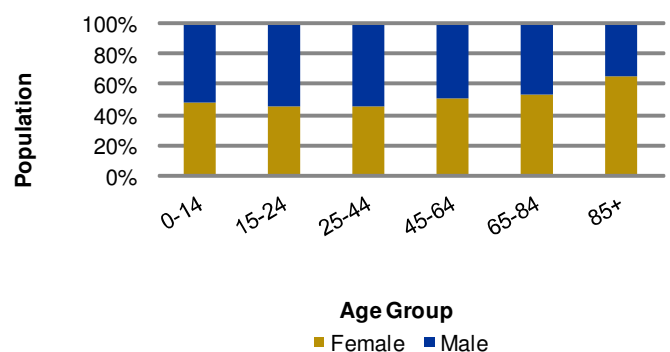
Projected Population - Brown County: 2005-2035



Projected Population - Brown County: 2005-2035



Projected Gender Distribution - Brown County: 2015



Race

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

In the South Central EDR between 2005 and 2015, the population is expected to grow 4.2 percent. The white population is not expected to change while populations of color are expected to grow 59.5 percent. Growth will be most notable in the Black population (77.1%). Growth in populations of color in the South Central EDR will exceed the national growth rate of 47.1 percent.

What providers need to know:

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

Suggestions:

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

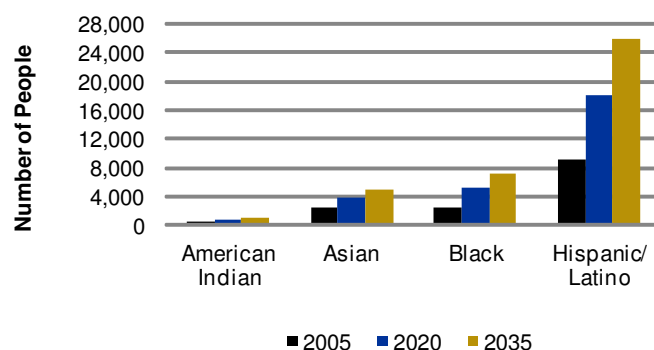
Foreign Born

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

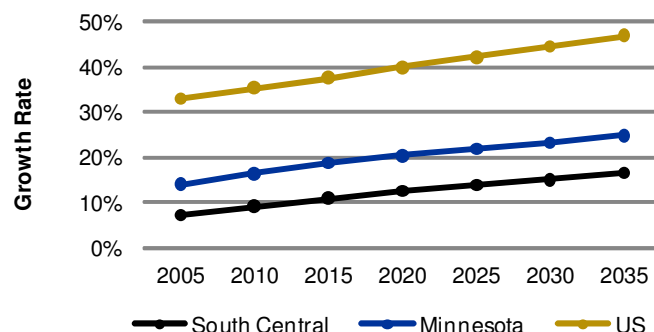
What providers need to know:

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

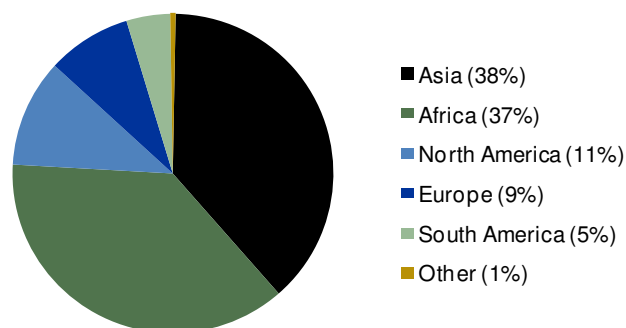
Projected Populations of Color - South Central: 2005-2035



Projected Growth Rates for Populations of Color: 2005-2035



Foreign Born Population by Region of Birth - Minnesota: 2007



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.

Socioeconomic 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.

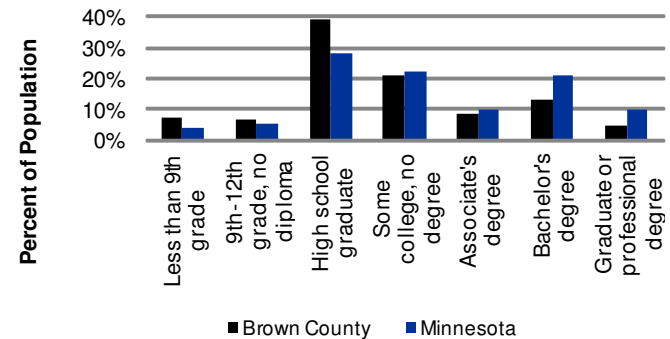
In Brown County, for all races, historic data indicate a lower percentage of individuals receiving at least a high school diploma compared to state level data. Attainment rates of a Bachelor's degree or greater in Brown County were lower than state level rates.

Income

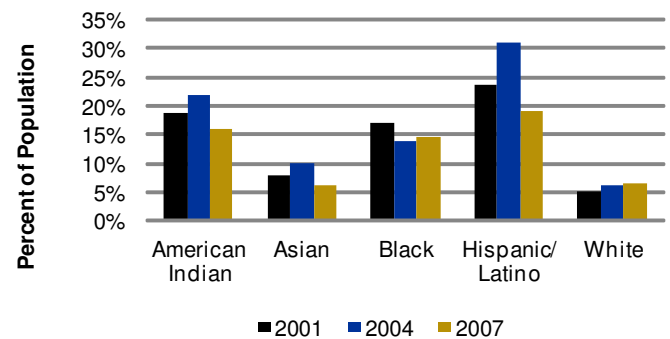
In Brown County, the median household income based on 2005-2007 estimates was \$48,697. Income level influences an individual's access to health care (as measured by rates of uninsurance) and is used to determine poverty status, which may determine eligibility for various assistance programs.

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

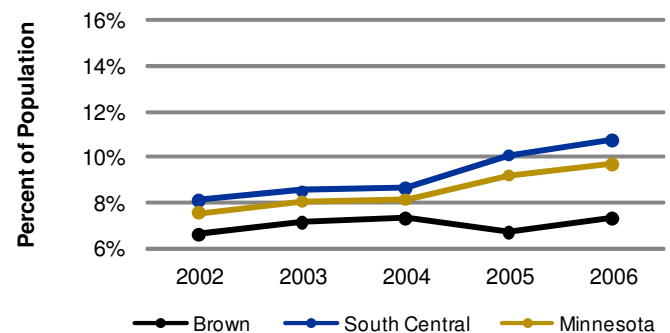
Education Attainment: 2005-2007



Uninsured by Race - Minnesota: 2001-2007



Poverty - All Ages - Minnesota: 2002-2006



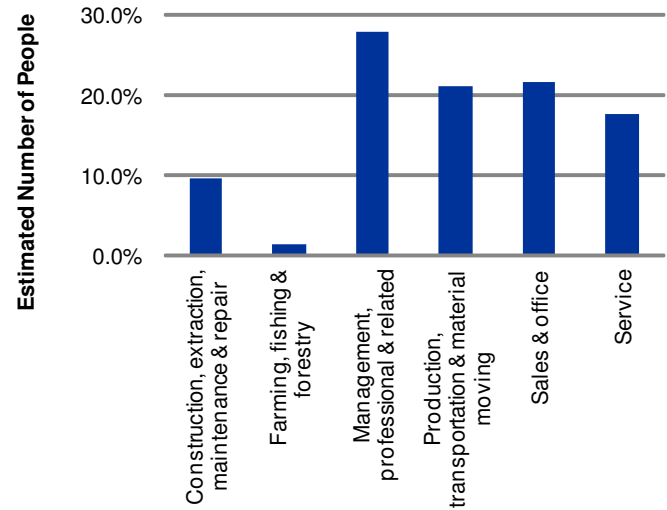
Poverty status, which is based on a minimum level of income necessary to achieve an adequate standard of living, is on the rise in Minnesota. According to federal poverty guidelines this level of income in 2008 equaled \$21,200 for a family of four. Families whose income falls near or below this amount may be eligible for medical assistance and other social service programs.

Occupation

According to 2005-2007 estimates, 71.2 percent of the population in Brown 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](http://www.dhs.gov/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.

Occupations - Brown County: 2005-2007



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

Brown County's birth rate of 10.8 per 1,000 population is lower than the regional and state-level rates of 13.1 and 14.2 respectively. In 2007, prenatal care was received in the first trimester for 88.3 percent of cases compared to 87.1 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

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

What providers need to know:

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

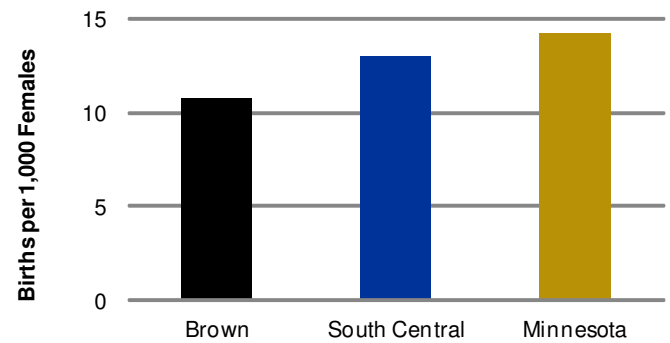
Suggestions:

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

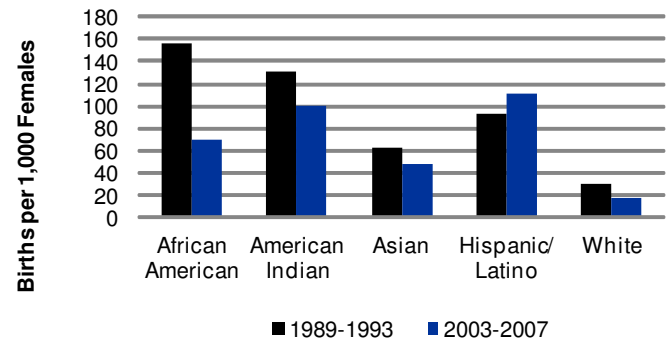
Next Steps CLAS Assessment • Visit www.culturecareconnection.org

- 1) Conduct a CLAS (Culturally and Linguistically Appropriate Services) Standards Assessment to identify areas of strength and opportunities for improvement in the services your organization offers to diverse populations. An online assessment which offers customized evaluation and recommendations can be found at: CLAS Standards Assessment.
- 2) Visit the Culture Care Connection Web site, an online learning and resource center aimed at providing Minnesota health care organizations with actionable tools in support of providing culturally and linguistically appropriate services.
- 3) Contact Stratis Health to learn more about how we can assist in your organization's efforts to build culturally and linguistically appropriate service offerings.

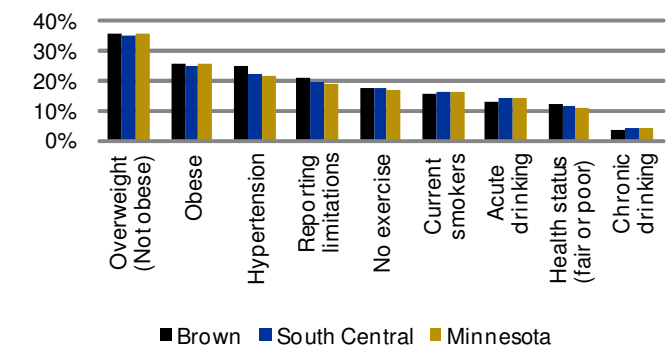
Birth Rate - All Ages: 2007



Teen Birth Rate By Race - Minnesota: - Age 15-19: 2007



Behavioral Risk Factors: 2007



Sources

2008 Minnesota County Health Tables, Minnesota Department of Health, Center for Health Statistics, 2008.

American Fact Finder, US Census Bureau, (<http://factfinder.census.gov>) viewed on 6/17/09.

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

“Minnesota High School Graduation Rates Will Peak in 2009,” Minnesota Office of Higher Education, *Insight*, 2006.

Minnesota’s Nonwhite and Latino Populations 2007, Minnesota State Demographic Center, 2008.

Minnesota Populations by Race and Hispanic Origin 2005 – 2035, Minnesota State Demographic Center, 2009.

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.



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NEW ULM MEDICAL CENTER
SOUTHWEST REGIONAL

Appendix B

Assessment Participants

Community Health Needs Assessment
and Implementation Plan 2014–2016



Who Was Involved in Assessment

Project Lead: Carisa Buegler, Director of Foundation and Community Engagement

Assisted by: Jennifer Maurer, Wellness Specialist

Feedback and commitment provided by:

Devin Nelson, *Chair, Habilitative Services*

Cheri LeBrun, *United Farmers Coop*

Dr. Michelle Wilkening, *Family Physician, Physicians Group of NU*

Carrie Anderson, *City of New Ulm Park and Recreation*

Karen Moritz, *Director of Brown County Public Health*

Ellie Sveine, *RN, Mayo Health System, Optimist Club member*

Donna Lambrecht, *Director of United Way of Brown County Area*

Kim Janke, *Director of the Underage Substance Abuse Coalition*

Cindy Winters, *Community/Public Policy Specialist, Heart of New Ulm*

Rebecca Fliszar, *Dietician, Heart of New Ulm*

Holly Glaubitz, *Worksite Wellness, Heart of New Ulm*

Kitty Hietala, *Marketing and Communications, New Ulm Medical Center*

JJ Johnson, *Manager of Substance Abuse, New Ulm Medical Center*

Anne Makepeace, *Director of Human Resources, New Ulm Medical Center*

Steve Schneider, *Director of Operations, New Ulm Medical Center*

Dr. Tawyna Krielkamp, *Family Physician, Physicians Group of New Ulm*

Dr. Bryana Andert, *Family Physician, Physicians Group of New Ulm*

Dr. Kara Jorve, *Family Physician, Physicians Group of New Ulm*

Julie Long, *Nurse Practitioner, New Ulm Medical Center*

Dr. Doug Fox, *Psychologist, New Ulm Medical Center*

Substance Abuse Team at NUMC

Inpatient Mental Health Team at NUMC

NUMC Board of Trustees

NEW ULM MEDICAL CENTER
SOUTHWEST REGIONAL

Appendix C

Full Indicator List

Community Health Needs Assessment
and Implementation Plan 2014–2016



County- Leading Health Indicators

People and Place

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
People and Place	1. Total population	Census	5,303,925	25,893
People and Place	2. Population by age and sex	Census	Table I	Table I
People and Place	3. Number of females aged 15-44	Census	1,045,681	4,320
People and Place	4. Number of births	MDH MCHS	70,617	297
People and Place	5. Birth rate	MDH MCHS	13.4	11.6
People and Place	6. School enrollment for prekindergarten – 12th grade	Census	837,640	3,567
People and Place	7. Number and percent of children under age 5	Census	355,504/6.7	1,573/6.1%
People and Place	8. Number and percent of children aged 0-19	Census	1,431,211/26.9	6,440/24.9%
People and Place	9. Child (under 15 years) dependency ratio (per 100 population 15-64)	Census	29.5	27.8
People and Place	10. Number of households	Census	2,108,843	10,890
People and Place	11. Number of deaths	MDH MCHS	37,801	276

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
People and Place	12. Total population by race and ethnicity	Census	Table II	Table II
People and Place	13. Number of prekindergarten – 12 th grade students by race/ethnicity	MDE	Table III	Table III
People and Place	14. Percent of prekindergarten – 12 th grade students with limited English proficiency	MDE	7.3%	2.1%
People and Place	15. Number and percent of people aged 65 years and older	Census	683,121/12.9%	4,899/18.9%
People and Place	16. Elderly (65+ years) dependency ratio (per 100 population 15-64)	Census	19.2	28.8
People and Place/Opportunity for Health	17. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	14.5
People and Place	18. Arsenic levels in MN	Arsenic MDH	n/a	
People and Place	19. Radon levels by zone (low, moderate, high)	US EPA	High/moderate	High

Opportunity for Health

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
Opportunity for Health	20. Four year high school graduation rate	MDE	76.9%	79.3%
Opportunity for Health	21. High school dropout rate	MDE	4.8%	4.6%
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%	53.1%
Opportunity for Health	23. Percent of prekindergarten – 12th grade students receiving special education	MDE	14.6%	16.3
Opportunity for Health	24. Unemployed rate - annual average	MN DEED	6.6%	6.9%
Opportunity for Health	25. Total per capita income	Census	\$42,953	\$36,576
Opportunity for Health	26. Percent of prekindergarten – 12th grade students eligible for free and reduced meals	MDE	35.5%	35.1%
Opportunity for Health	27. Percent of people under 18 years living in poverty	Census	11.4%	13%
Opportunity for Health	28. Percent of all ages living in poverty	Census	11.6%	11.4%
Opportunity for Health	29. Percent of people of all ages living at or below 200% of poverty	Census 5 yr ACS	25.5%	25.8%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
Opportunity for Health	30. Percent of housing occupied by owner	Census 5 yr ACS	78.1%	84.1%
Opportunity for Health	31. Percent of births to unmarried mothers	MDH MCHS	33.5%	33%
Opportunity for Health	32. Carbon monoxide poisoning (hospitalizations and ED visits age adjusted rates per 100,000)	MNHDD	6.54/.63	n/a
Opportunity for Health	33. Percent of dwellings built before 1940	Census 2000	3.2%	n/a
Opportunity for Health	34. Percent of birth cohort tested with elevated blood lead levels	MDH Lead	.5%	0
Opportunity for Health	35. COPD hospitalizations (age adjusted rate per 10,000)	MNHDD	31.5	26.9
Opportunity for Health	36. Percent of children under 18 living in single parent-headed households	Census 5 yr ACS	26.1%	22.2%
Opportunity for Health/People and Place	37. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	14.5%
Opportunity for Health	38. Percent of 9th graders who have changed schools at least once since the beginning of the school year	MSS	5%	4%
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	6.8
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%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
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%	25%
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%	26%
Opportunity for Health/Healthy Living	43. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	9.3
Opportunity for Health	44. Number of physicians per 10,000 population	MDH ORHPC	27	17
Opportunity for Health	45. Number of dentists per 100,000	MDH ORHPC	61.4	14 total
Opportunity for Health	46. Percent currently uninsured	MDH MNHAS	9	9%
Opportunity for Health/Healthy Living	47. Percent of mothers who initiated prenatal care in the 1 st trimester	MDH MCHS	85.9%	89.1%

Healthy Living

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
Healthy Living	48. Birth rate per 1,000 population	MDH MCHS	13.4	11.5
Healthy Living	49. Number of births	MDH MCHS	70,617	297
Healthy Living	50. Percent of births by race/ethnicity of mother	MDH MCHS	Table IV	Table IV
Healthy Living	60. Percent of mothers who smoked during pregnancy	MDH MCHS	9.8%	13.3%
Healthy Living	61. Percent of births to unmarried mothers	MDH MCHS	33.5%	33%
Healthy Living/Opportunity for Health	62. Percent of mothers who initiated prenatal care in the 1st trimester	MDH MCHS	85.9 %	89.1%
Healthy Living	63. Percent of births that were born premature, less than 37 weeks gestation (singleton births)	MDH MCHS	7.8%	9.3%
Healthy Living	64. Percent of birth born low birth weight, less than 2,500 grams (singleton births)	MDH MCHS	4.8%	3.6%
Healthy Living	65. Number of infant deaths	MDH MCHS	429	2
Healthy Living	66. Percent of 9 th graders who participate in religious activities one or more times per week	MSS	43%	50%
Healthy Living	67. Teen birth rate per 1,000 females aged 15-19 years	MDH MCHS	26.6	21.2

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
Healthy Living/Opportunity for Health	68. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	6.8
Healthy Living	69. Percent of 9th graders who ate five or more servings of fruit, fruit juice, or and vegetables yesterday	MSS	18%	20%
Healthy Living	70. Percent of 9th graders who drank three or more glasses of pop or soda yesterday	MSS	14%	18%
Healthy Living	71. Percent of adults who consumed five or more servings of fruits and vegetables per yesterday	Local Surveys		31.5%
Healthy Living	72. Percent of adults who reported 30+ minutes of moderate physical activity on five or more days per week	Local Surveys		46.7%
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%	53%
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%	68%
Healthy Living	75. Percent of 9th graders who spend six or more hours per week watching TV, DVDs or videos	MSS	44%	55%
Healthy Living	76. Percent of adults who are excessive drinkers (binge+ heavy)	Local Surveys	20.2%	21%
Healthy Living	77. Percent of 9th graders who engaged in binge drinking in the last two weeks	MSS	10%	13%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
Healthy Living	78. Percent of 9th graders who used alcohol one or more times in the last 12 months	MSS	32%	43%
Healthy Living	79. Percent of 9th graders who used alcohol one or more times in the 30 days	MSS	19%	28%
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%	5%/30%
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%	22%
Healthy Living	82. Percent of 9th graders who smoked cigarettes during the last 30 days	MSS	9%	10%
Healthy Living	83. Percent of adults who are current smokers	Local Surveys	16.8%	
Healthy Living	84. Percent of 9th graders who used chewing tobacco, snuff, or dip during the last 30 days	MSS	5%	6%
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%	18%
Healthy Living	87. Percent of 9th graders who used marijuana one or more times in the last 30 days	MSS	10%	10%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
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%	62.1%
Healthy Living	91. Percent of 9th and 12th graders who have ever had sexual intercourse	MSS	20%/51%	21%/58%
Healthy Living	92. Among sexually active 9 TH and 12 th grade students: percent reporting always using a condom	MSS	56%/45%	61%/56%
Healthy Living	93. Percent of 9th graders who report always wearing a seatbelt when riding in a car	MSS	66%	52%
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%	14%
Healthy Living	95. Percent of 9th graders who feel that people care about them very much or quite a bit (parents, other adult relatives, teacher/other adults, religious or spiritual leaders, other adults in the community, friends)	MSS	Table V	Table V
Healthy Living	96. Percent of 9th graders who felt sad all or most of the time in the last month	MSS	14%	17%
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%	50%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
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%	45%
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%	53%
Healthy Living	100. Percent of 9th graders who had suicidal thoughts in last year	MSS	17%	24%
Healthy Living	101. Percent of 9th graders who tried to kill themselves in the last year	MSS	3%	6%

Chronic Diseases and Conditions

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
Chronic Dis. and Cond.	102. Percent of 9th graders who are overweight but not obese according to BMI	MSS	13%	14%
Chronic Dis. and Cond.	103. Percent of 9th graders who are obese according to BMI	MSS	9%	8%
Chronic Dis. and Cond.	104. Percent of adults who are overweight according to BMI	Local Surveys	38.1%	38.%
Chronic Dis. and Cond.	105. Percent of adults who are obese according to BMI	Local Surveys	24.7%	28.4%
Chronic Dis. and Cond.	106. Percent of WIC children under aged 2-5 years who are obese according to BMI	MDH WIC	13.1%	11.8%
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	Table VI
Chronic Dis. and Cond.	108. Asthma hospitalizations (age adjusted rate per 10,000)	MNHDD	7.5	6.7
Chronic Dis. and Cond.	109. Cancer incidence per 100,000 (all cancer types combined, age adjusted rate per 100,000)	MDH MCSS	474.9	470.4
Chronic Dis. and Cond.	110. Breast cancer incidence (age adjusted rate per 100,000)	MDH MCSS	127.3	123.7
Chronic Dis. and Cond.	111. Heart attack hospitalizations (age adjusted rate per 10,000)	MNHDD	27.3	37
Chronic Dis. and Cond.	112. Heart disease prevalence	Local Surveys	4.9%	4.3%
Chronic Dis. and Cond.	113. Stroke prevalence	Local Surveys	1.8%	2.5%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
Chronic Dis. and Cond.	114. Diabetes prevalence	Local Surveys	6.2%	7.6%

Infectious Disease

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
Infectious Disease	115. STD numbers (e.g. chlamydia, gonorrhea)	MDH IDEPC	Table VII	Table VII
Infectious Disease	116. Number of tuberculosis cases	MDH IDEPC	135	0
Infectious Disease	117. Vector borne diseases (e.g. Lyme disease, West Nile virus)	MDH IDEPC	Table VIII	Table VIII

Injury and Violence

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Brown
Injury and Violence	118. Years of potential life lost before age 65 (e.g. due to injury or violence)	MDH MCHS	30,010	135
Injury and Violence	119. Unintentional injury death - age adjusted rate per 100,000	MDH MCHS	36	36.3
Injury and Violence	120. Percent of motor vehicle injuries and deaths that are related to alcohol	MN DPS	31.9%/8%	50%/10.1%
Injury and Violence	121. Percent of 9th graders who report that someone they were going out with has ever hit, hurt, threatened or forced them to have sex	MSS	10%	10%
Injury and Violence	122. Rate of children maltreatment per 1,000 children aged 0-17	MN DHS	17.6	28.6
Injury and Violence	123. Suicide deaths	MDH MCHS	599	2

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

Brown

Age Group	Male	Female	Total
0-4	852	721	1,573
5-9	805	736	1,541
10-14	821	727	1,548
15-17	528	508	1,036
18-19	384	358	742
20-24	822	793	1,615
25-29	745	698	1,443
30-34	665	640	1,305

35-39	649	584	1,233
40-44	743	739	1,482
45-49	960	990	1,950
50-54	1,085	1,082	2,167
55-59	931	909	1,840
60-64	779	740	1,519
65-69	567	618	1,185
70-74	443	498	941
75-79	415	542	957
80-84	337	482	819
85&up	325	672	997
Total	12,856	13,037	25,893

TABLE II

		White	Black/ African American	Amer. Indian/ Alaskan Native	Asian/ Pacific Islander	Two or More Races	Hispanic/ Latino (any race)
MN	Total population by race and ethnicity	4,524,062	274,412	60,916	216,390	125,145	250,258
Brown		25,893	61	21	155	183	860

TABLE III

Number of prekindergarten – 12 th 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
Brown	3,136	20	0	37	347	3,540

TABLE IV

Percent of births by race/ethnicity of mother	White	African American	American Indian	Asian	Latina
Statewide	74.5	9.4	2.1	6.9	8.0
Brown	94.6	.3	0	1.3	5.1

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
Statewide	45	55	42	86	78
Brown	48	43	40	87	76

TABLE VI

Leading causes of death - age adjusted rates per 100,000 (e.g. cancer, heart disease, stroke)	Heart Disease	Cancer	Stroke
Statewide	121.81	169.08	34.14
Brown	164.4	194.7	n/a

TABLE VII

STD numbers (e.g. chlamydia, gonorrhea)	Chlamydia	Gonorrhea	Primary/Secondary Syphilis	Syphilis - All Stages	HIV
Statewide	15,294	2,119	149	347	331
Brown	36	1	0	0	1

TABLE VIII

Vector borne diseases	Campylo-bacteriosis	Giardiasis	Lyme Disease	Human Anaplasmosis	West Nile	Salmo- nellosis	Shig-ellosis
Statewide	1,007	846	1293	720	8	695	66
Brown	6	0	0	0	0	3	0

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

NEW ULM MEDICAL CENTER
SOUTHWEST REGIONAL

Appendix D

Hanlon Process

Community Health Needs Assessment
and Implementation Plan 2014–2016



First Things First: Prioritizing Health Problems

Introduction

Despite the many accomplishments of local public health, we continue to see emerging population-wide health threats as we forge ahead into 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:¹

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 Criteriaⁱⁱ

Criteria to Identify Priority Problem	Criteria to Identify Intervention for Problem
<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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 \(APEXPH\)](#).

Multi-voting Techniqueⁱⁱⁱ

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

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

low ← Need → high

Nominal Group Technique^v

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

Step-by-Step Instructions:

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

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

John Doe County Health Department: Nominal Group Technique Example

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

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

Table 3.1: Count of Staff Responses to QI Focus Areas

Priority Health Indicator	1 st Choice Score = 3	2 nd Choice Score = 2	3 rd 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	<ul style="list-style-type: none"> Size of health problem should be based on baseline data collected from the individual community. 	<ul style="list-style-type: none"> Does it require immediate attention? Is there public demand? What is the economic impact? What is the impact on 	<ul style="list-style-type: none"> 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.
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**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:

- **Propriety** – Is a program for the health problem suitable?
- **Economics** – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
- **Acceptability** – Will a community accept the program? Is it wanted?
- **Resources** – Is funding available or potentially available for a program?
- **Legality** – Do current laws allow program activities to be implemented?

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

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

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

Where:

D = Priority Score

A = Size of health problem ranking

B = Seriousness of health problem ranking

C = Effectiveness of intervention ranking

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

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

McLean County Health Department - The Hanlon Method Example:

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

1. **Rate against specified criteria** – To rate each health problem, MCHD used the following considerations for each Hanlon criterion. **Table 3.2** illustrates the top three of the eight health problems and corresponding ratings for each criterion.
 - *Size of the problem* – the percentage of the population with the problem, with an emphasis on the percentage of the population at risk for the problem
 - *Seriousness of the problem* – morbidity rates, mortality rates, economic loss, and the degree to which there is an urgency for intervention
 - *Effectiveness of the intervention* – the degree to which an intervention is available to address the health problem
2. **Apply the ‘PEARL’ test** – After long discussion, all eight health problems passed the ‘PEARL’ test as the interventions for each problem were judged to be proper, economical, acceptable, feasible based on available resources, and legal.
3. **Calculate the priority scores** – Priority scores were calculated by plugging in the ratings from Columns A through B into the formula in Column D. The calculations of the top three priority scores are illustrated in **Table 3.2**

Table 4.2: MCHD Hanlon Priority Scoring

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

Livingston County Department of Health - The ‘PEARL’ Test Example:

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

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

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

Prioritization Matrix^{iv}

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

Step-by-Step Instructions:

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

Table 5.1: Example Prioritization Matrix

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

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

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

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

Lawrence-Douglas County Health Department: Example Prioritization Matrix

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

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

Table 5.2: LDCHD Prioritization Matrix

Proposed Area for Improvement Based on LHD Self-Assessment	Evaluative Criteria					Total Score
	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)	
Media strategy & Communications to raise public health awareness	3 X (.25)	4 X (.25)	4 X (.5)	3 X (.5)	3 X (.75)	7.5
Work within network of stakeholders to gather and share data and information	2 X (.25)	3 X (.25)	2 X (.5)	1 X (.5)	1 X (.75)	3.5
Continuously develop current information on health issues that affect the community	4 X (.25)	2 X (.25)	3 X (.5)	1 X (.5)	2 X (.75)	5

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

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

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

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

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

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

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

Conclusion

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

Appendices

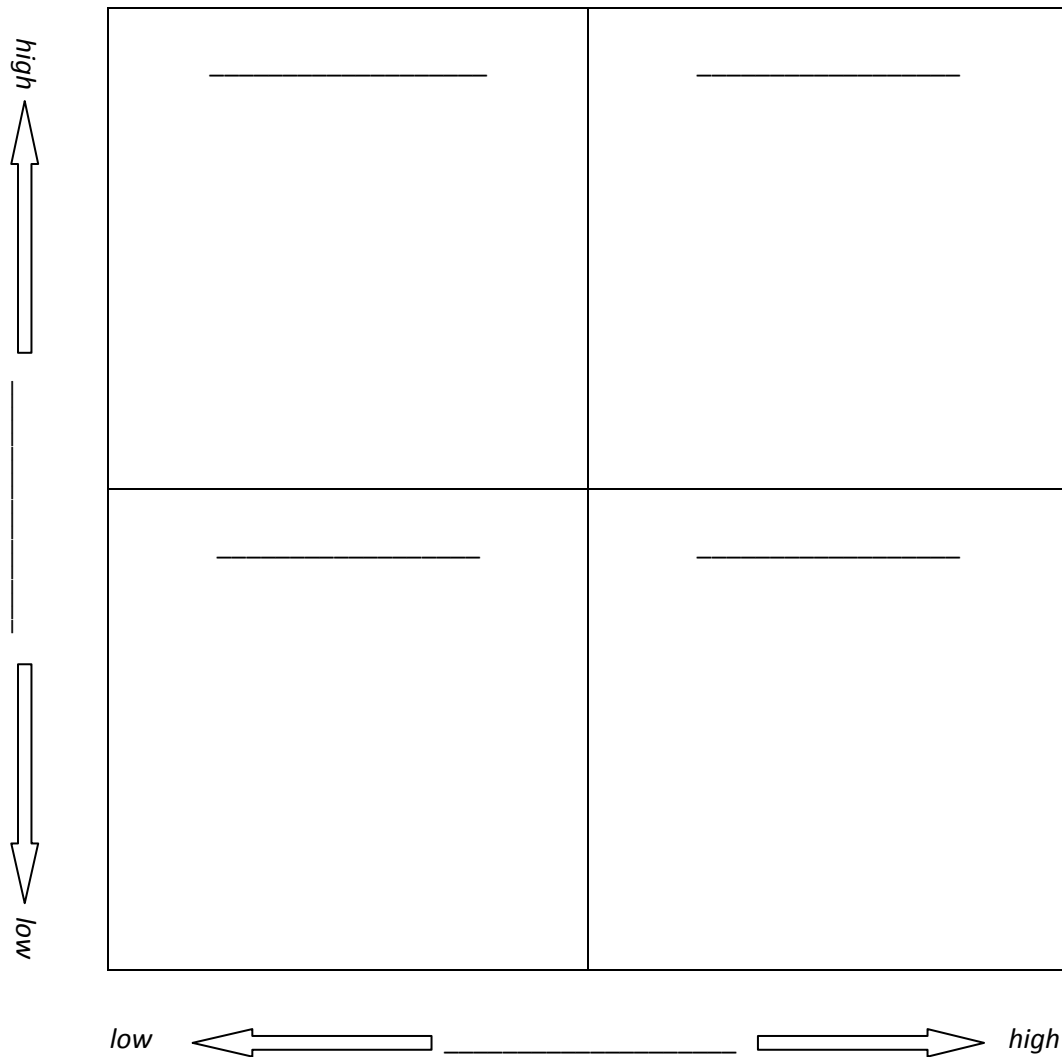
3 Round Multi-voting Template

[illegible]

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

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.

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^{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.

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Appendix E

Hanlon Ranking Sheet

Community Health Needs Assessment
and Implementation Plan 2014–2016



Regional Priority Sheet – New Ulm Medical Center

Aging Population

Asthma

Dental Care

Education

Maltreatment of Children

Mental Health

Per Capita Income

Premature and Low Birth Weights

Overweight/obesity

Substance Abuse

Tobacco Use

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Appendix F

Justification Notes

Community Health Needs Assessment
and Implementation Plan 2014–2016



Health Needs Identified

The New Ulm and surrounding areas most significant and wide-spread health issues according to our data review and using the Hanlon Method to prioritize are (including examples of data that are concerning):

- **Obesity**
 - The Centers for Disease Control reports that, for the first time in 100 years, children's life expectancy is projected to decline mainly due to poor lifestyle choices around inactivity, nutrition and overweight.
 - Childhood obesity has more than tripled in the U.S. in the past 30 years.
 - At least 24% of female children and 27% male children ages 9-18 living in New Ulm are overweight or obese.
 - MDH reports that 35-45% of the children ages 2-5 in the WIC program in Brown County are overweight or obese.
 - 72% of adults screened through the Heart of New Ulm project were overweight or obese.
- **Substance Abuse**
 - Minnesota Department of Public Safety reported that half of the motor vehicle injuries and deaths in Brown County are related to alcohol.
 - 21% of Brown County adults are excessive drinkers.
 - In the last year 30% of high school students reported that they have drove a motor vehicle after using alcohol or drugs.
 - 43% of 9th graders have used alcohol one or more times in the last year.
 - In the last year 18% of 9th graders have used marijuana.
- **Mental Health**
 - 14.5% of residents 65 and over are living alone.
 - In the last 30 days, 50% of 9th graders reported that a student has made fun of or teased them.
 - In the last month 17% of 9th graders stated they have felt sad all or most of the time.
 - The number of 9th graders in Brown County who have tried to kill themselves in the last 12 months is double the state-wide average of 3%.

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Appendix G

Framing CHNA Health Disparities

Community Health Needs Assessment
and Implementation Plan 2014–2016



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 healthcare disparities?

The care that patients access and receive in the hospital, clinic, community and household setting is also a factor in health disparities. Evidence of disparities within the health care setting has been documented. For example,

- the 2003 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* highlighted racial and ethnic disparities in access to care and also disparities in quality of care for those who had access (IOM, 2012), and
- the most recent *National Healthcare Disparities Report* documents socioeconomic, racial/ethnic and age disparities for a large percentage of quality of care measures they assessed (AHRQ, 2011).

What are a few examples of disparities?

National Level

Health disparities have persisted over time, where minority racial groups such as African Americans and American Indians have higher mortality rates compared to whites (IOM, 2012). Examples include:

- gaps in heart disease and cancer mortality rates between African Americans and whites (even though these mortality rates have declined in both groups, the gap between both racial groups still exists),
- a considerable gap in diabetes-related mortality rates has been present between American Indians and whites since the 1950s, and

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

Health disparities have also been documented where racial and ethnic minorities “experience an earlier onset and a greater severity of negative health outcomes” (IOM, 2012). Examples include:

- breast cancer outcomes,
- major depression outcomes, and
- and first birth neonatal mortality.

State Level

Statewide, there are racial/ethnic disparities in the number and magnitude of select health indicators, especially for African Americans and American Indians (MDH, 2009a; MDH, 2009b).

Examples include:

- increased incidence of select STDs (HIV, gonorrhea, chlamydia),
- pregnancy and birth disparities (prenatal care, low birth weight, teen births, infant mortality),
- select chronic disease mortality (diabetes, heart disease, cancer, chronic lower respiratory disease), and
- stroke, mortality rates, and homicide.

Disparities are also present among Hispanics, especially with select STDs incidence, pregnancy and birth disparities, and diabetes mortality rates (MDH, 2009a; MDH, 2009b). All of the mentioned racial/ethnic minorities also have higher rates of uninsurance compared to Whites (MDH, 2009b). Evidence also suggests significant disparities for specific health indicators when comparing urban versus rural populations (MDH, 2011). Examples include:

- higher diabetes, stroke, heart disease, pneumonia and influenza mortality rates are some examples of disparities in rural populations compared to urban populations, and
- higher uninsurance, smoking, obesity, and suicide rates and reporting of “fair” or “poor” health are also examples of disparities in rural communities.

Metro Area

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

Hennepin County

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

Allina Health

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

- an internal study by Pamela Jo Johnson, MPH, PhD and her cohorts identified significant disparities in hospital admission rates for potentially-avoidable hospital care for Ambulatory Care Sensitive Conditions (ACSC), especially for chronic conditions. Overall, 10% of 2010 hospital admissions at Abbott Northwestern Hospital were due to diabetes complications and significant disparities by race/ethnicity were noted. Specifically, 36% of Hispanic admissions, 20% of American Indian admissions, and 15% of Black admissions were due to diabetes, compared with only 8% of White admissions (Johnson et al, 2012), and
- preliminary analysis of 2010 optimal diabetes control data from Allina clinics 2010 data by Jennifer Joseph, MPH, and her cohorts show substantial disparities in optimal status by race/ethnicity. Only 37% of Blacks and 37% of American Indians achieved optimal control status compared with 51% of non-Hispanic whites. Analysis indicates that Blacks and American Indians have significantly higher odds of sub-optimal diabetes control compared to non-Hispanic whites (Joseph et al, 2012).

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

What are healthcare systems doing to eliminate healthcare disparities?

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

Improve:

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

Reduce:

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

Identifying Healthcare Disparities within the Hospital and Clinic Setting

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

Eliminating Healthcare Disparities within the Hospital and Clinic Setting

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

- Culturally-Responsive Care
- Cultural Competence Training for Providers
- Interpreter Services (for patients with a primary language other than English)
- Community Health Workers and Promotoras
- Innovative HIT Tools
- Patient-Centered Care
- Patient-Centered Communication
- Bilingual Staff
- Data Collection & Analysis
- Care Management
- Care Navigators
- Coordinated Care
- Prevention and Wellness Initiatives
- Advanced Care Teams
- Meaningful Use
- Patient Materials/Signage in Multiple Languages
- Workforce Diversity

How can Allina's Community Engagement Programs and Projects Such as the CHNA Reduce Disparities?

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

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

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

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

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Appendix H

Community Dialogue Report

Community Health Needs Assessment
and Implementation Plan 2014–2016





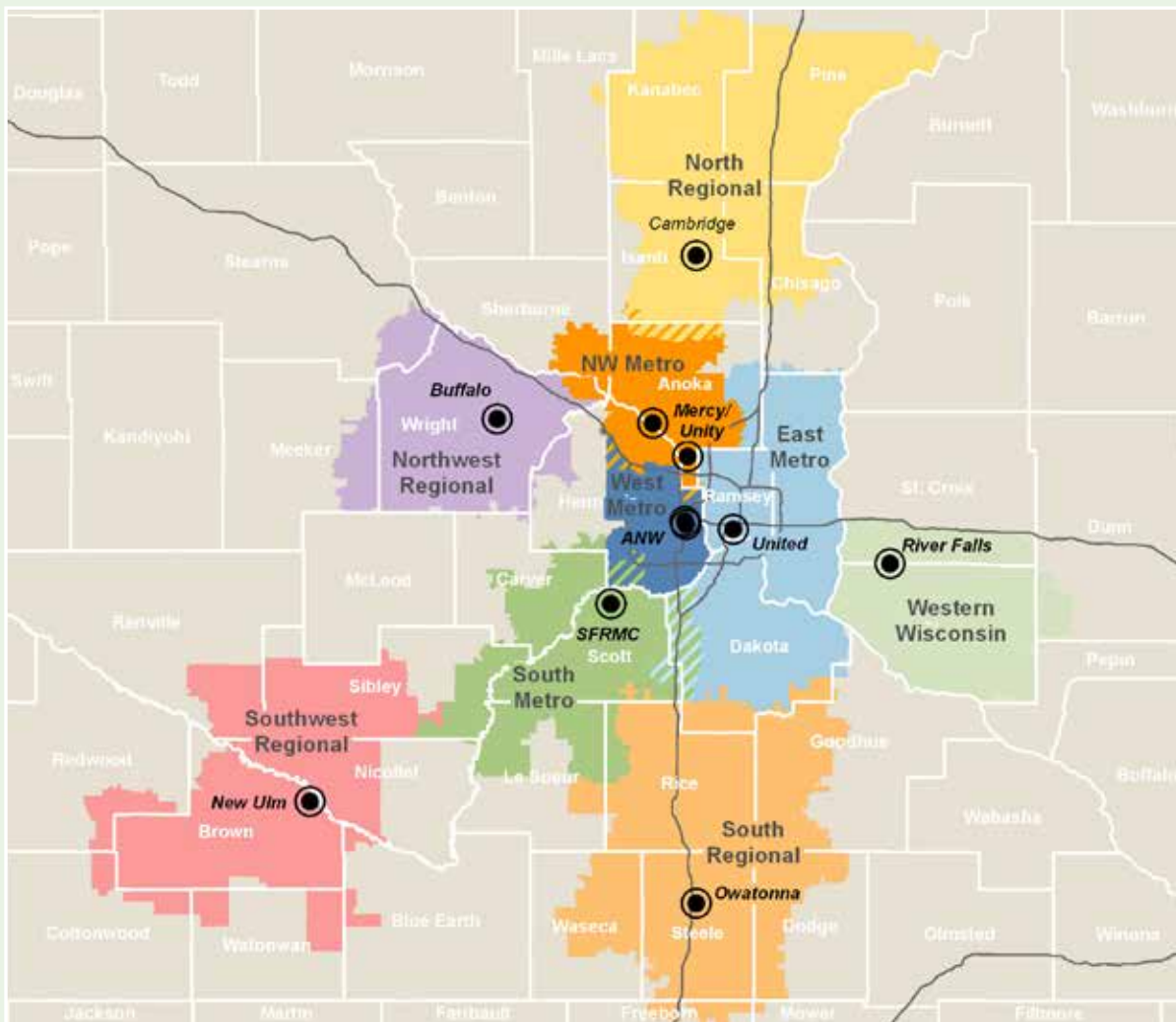
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APRIL 2013

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 New Ulm Medical Center, part of the Southwest 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:

- **OBESITY,**
- **MENTAL HEALTH,**
- **AND SUBSTANCE ABUSE.**

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 forty-three people participated.

This summary highlights the findings from the 2013 dialogues in the Southwest Region, which includes New Ulm Medical Center.

In March 2013, New Ulm Medical Center and Allina Health convened two Community Dialogues in the Southwest 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, mental health, and substance abuse.

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 Southwest 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

New Ulm (March 12)

Twenty community members participated in the March 12 New Ulm community dialogue. The majority of participants were between 45 and 64 years of age. Nearly all of the participants reported living in a small town or a large town/city. Participants indicated representing a variety of sectors such as health care, education, and nonprofits. They also reported a diversity of expertise in health topics, including chronic disease management/treatment/prevention, mental health, and obesity prevention. Many participants reported representing and/or working with adults (25-64) and white residents.

New Ulm (March 28)

Twenty-three community members participated in the March 28 New Ulm community dialogue. Nearly all of the participants were between 25 and 44 or 45 and 64 years of age. Many participants indicated representing the health care sector. To a lesser extent, participants identified, manufacturing/construction, representing the education or nonprofit sectors. They also identified an array of expertise in health topics, such as chronic disease management/treatment/ prevention, physical activity, and mental health. Several participants also cited working with and/or representing individuals with mental health concerns, white residents, parents of children, adults (24-64), and senior citizen (65+).

Community impact



OBESITY

Participants were asked to reflect on how obesity impacts people in their community. They reported that obesity leads to other chronic health issues and medical conditions such as diabetes and heart disease. Some participants expressed concern regarding the elevated level of obesity among young children. They also cited the adverse impact of obesity on the increased cost of healthcare, quality of life, productivity, and mental health. Participants referenced a variety of local community assets that are currently used or could be used to improve local health. Several participants highlighted the work of the Heart of New Ulm, particularly the focus on screenings and prevention.

MENTAL HEALTH

Participants were asked to reflect on how mental health impacts people in their community. They reported that mental health affects families, productivity, employment, and quality of life. Participants indicated that people struggle to access mental health services and providers as a result of a lack of resources or constraints such as distance. Some participants highlighted the stigma that surrounds mental illness and how it may drive people to not seek services and supports or share knowledge of their mental illness with others.

SUBSTANCE ABUSE

Participants were asked to reflect on how substance abuse impacts people in their community. They indicated that substance abuse negatively affects families/children, personal health, public safety, employment, and the cost of medical services (i.e. increased costs). Participants identified a series of causes, contributing factors, or barriers related to substance abuse such as: a limited number of referrals from schools, the stealing of prescription medicines by youth, and mixed messages regarding the consumption of alcohol. Some participants reported that the local community's focus on alcohol at public events (e.g., Bock Fest, Oktoberfest) promotes a culture of drinking.

Addressing health concerns in the community

OBESITY

Participants were asked to reflect on what should be done to address obesity. They shared a range of ideas regarding increasing opportunities and education focused on physical activity, nutrition, and healthy living, such as:

- Giving incentives for healthy lifestyles
- Having outdoor recreational opportunities
- Offering health coaches and nutritionists
- Creating community gardens
- Increasing public education about healthy eating and exercise
- Increasing collaborations with schools focused on healthy eating and exercise

MENTAL HEALTH

Participants were asked to reflect on what should be done to address mental health. They suggested a variety of approaches including increasing awareness and access to services and supports, such as:

- Creating more community-based education on the types of mental illness and their symptoms, along with information on how to access services
- Offering more mental health screenings, particularly in schools
- Improving access to mental health providers

SUBSTANCE ABUSE

Participants were asked to reflect on what should be done to address substance abuse. They shared the importance of increasing awareness and access to services along with focusing on local policy and enforcement. They recommended a variety of approaches, such as:

- Hosting public education about responsible alcohol use
- Adopting a social host ordinance
- Increasing the penalty for possession of a substance
- Having better access to substance abuse treatment
- Promoting the use of medication drop off sites
- Limiting alcohol consumption at local festivities and events

How Allina Health can help address health concerns

OBESEITY

Participants were asked to reflect on how Allina Health could help address obesity. They reported that Allina Health could help address obesity through increasing opportunities and education focused on physical activity, nutrition, and healthy living, growing community partnership, and drawing on local assets. Participants specifically suggested:

- Increasing counseling for children and adults who are overweight.
- Providing incentives for day cares to buy and serve fresh fruits and vegetables.
- Supporting community gardens for low income people.
- Offering discounted rates for memberships at health clubs.
- Giving financial rewards for losing and keeping off weight.
- Extending the Heart of New Ulm's work to youth.
- Having free, individualized nutrition counseling.

MENTAL HEALTH

Participants were asked to reflect on how Allina Health could help address mental health. They shared that Allina Health could help address mental health through increased education and access to services. Participants specifically noted:

- Providing mental health trainings on how to identify the symptoms of mental illnesses.
- Promoting Allina's mental health program and providing more outpatient treatment programs.
- Creating support groups for parents of children with Autism, ADHD, and depression.
- Increasing mental health screenings at worksites and schools.
- Extending the Heart of New Ulm model to mental health.
- Educating providers who work with seniors about what to look for and what steps to take in regards to depression.

SUBSTANCE ABUSE

Participants were asked to reflect on how Allina Health could help address substance abuse. They indicated that Allina Health could help address substance abuse by increasing awareness/education, access to services, and community partnerships. Participants specifically referenced:

- Sponsoring alcohol and drug free celebrations (e.g. having the 4th of July as an alcohol and drug free event).
- Partnering with schools to offer supports for students after treatment.
- Expanding education regarding expired or unused medicine drop-off sites.
- Improving access to those seeking help with their addictions.

Conclusion

The community dialogues were an opportunity for New Ulm Medical Center to hear from a broader group of community members and identify ideas and strategies to respond to the priority issues to inform the action-planning phase of the needs assessment, and ultimately the action plan for New Ulm Medical Center 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.



NEW ULM MEDICAL CENTER
SOUTHWEST REGIONAL

Appendix I

Community Inventory

Community Health Needs Assessment
and Implementation Plan 2014–2016



Inventory of Community Assets – New Ulm Medical Center

The following are examples of community assets that exist today to address the following community health issues. This list is certainly not exhaustive, but gives core examples of great work already being done in our area.

Obesity Inventory

- Heart of New Ulm
- Heart Beat Connections (HBC)
- NUMC Childhood Obesity (School Health Connection, grants)
- Park and Rec
- Community Education
- Springfield County Initiative
- Fitness Centers (Anytime, Curves)
- Weight Watchers
- Chiropractors
- Schools
- Youth Sports/Activities
- Overeaters Anonymous
- Brown County Public Health
- Employers
- CSA/ Farmer's Markets
- State & City Parks (Bike Trails, BMX, BC Trails Coalition, DNR)
- Brown County Extension (WIC, Cooking Classes)

Substance Abuse Inventory

- New Ulm Medical Center
- Underage Substance Abuse Coalition
- Healthy Communities Healthy Youth
- Brown County Teen Center
- Drug Court – Juvenile & Adult
- 12 Step Program
- School Counselors
- Brown County Family Services
- Employers
- Detox
- Law Enforcement
- Parents
- Media
- Pharmacies

Mental Health Inventory

- Sioux Trails
- NUMC (free depression screening day)
- Brown County Family Services
- Brown County Public Health (post-partum, prenatal, children)
- Greater Minnesota (adolescent group homes, home based services)
- Emotions Anonymous
- Yellow Ribbon Program
- Bridge on Center
- Beyond Yellow Ribbon (troops)
- Healthy Communities Healthy Youth (SPOTS)
- Other County Counselors
- Law Enforcement
- CADA House
- Pharmacies

Appendix J

CADCA's Seven Strategies for Community Change

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).