Community Health Needs Assessment and Implementation Plan 2014–2016

Allina Health

PHILLIPS EYE INSTITUTE

WEST METRO

Identifying and Responding to Community Needs

PHILLIPS EYE INSTITUTE
2215 Park Avenue
Minneapolis, MN 55404

Phillips Eye Institute is the third largest eye specialty hospital in patient volume in the United States. Dedicated to the diagnosis and treatment of eye diseases and disorders, Phillips Eye Institute draws patients from a five state region to be treated by a Medical Staff of more than 170 ophthalmologists.

Phillips Eye Institute offers an extensive array of specialty services from diagnostic tests and vision rehabilitation to laser eye treatments and specialized eye surgery.

Phillips Eye Institute was the vision of many community leaders, designed to function as a free-standing eye specialty center associated with Mount Sinai Medical Center. It was developed by and for ophthalmologists. The dream of creating this unique facility was realized because of the persistence, determination and resourcefulness of a large group of people.

Jay Phillips was the main benefactor of Mount Sinai Hospital and a strong supporter of Mount Sinai's Division of Ophthalmology. Because of his generous philanthropic support, Phillips Eye Institute is named in honor of his philanthropic support.

Phillips Eye Institute also has a long history of working to improve health in the community it serves through charitable giving by the Phillips Eye Institute Foundation and direct programming efforts which address health needs in the community. Examples include the Early Youth Eyecare (E.Y.E.) program and the patient assistance transportation program.

LEAD PARTIES ON THE ASSESSMENT

Alison Pence, director, Community Engagement, West Metro Region

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

Dimpho Orionzi, project coordinator, System Office, Allina Health

John Salisbury, student intern, System Office, Allina Health

2012 Phillips Eye Institute Key Measures

Licensed Beds...**20**

Staffed Beds...**8**

Total Operating Revenue **$33,120,170**

Total Operating Expense..............**$29,452,026**

Total Admits...**137**

Adjusted Admits...**5,871**

Total Patient Days **157**

Total Number of Outpatient Visits **14,504**

Number of Full Time Equivalents **126.9**

Allina Health and Phillips Eye Institute Service Area

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

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

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

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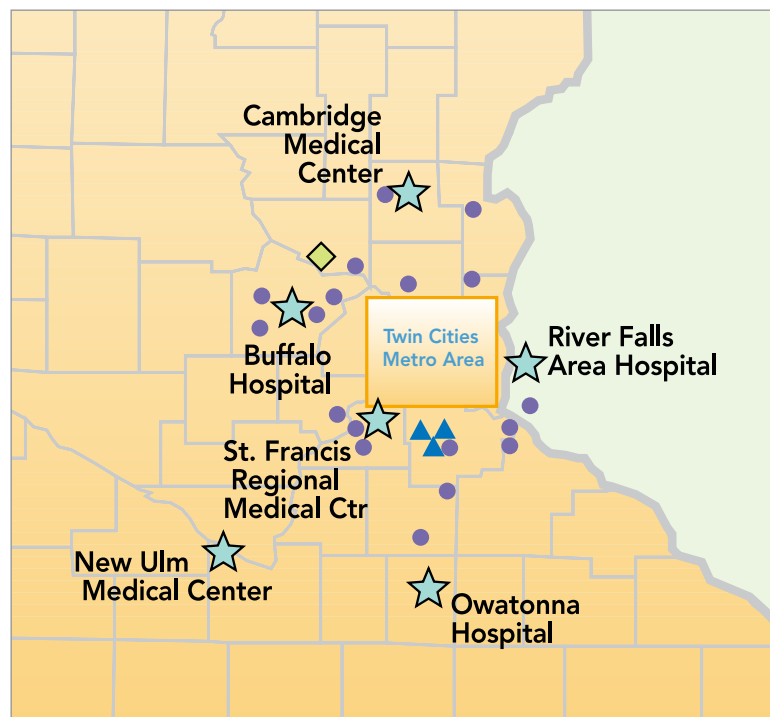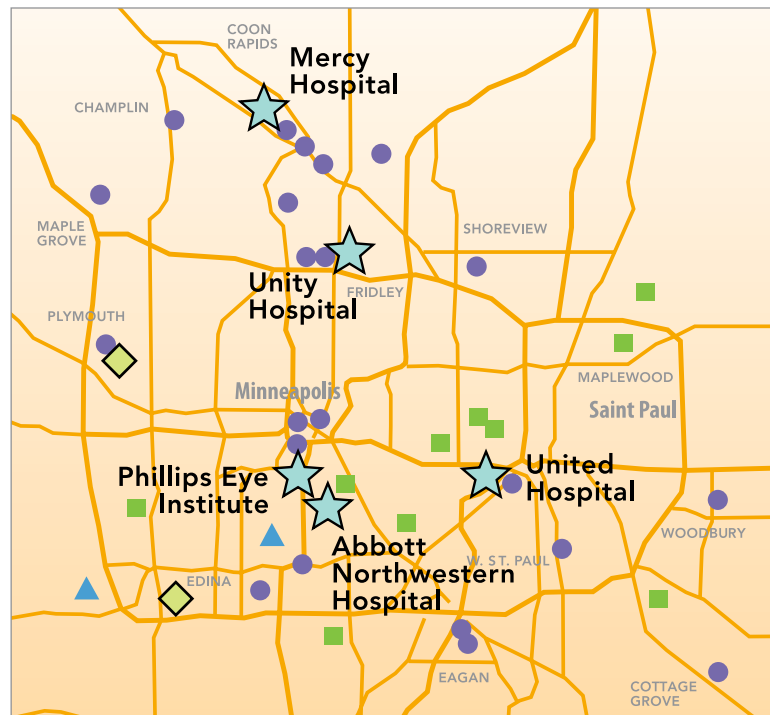
- ★ Allina Health Hospital
- ◆ Allina Health Ambulatory Care Center
- ● Allina Medical Clinic
- ■ Aspen Medical Group
- ▲ Quello Clinic

Map 1 labels: COON RAPIDS, Mercy Hospital, CHAMPLIN, MAPLE GROVE, SHOREVIEW, PLYMOUTH, FRIDLEY, Unity Hospital, Minneapolis, MAPLEWOOD, Saint Paul, Phillips Eye Institute, United Hospital, WOODBURY, Abbott Northwestern Hospital, W. ST. PAUL, EDINA, EAGAN, COTTAGE GROVE

Map 2 labels: Cambridge Medical Center, Twin Cities Metro Area, River Falls Area Hospital, Buffalo Hospital, St. Francis Regional Medical Ctr, New Ulm Medical Center, Owatonna Hospital

Description of Community Served by Phillips Eye Institute

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

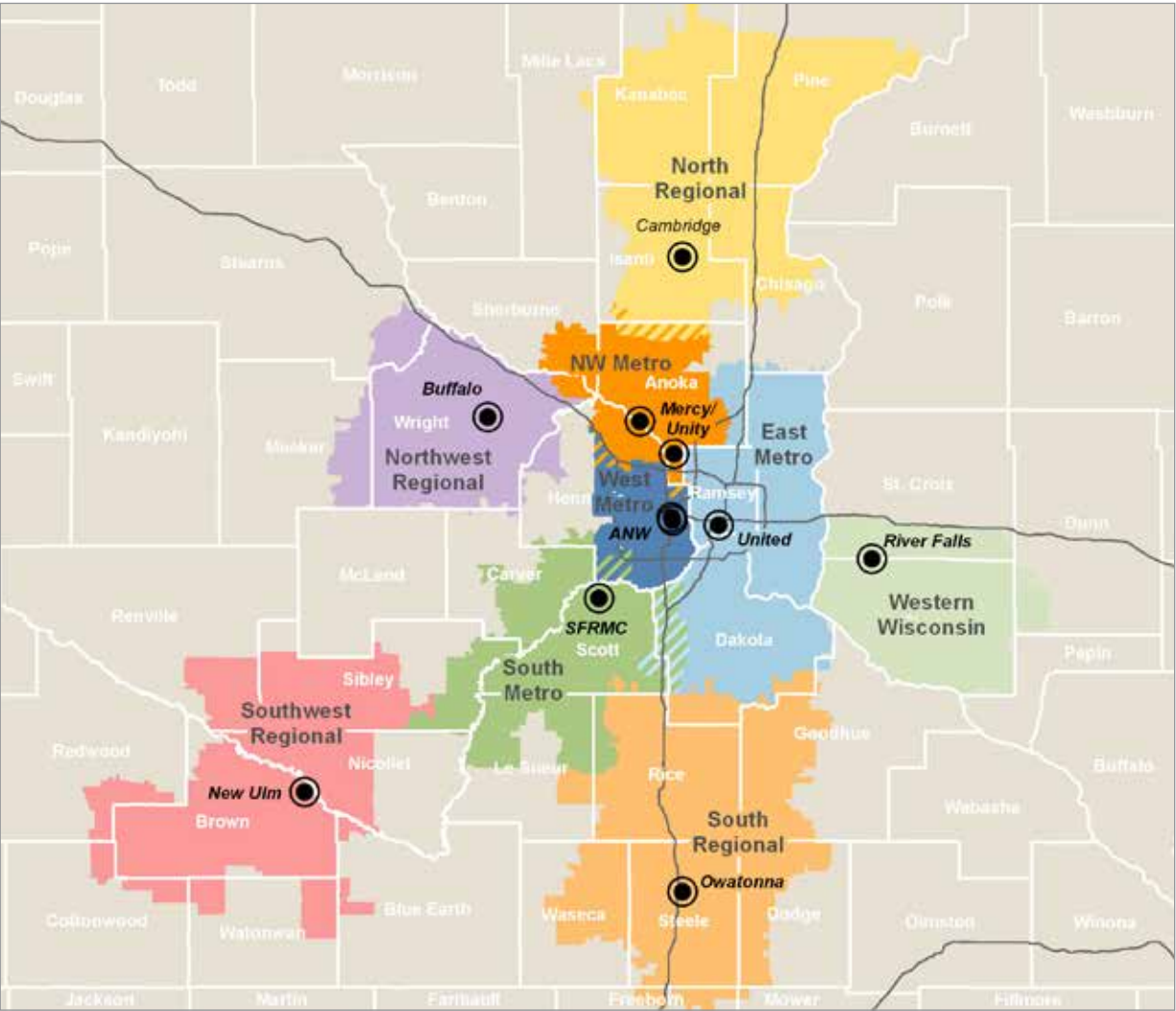FIGURE 1: COMMUNITY BENEFIT & ENGAGEMENT REGIONAL MAP

For the purposes of community benefit and engagement, Allina Health divides its service area into nine regions. The region associated with Phillips Eye Institute is known as the West Metro Region and primarily serves Hennepin County in Minnesota. For the West Metro Region Community Health Needs Assessment (CHNA), the focus of inquiry was Hennepin County. Also within the West Metro Region is Abbott Northwestern Hospital, a hospital that is also a part of Allina Health. Although Abbott Northwestern Hospital and Phillips Eye Institute are located in the same community and used the same data and process for the community health needs assessments, they have distinct priority needs and implementation plans. See Appendix A for a detailed report on Hennepin County, prepared by Stratis Health. All appendices can be found on the Allina Health website (**allinahealth.org**).

FIGURE 2: WEST METRO REGION MAP

Assessment Partners

Phillips Eye Institute'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, Phillips Eye Institute partnered with Wilder Research, a branch of the Amherst H. Wilder Foundation, to conduct the community health dialogues in the West Metro region. Wilder Research developed the dialogue plan and materials, provided technical assistance related to recruitment strategies, facilitated the dialogues and synthesized the information into a report. In addition, Phillips Eye Institute partnered with the Division of Applied Research (DAR) at the system office of Allina Health to conduct qualitative interviews with community members. 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 West Metro Region Community Engagement Lead guided the effort for Phillips Eye Institute.

The Phillips Eye Institute assessment was conducted in three stages: data review and setting priorities, community health dialogues and qualitative interviews and action planning. The process began in April of 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 Phillips Eye Institute Community Engagement Team, the Phillips Eye Institute Senior Leadership Team and the Phillips Eye Institute Foundation Board. The following is a description of the assessment steps and timeline.

PHASE 1	DATA REVIEW AND PRIORITY-SETTING

MAY – JULY 2012 — **DATA COLLECTION**

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

SEPTEMBER 2012 — **DATA REVIEW**

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

OCTOBER 2012 — **ISSUE PRIORITIZATION**

Reviewed Hennepin County Community Health Improvement Process (CHIP) data packet and completed formal prioritization process with stakeholders

PHASE 2	COMMUNITY HEALTH DIALOGUES

FEBRUARY – MARCH 2013 — **DATA COLLECTION**

Conducted community health dialogues and qualitative interviews of community members related to priority areas identified in the data review and prioritization process

APRIL 2013 — **REPORT PRODUCTION**

Developed report of findings from needs assessment, community dialogues and determined preliminary findings from the qualitative interviews

PHASE 3	ACTION PLANNING

APRIL – JUNE 2013 — **IMPLEMENTATION/PLAN**

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

AUGUST – DECEMBER 2013 — **APPROVAL**

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

Data Review and Priority-Setting

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

Data Collection and Review

For this phase in the process, Phillips Eye Institute did not collect primary data, but instead compiled existing public health data to create a set of indicators specific to health in Hennepin 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 Hennepin County and comparison data for other counties in the state.

In 2012, the Hennepin County Community Health Improvement Partnership (CHIP) gathered diverse public and private stakeholders to shape a shared vision for a healthy community.

Together the partnership:

- Identified priority areas needing attention
- Built a foundation for future collaborative action including a framework and guiding principles for working together to tackle challenging but important health goals for Hennepin County.

The Community Health Improvement Plan for Hennepin serves as a guide for how local health boards, hospitals, health plans, clinics and other community organizations will focus and align their work to improve the health of the population and communities they jointly serve.

Building upon a survey, the community health assessment and three community health forums, the plan brings us to the launch point for action by partner organizations that are committed and ready to work together. A multi-disciplinary leadership body will guide the work of the action phase of this collaborative partnership.

The partnership selected the following strategic health issues and targeted health improvement goals for concentrated and aligned focus. Specific, measurable objectives for the goals will be identified during the CHIP action phase.

The CHIP process determined five health priorities for Hennepin County in 2012-2015

1. Maternal and child health: Increase childhood readiness for school
2. Nutrition, obesity & physical activity: Increase regular physical activity and proper nutrition
3. Social & emotional well-being: Increase community and social connectedness
4. Health care access
5. Social conditions that impact health.

The work from this process was incorporated into the West Metro's local strategic planning to improve health in its community. See Appendix D for a full summary of the Hennepin County CHIP Process.

Prioritization Process

In order to systematically select priorities, the West Metro Community Engagement lead held a series of stakeholder meetings. Participants were asked to look at both the data assembled by Allina Health and the priorities selected by Hennepin County to determine whether the hospitals in the West Metro area wanted to select priorities identified by the CHIP plan as their priority issues or to choose other priority issues to focus its community health improvement efforts on in 2014-2016.

- 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 these discussions can be found in Appendix E.

Stakeholders were also given a report prepared by the Health Disparities Work Group of Allina Health (see Appendix F). 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, Phillips Eye Institute chose to focus on the following issues identified in the Hennepin County CHIP process:

1. Maternal and child health: Increase childhood readiness for school

2. General health promotion/care access

The priority health needs were chosen based on the ability of the Phillips Eye Institute to collaborate, utilize assets and implement interventions beyond clinical services in addressing these needs in the community.

IDENTIFIED HEALTH NEEDS NOT SELECTED AS PRIORITIES

Nutrition, obesity & physical activity: Increase regular physical activity and proper nutrition: Although this was one of the CHIP goals for the West Metro Region, stakeholders felt that this issue was one that could be more effectively addressed by Abbott Northwestern Hospital.

Social conditions that impact health: when thinking about Allina Health as an organization with a focus of providing health care, stakeholders felt this was an important issue but fell outside of the core competencies that Allina Health could provide for the community.

Homelessness: Although homelessness was not an issue identified by the Hennepin County CHIP process, it came up multiple times during the West Metro stakeholder meetings. Ultimately, stakeholders agreed this was an important issue, but one that is outside of the scope of Allina Health to effectively address.

Community Health Dialogues

In spring 2013, Abbott Northwestern Hospital and Phillips Eye Institute held a series of meetings which were designed to solicit feedback from the community on how Phillips Eye Institute 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 Phillips Eye Institute 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 Phillips Eye Institute's Community Engagement Lead to community members including representatives from education, local government, religious, social service and other non-profit organizations in the community. There was intentional outreach to representatives from the medically underserved, low income and minority populations, and populations with chronic disease conditions to ensure vulnerable populations were included. All potential participants were told that their feedback was important in representing the many roles they might play in the community: as a worker, neighbor and citizen. A total of 20 people participated in the two community health dialogues in the West Metro Region.

KEY QUESTIONS

Participants were asked to answer the following questions:

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

KEY FINDINGS

Obesity: Dialogue participants felt that Phillips Eye Institute's role, as part of Allina Health, would be through promoting nutrition/ access to healthy foods, creating more opportunities for exercise and physical activity, and more community-based education focused on physical health. Suggestions included:

- Supporting local health foods initiatives in schools and grocery stores
- Establishing community owned bikes
- Offering free opportunities for exercise in partnership with local community centers and churches
- Creating educational programing focused on healthy eating and community gardens
- Assembling an incentive program to encourage weight loss
- Funding the placement of community health workers in local clinics to focus on nutrition and health eating.

Mental health through community and social connections: Dialogue participants felt that Phillips Eye Institute's role, as part of Allina Health, to address this issue in the community would be by facilitating access to mental health resources and convening community members to focus on local mental health issues. Participants specifically noted:

- Establishing "mobile" mental health practitioners who can travel to community centers and satellite clinics
- Holding community forums to discuss and define mental health illness
- Organizing community events through the Backyard Initiative to address isolation among community members
- Providing online access to mental health professionals.

Children's health through school readiness: Dialogue participants felt that Phillips Eye Institute's role, as part of Allina Health, could help address children's health through school readiness by expanding services currently offered in schools and increasing collaboration with community organizations. Ideas included:

- Sustaining the Phillips Eye vision screening and extend it to other schools
- Creating incentives for families who attend school fairs or parent teacher conferences
- Supporting school readiness health screenings
- Partnering with local academic and nonprofit groups to focus on children's holistic health and establishing strong health behaviors early in a child's life.

For a full copy of the report see Appendix G.

Qualitative Interviews

To augment the Abbott Northwestern Hospital CHNA process, the Division of Applied Research videotaped interviews of community members to help the hospital and Allina Health understand the unmet health needs of the community, solicit how Phillips Eye Institute could most effectively address the selected priority issues, and inform action planning.

Through the Backyard Initiative (a program of Allina Health) the Division of Applied Research partnered with the Cultural Wellness Center (a community based organization) and Citizen Health Action Team leads (resident lead groups in the Backyard Initiative that design and implement health and wellness projects) to identify potential interviewees residing in proximity to Phillips Eye Institute. Prospective participants were contacted by phone to introduce the opportunity and determine interest and eligibility.

In order to maximize diversity, selection preference was given to people living within proximity (approximately a 2-mile radius) to Phillips Eye Institute who have chronic disease needs, and who are long-term residents of the area, recent immigrants, members of the medically underserved, low-income, and minority populations of the community. All potential participants were told that their participation would help the hospital understand some of the unmet health needs of the people living in its community as a means to better serve the community.

A total of nine community members were interviewed and filmed for approximately one hour each.

INTERVIEW QUESTIONS

Each participant was asked a series of questions related to each community health priority identified in the West Metro community health needs assessment. The questions specific to Phillips Eye Institute's needs assessment process centered on school readiness.

RESULTS

Qualitative data analysis was conducted on each interview. Complete results will be integrated into the action planning process for Phillips Eye Institute and Allina Health where applicable. In addition, interview footage and voice-over narrative will be combined to create a concise, effective messaging video which conveys identified actionable opportunities to Phillips Eye Institute, Allina Health and the community.

For a detailed summary of the qualitative interview process, questions and emerging findings, see Appendix H.

Community Assets Inventory

Between the community health dialogues and the action-planning phase, the Community Engagement Lead for Phillips Eye Institute 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 a full inventory of hospital and community-based programs.

Action Planning

The final phase of the CHNA process was to develop the implementation plan for Phillips Eye Institute. 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. Phillips Eye Institute used its Phillips Eye Institute Community Engagement Team to engage with internal and external stakeholders including the Phillips Eye Institute Senior Leadership Team, the Phillips Eye Institute Foundation, the Minneapolis Public Schools and the St. Paul Public Schools over three meetings to develop the implementation plan for FY 2014–2016.

THE PROCESS INCLUDED FOUR STEPS:

1. Identifying key goals, objectives and indicators related to the priority issues
2. Reviewing Community Health Dialogues report, themes from the qualitative interviews 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, Phillips Eye Institute 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, themes from the qualitative interviews 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

Phillips Eye Institute used CADCA'S "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, Phillips Eye Institute 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, Phillips Eye Institute identified when the hospital was going to lead the work, support the work or partner on the work. This was important to not only budget accordingly, but to identify and leverage the expertise of the various assets in the community.

Implementation Plan

The implementation plan is a three-year plan depicting the overall work that Phillips Eye Institute 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.

Maternal & child health: Increase childhood readiness for school

GOAL: Increase childhood readiness for school

INDICATOR

- Increase proportion of children who access vision care

Phillips Eye Institute's strategy to increase childhood readiness for school in its community will focus on increasing access to eye care for all children and populations with unmet vision care needs and examining the connection between access to vision care and school readiness. Planned programs include:

- Expanding Early Youth Eye care (E.Y.E) program to include all elementary schools in Minneapolis and St. Paul. *Partners: Minneapolis Public Schools, St. Paul Public Schools.*

- Expanding the Kirby Puckett Education Center to include the creation of a mobile eye clinic to serve populations not currently receiving vision services. *Partners: Minneapolis & St. Paul Public Schools, Organizations serving low-income populations, Outstate communities.*

- Partnering with Wilder Research or the University of Minnesota to examine the link between access to vision care and school readiness. *Partners: Wilder Research, University of MN, Minneapolis & St. Paul Public Schools*

General health promotion/ care access

GOAL: Increase access to health care services

INDICATOR

- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care.

Phillips Eye Institute's strategy to increase access to health care services in its community will focus on providing transportation services to Phillips Eye Institute patients. Planned programs include:

- Continuing to provide free transportation for Phillips Eye Institute patients to access their vision care services.

Conclusion

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

AllinaHealth

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Appendix A

Hennepin County Profile

Community Health Needs Assessment
and Implementation Plan 2014–2016

ALLINA HEALTH

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Demographics Affecting Health - Hennepin County Profile

(Twin Cities Region)

Factors influencing individual and population health in Minnesota

Through Stratis Health's Culture Care Connection Minnesota County Profiles, health care organizations can better understand their geographic service areas by examining the characteristics of individual counties, surrounding regions, 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 organizations 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.

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

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

Demographics   Age • Gender • Race • Foreign Born • Language

Demographic data reveal the following state-level trends:

• Minnesota's population continues to become more diverse. Between 2000 and 2010, the Asian, Black, and Hispanic/Latino populations increased at a rate of 50.9%, 59.8%, and 74.5%, respectively, compared with the white population which increased only 2.8%.

• One in ten, or 10.3%, of households in Minnesota speak a language other than English at home.

• 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 a notable exception in older age groups which have larger proportions of females.

In the Twin Cities region, the population increased by 12.5%, from 2,642,056 in 2000 to 2,971,500 in 2010 based on EDR data. In Hennepin County, the population increased by 3.3%, from 1,116,039 in 2000 to 1,152,425 in 2010 based on EDR data.

StratisHealth

CULTURE CARE CONNECTION

Funding provided by

UCare

Sources:

Minnesota Population by Race and Hispanic Ethnicity, State Demographic Center, viewed 06/06/2012
http://www.demography.state.mn.us/resource.html?Id=31946

Minnesota Quick Facts, U.S. Census Bureau, viewed 06/06/2012
http://quickfacts.census.gov/qfd/states/27000.html

Population Projections for Minnesota Regions, Minnesota State Demographic Center, viewed 06/06/2012
http://www.demography.state.mn.us/projections.html

Minnesota Population Change by County, Minnesota State Demographic Center, viewed 06/06/2012
http://www.demography.state.mn.us/projections.html

Age

According to the 2010 Census, the number of Minnesotans age 65 and older increased 15% while the number of those over 85 increased almost 25% since the 2000 census. The median age in Hennepin County was 35.9 years compared with 37.4 for the state. The overall age composition of the state has become much older in the past ten years.

Population statistics (Hennepin County):

Under 15 years: 18.9%

15 - 24 years: 13.6%

25 - 44 years: 29.6%

45 - 64 years: 26.4%

65 and older: 11.3%

Population Distribution by Age Group: 2010

What providers need to know:

According to the 2010 Census, the proportion of Minnesota's older population, as well as its ethnic and immigrant populations, has grown at a faster pace than the rest of the state's population. These growing populations will continue to exert pressure on health care resources. Consider whether your organization is prepared to meet the special needs of these populations.

Projected Population - Hennepin County: 2005-2035

Suggestions:

Become familiar with the needs of ethnic and immigrant populations, as well as older age groups. Develop strategies to accommodate these emerging populations, including strategies for making referrals to transportation services, allowing more time for patient encounters, familiarizing yourself with the common health concerns and social issues of immigrants and the elderly, as well as providing health information in languages other than English and in alternative formats.

Sources:

Profile of General Population and Housing Characteristics, American Community Survey: 2010 Demographic Profile Data, viewed 06/06/2012
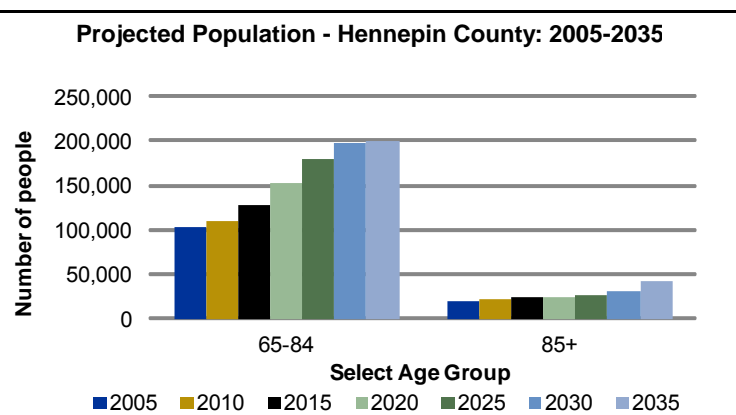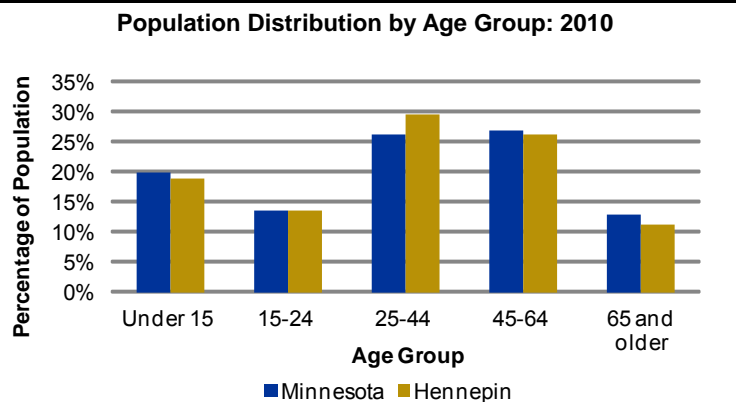http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1prodType=table

Projected Minnesota Population by Age and Gender by County, Region and Metropolitan Areas: 2007, viewed 06/06/2012
http://www.demography.state.mn.us/projections.html

The Older Population: 2010 Census Briefs, viewed 06/06/2012
http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf

Gender

The overall gender distribution for Hennepin County in 2010 was 50.9% female, 49.1% male.

Variations appear when the data are viewed by age range:

Age Range	Male	Female
Under 15	50.9%	49.1%
15 to 24	50.1%	49.9%
25 to 44	50.3%	49.7%
45 to 64	49.1%	50.9%
65 and older	42%	58%

Source:
Demographic and Housing Estimates, American Community Survey 2010, viewed 06/06/2012
http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_DP05prodType=table

Gender Distribution - Hennepin County: 2010

Race

Minnesota's population is considerably less diverse than the U.S. population. Minnesota's populations of color accounted for 14.7% of the population in 2010, compared with 27.6% of the national population. However, between 2000 and 2010, populations of color grew faster in Minnesota, at a rate of 50.2%, compared with 21.8% nationally.
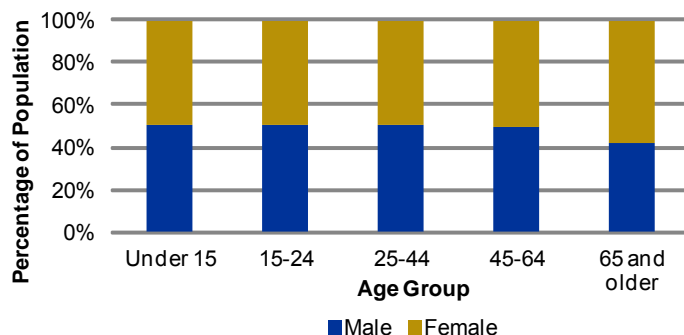
The Twin Cities metro area population is projected to grow 9% - 10% per decade, well below the historic growth rates of 15% per decade in the 1980s and 1990s. In 2010, people of color comprised 24% of the regional population. By 2040, the Metropolitan Council projects 43% of metro residents will be people of color. The Hispanic population is expected to nearly triple, and other populations of color are expected to more than double, while the White non-Hispanic population will decrease 2%.

Between 2000 and 2010, the actual growth rate in populations of color in Hennepin County was 36%, higher than the national growth rate of 21.8%.

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, staff and patient populations within health care organizations will become more diverse as well.
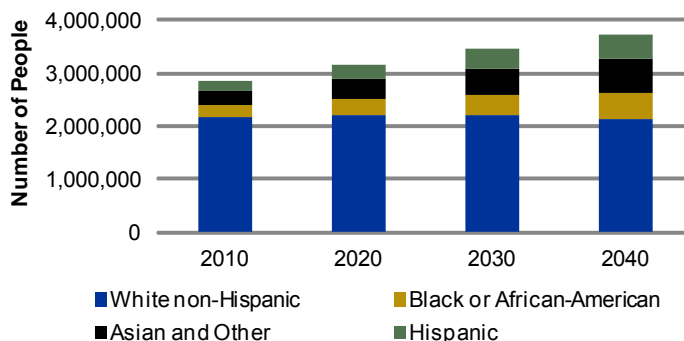

Projected Growth Rates - Populations of Color: 2005-2035
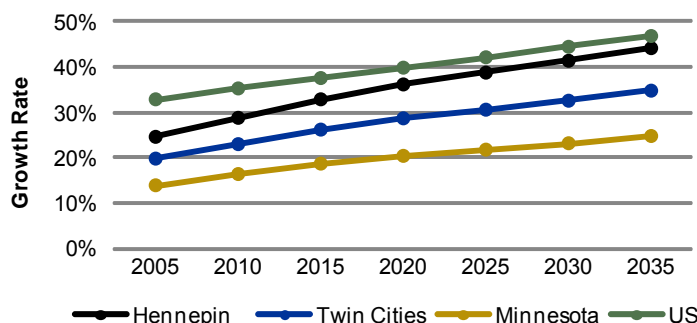
Projected Populations of Color - Twin Cities: 2010-2040

Suggestions:

Get to know your 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 helps to ensure effective health care. Diversity in Minnesota

Sources:
2010 Minnesota Population by Race and Hispanic Origin for Counties, Minnesota State Demographic Center, viewed 06/06/2012
http://www.demography.state.mn.us/resource.html?Id=31973

2011 Minnesota County Health Table: Demographics, viewed 06/06/2012
http://www.health.state.mn.us/divs/chs/countytables/profiles2011/index.html

2002 Minnesota County Health Table: Demographics, viewed 06/06/2012
http://www.health.state.mn.us/divs/chs/countytables/profiles2002/demo.htm

What Lies Ahead: Population, Household and Employment Forecasts to 2040, Metropolitan Council, viewed 06/06/2012
http://archive.leg.state.mn.us/docs/2012/other/120456.pdf

Minnesota population projections by race and ethnicity, 2009, viewed 06/06/2012
http://www.demography.state.mn.us/projections.html

Foreign Born

Foreign born refers to people residing in the U.S. at the time of the census who were not U.S. citizens at birth. The foreign-born population includes naturalized citizens, lawful permanent immigrants, refugees, asylees, legal nonimmigrants, and persons residing in the country without authorization.

Foreign Born Population by Region of Birth - Minnesota: 2010

- Asia (37.2%)
- Latin America (27.4%)
- Africa (20.2%)
- Europe (11.1%)
- North America (3.6%)
- Oceania (0.5%)

In 2010, the foreign born population represented 7.1% of Minnesota's total population. Data reveal the following percentage of foreign born population in Minnesota by region of birth.

• Asia: 37.2%

• Latin America (South America, Central America, Mexico, and the Caribbean): 27.4%

• Africa: 20.2%

• Europe: 11.1%

• North America (Canada, Bermuda, Greenland, St. Pierre and Miquelon): 3.6%

• Oceania: 0.5%

Of foreign born in Minnesota, 25.4% reported Hispanic/Latino origins. Almost 45% of Minnesota's foreign born were U.S. citizens, a change from 33.4% in 2000.
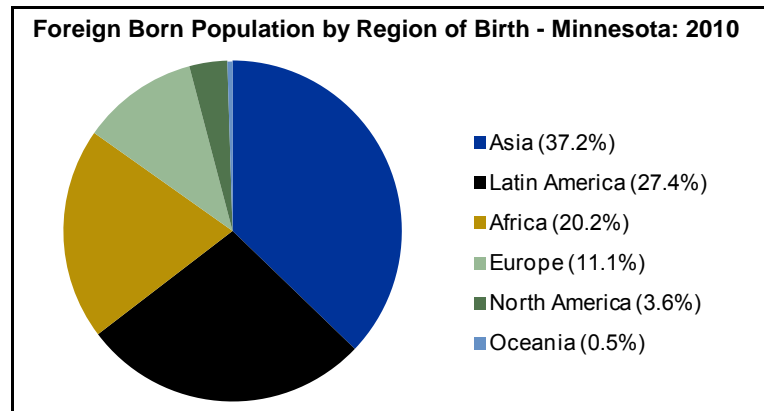
What providers need to know:

Important factors to consider in providing care to foreign born and immigrant populations include: nutritional status, mental health (especially in refugee populations), infectious diseases (such as Hepatitis B status), 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 length of time in the United States.

Suggestions:

Provide information to patients who are not familiar with the Western medical system, such as guidance on obtaining health insurance, setting up initial and follow-up appointments, and practicing preventive health, including cancer screenings. Become familiar with health screening recommendations for your patients based on their countries of origin and health status.

Conduct a CLAS (Culturally and Linguistically Appropriate Services) Standards Assessment to identify strengths 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.

Source:
MPI Data Hub, Migration Facts, Stats, and Maps, viewed 06/24/2012
http://www.migrationinformation.org/datahub/state.cfm?ID=MN#3

Language

According to the American Community Survey, 2008-2010, the languages most commonly spoken in Minnesota, other than English, were Spanish (3.8%), Asian and Pacific Islander languages (2.2%), and Other Indo-European languages (1.6%).

In Hennepin County during the period 2011-2012, Spanish was the primary language spoken other than English in 13,157 homes (8.4%), while Somali was spoken in 5,957 homes (3.8%) and Hmong in 4,413 homes (2.8%).

Languages Most Commonly Spoken in Hennepin County: 2011-2012

- English (79%)
- Spanish (8.4%)
- Somali (3.8%)
- Hmong (2.8%)
- Vietnamese (0.7%)
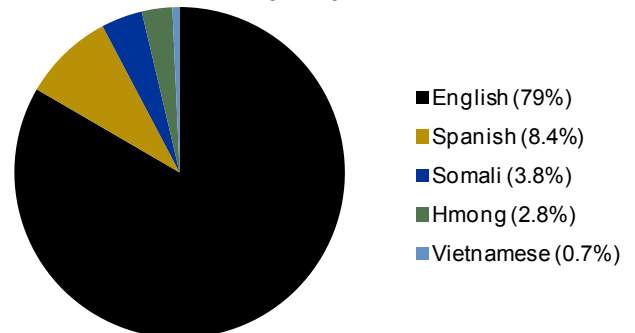
What providers need to know:

Language barriers pose a challenge to even the most basic clinical encounters. According to the U.S. Department of Health and Human Services Office of Minority Health:

- Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient with limited English proficiency at all points of contact, in a timely manner, during all hours of operation.

- Family and friends should not be used to provide interpretation services.

Suggestions:

Provide an interpreter to patients who do not speak English or who have limited English proficiency to freely communicate their expectations and preferences (Requirement CLAS Standard 4).

For all patients, especially those who speak English as a second language, use simple language, avoid technical terms, abbreviations, and professional jargon.

Sources:
Selected Social Characteristics in the United States, American Community Survey: 2008 - 2010, viewed 06/17/2012
http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP02prodType=table
Primary Home Language Totals: 2011-2012, Minnesota Department of Education, viewed 06/17/2012
http://education.state.mn.us/MDEAnalytics/Data.jsp
Think Cultural Health, viewed 06/17/2012
https://www.thinkculturalhealth.hhs.gov/Content/clas.asp

Socioeconomic Status   Education • Income • Occupation

The evaluation of patients' socioeconomic status can provide valuable insights into diverse populations. Socioeconomic status is the measure of an individual's economic and social position relative to others based on education, income, and occupation.

- Education influences occupational opportunities and earning potential, in addition to providing knowledge and life skills that can promote health.

- Income provides a means for purchasing health care coverage, but level of income determines 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

The number of high school graduates in Minnesota is projected to decline from 65,073 in 2010 to 59,727 by 2017. From 2017 to 2023 the number of graduates is expected to increase slightly, but will remain below the 2010 number of graduates.

As Minnesota's population continues to become more diverse, students of color will comprise a larger share of high school graduates in the future. The percentage of nonwhite graduates is projected to grow from 16% in 2010 to 23% of all graduates in 2023.

For all races, Hennepin County data indicate a lower percentage of individuals receiving at least a high school diploma, 19.8% compared with state level rates of 27.8%. Attainment of a Bachelor's degree in Hennepin County, at a rate of 29.4%, was higher than state level rates of 21.3%.

Sources:
Insight, Minnesota Office of Higher Education, viewed 06/06/2012
http://www.ohe.state.mn.us/pdf/Enrollment/INSIGHT/InsightNov10.htm

Selected Social Characteristics in the United States, American Community Survey 2008-2010, viewed 06/06/2012
http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP02prodType=table
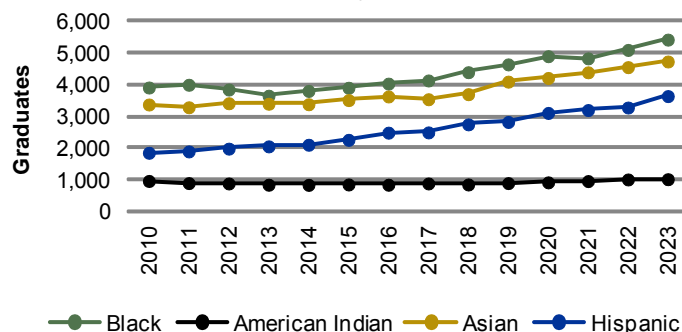
Income

Income level influences an individual's access to health insurance and health care. Rates of uninsured can be difficult to measure. Wide variability across racial and ethnic groups exists. Historically, white populations have been the most likely to be insured and Hispanic/Latino populations have been the least likely to be insured.

Income level is also used to determine poverty status, which can determine eligibility for various assistance programs.

Poverty status is based on a minimum level of income necessary to achieve an adequate standard of living. Poverty is on the rise in Minnesota. According to federal poverty guidelines, the poverty threshold in Minnesota in 2012 equaled $23,050 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.

Projected Number of Minnesota High School Graduates by Race/Ethnicity: 2010-2023

Education Attainment: 2006-2010
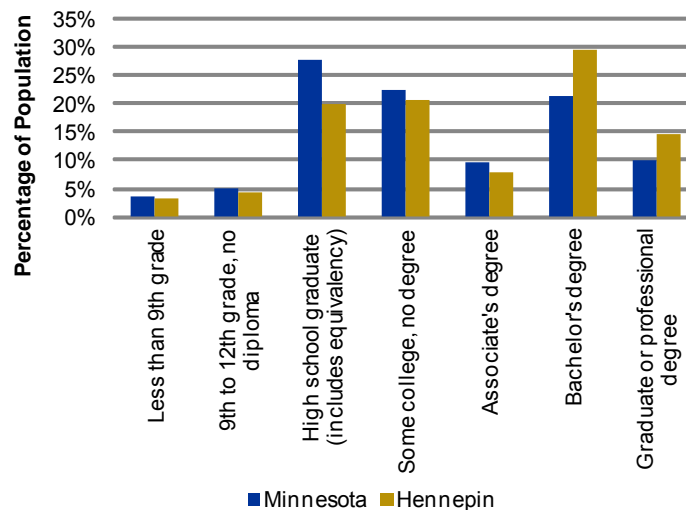
Poverty Status - All Ages: 2002-2008

In Hennepin County, the median household income based on 2006-2010 estimates was $61,328. Approximately 12.1% of county residents are below the poverty level.
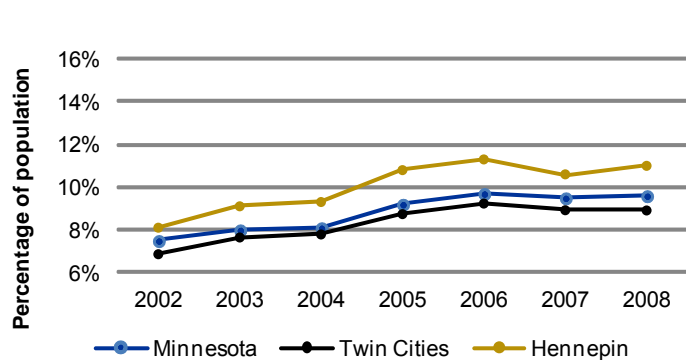
Employment

According to 2006-2010 American Community Survey estimates, 67.8% of the population 16 years of age and over in Hennepin County were employed. For current, quarterly unemployment data, visit the Minnesota Department of Employment and Economic Development.

Employment and lack of employment influence a variety of social and health risks, including access to health care insurance and physical and psychological needs. For example, individuals in office-based occupations are at risk for repetitive stress injuries and musculoskeletal disorders due to the sedentary nature of this work.

Individuals who are unemployed or experience job insecurity may face health risks such as increased blood pressure and stress.

What providers need to know:

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

Employment: 2006-2010

Chart showing Percentage of Population by industry category for Minnesota (blue) and Hennepin (gold): Agriculture and mining, Construction, Manufacturing, Wholesale trade, Retail trade, Transportation and warehousing, Information, Finance and insurance, Professional services, Educational and health care, Arts and entertainment, Other services, Public administration.

Suggestions:

Consider how a patient's socioeconomic status can affect the patient's 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. Dial 211 for the United Way First Call for Help to get information and referrals about employment, health services, etc. Establish a culturally sensitive plan for identifying and referring patients who may benefit from these services.

Health Status Data   Birth Rate • Morbidity

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

• A need exists for increased efforts to provide prenatal care in the general population, as well as an awareness of birth trends in populations of color.
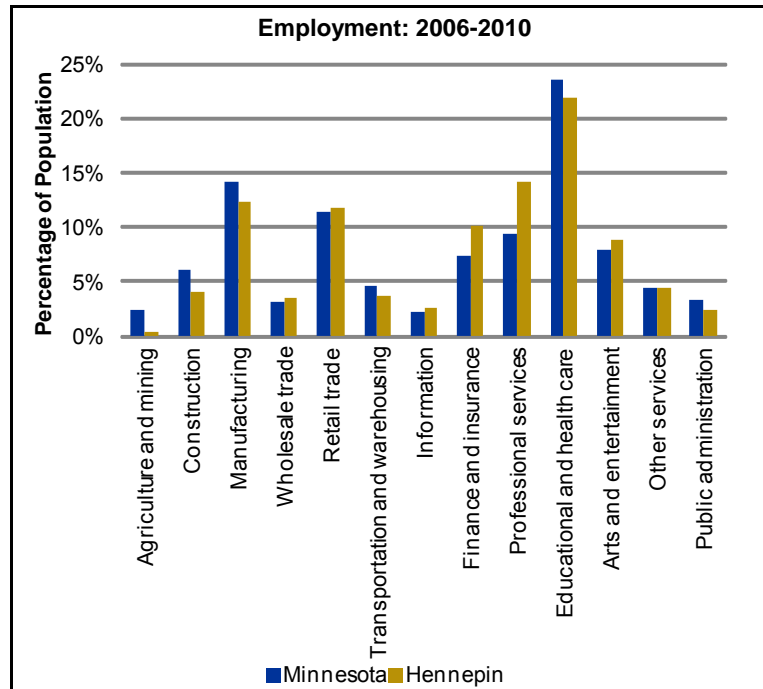
- Greater outreach is needed to encourage behaviors which decrease the burden of poor health in populations of color.

Birth Rate

Hennepin County's birth rate of 13.8 births per 1,000 is higher than state-level rates of 12.9 births per 1,000. In 2010, 81.4% of births in Hennepin County had adequate prenatal care (nine or more prenatal visits and seen in the first trimester) compared with 78.1% in 2007 and 76.6% in 2003.

Minnesota's teen birth rate dropped 19% from 2007 to 2010. About 22.5 births per 1,000 women age 15-19 occurred in 2010, compared with 34 births per 1,000 women nationally. However, Minnesota has wider racial disparities when it comes to teen birth rates compared with the nation. The birth rate among American Indian and Hispanic teens in Minnesota is more 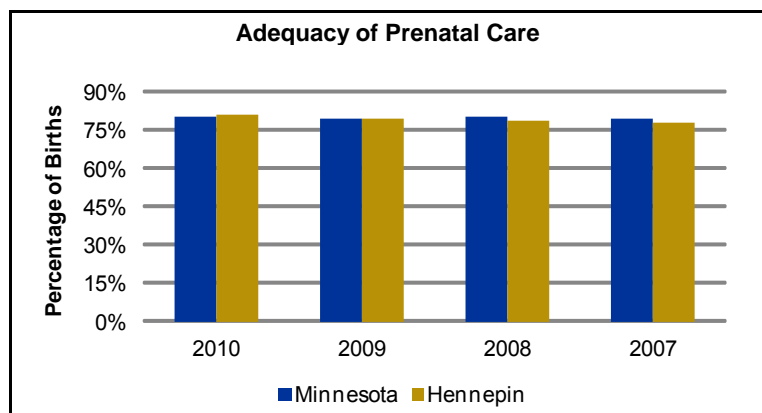than three times higher than the rate for white teens. The rate also is higher for African American and Asian/Pacific Islanders than for white teens.

Sources:
Minnesota County Health Tables, Minnesota Department of Health, viewed 06/06/2012
http://www.health.state.mn.us/divs/chs/countytables/index.htm
U.S. Centers for Disease Control and Prevention, viewed 06/06/2012
http://www.cdc.gov/nchs/data/databriefs/db89.htm

Adequacy of Prenatal Care

(Bar chart showing Percentage of Births by year for Minnesota and Hennepin, years 2010, 2009, 2008, 2007)

Morbidity

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

According to the latest available data from the Minnesota Department of Health (2009), Hennepin County residents are at higher risk for behavioral factors such as binge drinking and smoking than Minnesotans in general.

In Minnesota, the top three behavioral risk factors are obesity, hypertension and binge drinking.

Behavioral Risk Factors: 2009

(Bar chart showing percentages for Minnesota, Twin Cities, and Hennepin across categories: Overweight (Not obese), Obese, Current smokers, Binge drinking, Heavy drinking, Health status (fair or poor), Reporting limitations, No exercise, Hypertension)
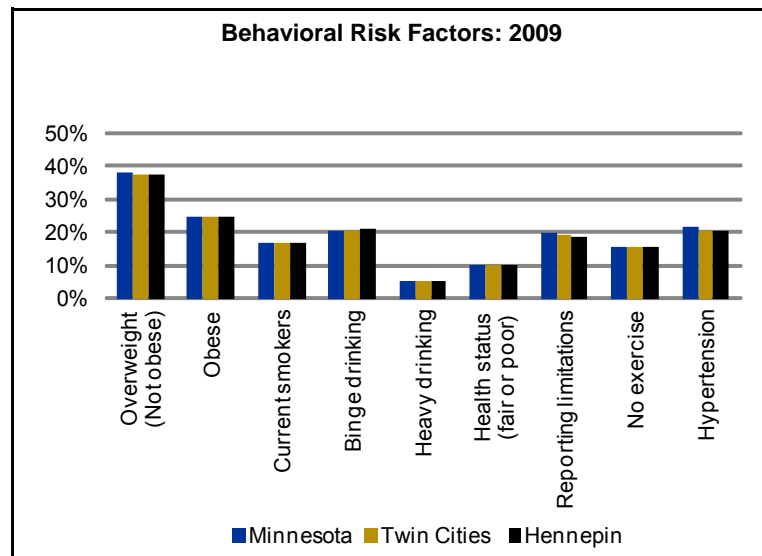
What providers need to know:

Patients have varying perceptions of the concepts of disease and preventive care. Helping 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 is important.

Suggestions:

Become familiar with the traditional cultural approaches to health care used by the patient populations seen frequently in your practice. Recognize that patients may use traditional cultural approaches and provide alternative treatment options that complement or at least do not violate cultural preferences.

Sources:
2010 Minnesota County Health Tables, Minnesota Department of Health, viewed 06/06/2012
http://www.health.state.mn.us/divs/chs/countytables/profiles2011/index.html

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. The online CLAS Standards Assessment offers customized evaluation and recommendations.

2) Visit the Culture Care Connection website, 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.

CULTURE CARE CONNECTION is an online learning and resource center designed to increase the cultural competence of health care clinicians, administrators, and ancillary staff serving diverse
populations.

"Culture" can refer to a variety of factors, including age, education, income, 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.

Appendix B
Community Partners

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
PHILLIPS EYE
INSTITUTE

Round 1 Dialogues

Mark Hinds	Lyndale Neighborhood Association	10/29
David Frank	City of Minneapolis	10/29
Heather Haen Anderson	Edina Community Foundation	10/24
Dr. Julie Boman	Childrens Hospitals & Clinics of Minnesota	10/29
Mary Brindle	Edina City Council	10/24
Kathy Iverson	City of Edina	10/24
Julie Zamora	Bloomington Public Health	10/24
Asad Aliweyd	New American Academy	10/24
Amber Spaniol	Robbinsdale Area Schools	10/30
Thaddeus Lesiak	Andersen School	10/23
Amy Shellenbarger	Community Univeristy Health Care Center	10/23
Flynn Rico-Johnson	Do.Town/Grassroots Solutions	10/24
Robin Fisher	Headway Emotional Health Services	10/24
Matt Tennant	Full Cycle	10/29
Stephanie Leonard	Bolder Options	10/23
LaDonna Hoy	Interfaith Outreach & Community Partners	10/30
Frances Lubecke	Volunteers Enlisted to Assist People (VEAP)	10/24
Officer Mike Kirchen	Minneapolis PD	10/30
Eva Sanchez	Portico Healthnet	10/23
Sandra Aslaksen	Our Saviour's Community Services	10/29
Tim Grote	ANW Facilities	10/25
Candice Washington	ANW Community Relations	10/25
Adam Juul	ANW Facilities	10/25
Joan Arbach	PEI Administrator	10/25
Mike Erickson	ANW/PEI Security	10/25
Dr. Anne Lukasewycz	ANW General Medicine Clinic	10/25
Carol Slings	ANW General Medicine Clinic	10/25
Tony LaCroix-Dalluhn	ANW Emergency Dept	10/25
Sue Durkin	WestHealth Emergency Dept	10/30
Jeff Roseland	WestHealth	10/30

Round 2 Dialogues – Wilder

Patsy Bartley	NIP Clinic	2/25
Officer Anne Marie Buck	Hopkins PD	2/5
Jessica Ayers-Bean	CampFire USA	2/25
Sandra Lee	City of Bloomington	2/5
Don Greeley	Minneapolis Police Department	2/25
Sharon Brown	Three Rivers Park District	2/5
Tim Thorpe	Pathways	2/5
Julie Thurn-Favilla	Augustana Care	2/5
Alyssa Krumholz	City of Plymouth	2/5
Judy Hanson	Wayzata Public Schools	2/5
Linda Seaton	Three Rivers Park District	2/5
Chris Bargeron	NIP Clinic	2/25
Jenny Bordon	Minneapolis Public Schools	2/25
Khusaba Seka	Anchor Families	2/25
Mark Anderson	Barbara Schneider Foundation	2/25
Mary Heiman	Minneapolis Public Schools	2/25
Carmen Teskey	Minneapolis Public Schools	2/25
Anthony Ongaro	Nice Ride Minnesota	2/25
LaDonna Hoy	Interfaith Outreach & Community Partners	2/25

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

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

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

Opportunity for Health

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

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

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

Healthy Living

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

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

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

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

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

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

Chronic Diseases and Conditions

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Anoka	Ramsey	Hennepin
Chronic Dis. and Cond.	102. Percent of 9th graders who are overweight but not obese according to BMI	MSS	13%	14%	14%	12%
Chronic Dis. and Cond.	103. Percent of 9th graders who are obese according to BMI	MSS	9%	10%	11%	8%
Chronic Dis. and Cond.	104. Percent of adults who are overweight according to BMI	Local Surveys	38.1%	38.5%	36.3%	32.8%
Chronic Dis. and Cond.	105. Percent of adults who are obese according to BMI	Local Surveys	24.7%	27.9%	24.4%	20.4%
Chronic Dis. and Cond.	106.Percent of WIC children under aged 2-5 years who are obese according to BMI	MDH WIC	13.1%	11.5%	14.6%	
Chronic Dis. and Cond.	107. Leading causes of death - age adjusted rates per 100,000 (e.g. cancer, heart disease, stroke)	MDH MCHS	Table VI	Table VI	Table VI	Table VI
Chronic Dis. and Cond.	108. Asthma hospitalizations (age adjusted rate per 10,000)	MNHDD	7.5	9	10.6	11.5
Chronic Dis. and Cond.	109. Cancer incidence per 100,000 (all cancer types combined, age adjusted rate per 100,000)	MDH MCSS	474.9	505.9	464.3	470.4
Chronic Dis. and Cond.	110. Breast cancer incidence (age adjusted rate per 100,000)	MDH MCSS	127.3	122	123.4	133.1
Chronic Dis. and Cond.	111. Heart attack hospitalizations (age adjusted rate per 10,000)	MNHDD	27.3	30	28.4	25.7
Chronic Dis. and Cond.	112. Heart disease prevalence	Local Surveys	4.9%	2.8%	2.3%	2.8%

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

Infectious Disease

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

Injury and Violence

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

TABLE I
State-wide

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

Anoka

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

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

Ramsey

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

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

Hennepin

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

TABLE II

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

TABLE III

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

TABLE IV

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

TABLE V

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

TABLE VI

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

TABLE VII

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

TABLE VIII

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

Local Surveys

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

Local Survey Websites

Bridge to Health 2005 and 2010
Results for Aitkin County, Carlton County, Cook County, City of Duluth, Itasca County, Koochiching County, Lake County, Pine County, St. Louis County, St. Louis County without Duluth

Southwest South Central Adult Health Survey 2010
Results for Big Stone County, Blue Earth County, Brown County, Chippewa County ,Cottonwood County ,Jackson County, Kandiyohi County, Lac qui Parle County, Le Sueur County, Lincoln County, Lyon County, Murray County, Nicollet County, Pipestone County, Redwood County, Renville County, Swift County, Waseca County, Yellow Medicine County

Metro Adult Health Survey 2010
Results for Anoka County, Carver County, Dakota County, Ramsey County, Scott County, Washington County

Survey of the Health of All the Population and the Environment (SHAPE) 1998, 2002, 2006, 2010
Results for Hennepin County

For Other Counties: 2010 MCHT, Morbidity and Utilization Tables 11 and 12

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

Acronyms

Atlas Online - Minnesota Center for Rural Policy and Development

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

MCHT - Minnesota County Health Tables

MDE - Minnesota Department of Education Data Center

MDH Arsenic - Minnesota Department of Health, Well Management

MDH HEP - Minnesota Department of Health, Health Economics Program

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

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

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

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

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

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

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

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

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

MN DHS - Minnesota Department of Human Services

MN DPS - Minnesota Department of Public Safety

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

MPHDA - Minnesota Public Health Data Access

MSS - Minnesota Student Survey

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

US EPA - US Environmental Protection Agency

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

Appendix D

Hennepin County
CHIP Report

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health

**PHILLIPS EYE
INSTITUTE**

2012 - 2015

COMMUNITY HEALTH IMPROVEMENT PLAN

for Hennepin County Residents

A collabortion of five local community health boards and multiple community partners

COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP

Convene ~ Catalyze ~ Collaborate

Hennepin

CITY OF
BLOOMINGTON
MINNESOTA

CITY OF EDINA, MINNESOTA

RICHFIELD

Minneapolis
City of Lakes

To Our Community,

We are excited to share with you the culmination of six months of planning that has resulted in a shared vision and plan for improving health in our community. The Community Health Improvement Partnership (CHIP) was formed to foster strong alliances across public and private organizations to target important health issues – together - for greater impact. More than 100 diverse organizations involved in health-related work provided input and guidance in the development of the CHIP vision and plan. Partnerships have been forged and teams are preparing to move into action to address health issues important to our community.
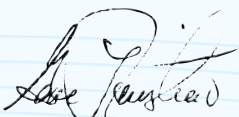
Tackling tough issues is not new to us. Working on many fronts, multiple public and private partners took on different aspects of tobacco use – from policy work to individual education and interventions. We have made great strides in reducing the adult smoking rates in our community – from 21.2% in 1998 to 12.1% in 2010. What IS new is the building of a coalition of partners that includes public health, hospitals, health plans and systems, clinics and non-profits, community organizations and the faith community across the whole county to focus on ways to collaborate and align efforts to make greater progress more quickly.

The following CHIP Plan has the support of the five community health boards serving Hennepin County and their governing officials. The plan is built on health data and formed by the collective vision of multiple stakeholder organizations from the community. It has a strong Steering Committee of leaders from organizations involved in improving health. It also has the support of a wide range of community organizations willing to work together to achieve our common vision.
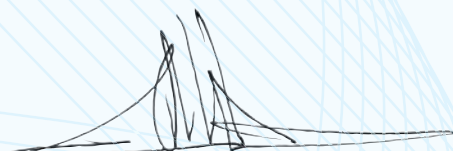
We know that together we can do more. That together we can build a synergy for collective impact – in ways none of us can do alone. That together, with a shared vision and aligned efforts, we can move our community forward to becoming healthier in the coming years. We hope that you will join us to support and create health for the residents of our county.
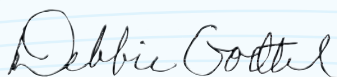
Mike Opat, Chair
Hennepin County Board of Commissioners and
Hennepin County Community Health Board

Gene Winstead
Mayor
City of Bloomington

James Hovland
Mayor
City of Edina

Debbie Goettel
Mayor
City of Richfield

Barbara Johnson, President
Minneapolis City Council / Board of Health

2012 Community Health Improvement Plan

Executive Summary

The local Community Health Improvement Partnership (CHIP) gathered diverse public and private stakeholders to shape a shared vision for a healthy community. Together the partnership:

• Identified priority areas needing attention and

• Built a foundation for future collaborative action including a framework and guiding principles for working together to tackle challenging but important health goals.

The Community Health Improvement Plan (plan) for Hennepin serves as a guide for how local health boards, hospitals, health plans, clinics and other community organizations will focus and align their work to improve the health of the population and communities they jointly serve. It is a shared plan that we hope will be incorporated into local strategic planning and inspire partnerships to improve health.

Building upon a survey, the community health assessment, and three community health forums, the plan brings us to the launch point for action by partner organizations that are committed and ready to work together. A multi-disciplinary leadership body will guide the work of the action phase of this collaborative partnership.

The partnership selected the following strategic health issues and targeted health improvement goals for concentrated and aligned focus. Specific, measurable objectives for the goals will be identified during the CHIP action phase.

Strategic Health Issue	Targeted Health Improvement Goal 2012-2015
Maternal and Child Health	Increase childhood readiness for school
Nutrition, Obesity & Physical Activity	Increase regular physical activity and proper nutrition through improvements to the physical environment
Social & Emotional Wellbeing	Increase community and social connectedness
Health Care Access	Develop health care access strategies that will help achieve the targeted goals above
Social Conditions that Impact Health	Develop strategies to address social conditions that impact the targeted goals above

The CHIP initiative began as a collaboration of the five Community Health Boards serving Hennepin County:

- Hennepin County Human Services and Public Health Department,
- Minneapolis Department of Health and Family Support, and
- Bloomington Division of Public Health: on behalf of the Community Health Boards of Bloomington, Edina and Richfield.

Health departments, hospitals, health systems, health plans and federally qualified health centers are all strengthening their efforts to incorporate local community health needs assessments and collaborative planning into their work. Representatives from each of these groups joined the Community Health Improvement Partnership to align their local assessments and develop a collaborative approach to address common priorities.

The partnership concentrated on creating health – not simply correcting problems. Themes important to the CHIP stakeholders included prevention and health promotion; building on strengths and supporting strong beginnings; viewing health holistically as physical, mental, emotional and spiritual; engaging the community as we move forward; and the importance of addressing basic needs, health care access, and social conditions that impact health.

The stakeholders' shared vision is a healthy community with the characteristics, listed below (in no particular order.)

This health improvement plan takes the solid foundation of our strong community and moves it to the next level: aligning health improvement efforts across multiple organizations for collective impact. By focusing on a few important health issues together, the partnership will maximize current efforts, better address gaps and policy issues, and advocate for changes that will have lasting impact on the health of our residents.

We are at the launch point for action – with a vision, guidelines and goals. Action teams will begin meeting by fall 2012 to determine specific objectives and strategies for aligned work and how to evaluate the impact of CHIP efforts for each targeted goal. Watch for a supplement to this plan to be published in early 2013. Future updates to this multi-year plan can be found at this website: www.hennepin.us/CHIP.

Shared Vision of Characteristics of a Healthy Community

Safety
Environments that foster health
Community connectedness & engagement
Economic vitality
Equitably accessible high quality infrastructure
Basic needs are met
Quality educational opportunities
Good physical & mental health
Multi-sector leaders promote the common good
Active participation in creating health

Table of Contents

Appendices are in a separate document

CHIP ACKNOWLEDGEMENTS

CHIP Plan Highlights

Introduction

The five Community Health Boards of Hennepin County convened the Community Health Improvement Partnership (CHIP) to foster and strengthen successful partnerships to improve health in our shared community. The intent of this collaborative work is to:

- Develop a shared vision for improving health across public and private organizations.

- Establish common health-related priorities within and across multiple organizations.

- Identify actionable steps that could be executed collectively or collaboratively.

- Foster complementary action and alignment of efforts.

- Coordinate use of assets and resources to gain efficiencies and bridge gaps.

This plan, written on behalf of the partnership for the period 2012-2015 is intended to:

- Document the progress to-date.

- Be a guide for collaborative planning and action.

- Influence strategic planning efforts at the individual organizational level.

It has been developed using the Mobilizing for Action through Planning and Partnerships (MAPP[1]) process, a community engagement planning tool.

The CHIP assessment and planning work focused on two tracks:

1. Reviewing and compiling recent assessment data collected by the three partner public health departments and data drawn from other state and national sources.

2. Engaging community stakeholders through the CHIP Survey and the CHIP Forum Series - using the MAPP assessments as guides and the Technology of Participation (ToP®)[2 & 3] process to facilitate conversations.

Highlights of the CHIP planning process follow. The Highlighted Data section tells you why a selected health issue is important and how we're doing in Hennepin. The Plan Development section catalogues how the CHIP Plan was developed - through the Community Health Assessment and Planning Phase up to the point of selecting goals. Appendices to the plan (separate documents) provide expanded details and data used during the process. A supplement to the plan will be written once the CHIP Action Teams develop objectives, strategies, and work plans for moving into action. A link to the data sources used or created in this work can be found on the Hennepin County Public Health Data website **www.hennepin.us/PublicHealthData**.

The Partners

CHIP Conveners

Within Hennepin County, there are five Community Health Boards that, under state law, have public health responsibilities and serve county residents:

- Hennepin County Human Services and Public Health
- The City of Minneapolis Department of Health and Family Support
- The three health boards served by the Bloomington Division of Public Health Bloomington, Edina and Richfield Boards of Health

Some public health duties are carried out within the geographic boundaries of a single health board; others overlap boundaries; still others are done in partnership. Each of these health boards regularly completes community health assessments and health improvement plans for their own jurisdiction.

They each have state obligations to complete an updated assessment and improvement plan by February 2015. The state obligations include standards for assessments and improvement plans which are now aligned with the national Public Health Accreditation standards. Additionally, local public health has been named as a recommended participant in the Community Health Needs Assessments that all tax-exempt hospitals are required to do.

These assessment and planning efforts all have the potential to ask for community stakeholder involvement from the same organizations. Given the opportunity for synergy and efficiency, the five health boards determined to do a combined Community Health Assessment and Community Health Improvement Plan that would serve public health, hospitals, health systems, health plans, federally qualified health centers, and other organizations across the jurisdiction.

From this, the county-wide Community Health Improvement Partnership (CHIP) was formed – convened by the five health boards. Staff from all of the health boards were closely involved in the CHIP assessment and planning processes. Hennepin Human Services and Public Health provided the coordination, staffing and logistics support for this initiative.

CHIP Catalyzers

One of the conveners' first steps was to establish a CHIP Leadership Group to guide the assessment and planning phase of this work. In addition to representation from the five health boards, the Leadership Group included representatives of the West Metro Hospital group and community leaders from a cross section of organizations, associations, and coalitions involved in health-related work. This group provided guidance, expertise, and assessment and planning support – in addition to participating in and recruitment for the stakeholder forums.

The CHIP Leadership Group members for February – June 2012 are listed below. Most all of the Leadership Group members have committed to continue onto the CHIP Steering Committee. This committee will guide the Action Phase of the CHIP work and will include new members.

CHIP LEADERSHIP GROUP

February – June 2012

Organization	Member
Community Health Board *Minneapolis*	Gretchen Musicant, Commissioner* Minneapolis Department of Health and Family Support
Community Health Boards *Bloomington, Edina, & Richfield*	Karen Zeleznak, Public Health Administrator* Bloomington Division of Public Health
Community Health Board *Hennepin County*	Susan Palchick, Manager, Public Health Protection & Promotion* Hennepin County Human Services & Public Health Department
Charitable Org/Foundation *United Way*	Alana Wright, Community Impact Manager – Health * United Way
Cultural Organization *Somali Health Coalition*	Anab Adan Gulaid, Coalition Member Somali Health Coalition Participating Alternate: Hodan Hassan
Faith Based *Greater Minneapolis Council of Churches*	Brian Herron, Pastor * Zion Baptist Church
Businesses Focusing on Health *Itasca Project*	Donna Zimmerman, Vice President, Health Partners * Participating Alternate: Deanna Varner
Hospitals & Health Systems *West Metro Hospital Association*	Eric Smith, Advocacy and Health Policy Coordinator * Children's Hospitals & Clinics of MN
Health Care Reform Specialist *Hennepin Health*	Jennifer DeCubellis, Area Director, Hennepin Health * Hennepin County Human Services & Public Health Department Participating Alternate: Mark Brooks
Health Research & Quality *Stratis Health*	Jennifer Lundblad, President & CEO * Stratis Health Participating Alternate: Kim McCoy
Health Disparities Specialist *Office of Minority & Multi-Cultural Health*	Jose Gonzalez, Director * State Office of Minority & Multicultural Health Minnesota Department of Health
Health Plans *Minnesota Council of Health Plans*	Kenneth Bence, Director, Public Health & State Programs* Medica
Housing & Homelessness *City-County Office to End Homelessness*	Lisa Thornquist, Heading Home Hennepin
Hospitals & Health Systems *West Metro Hospital Association*	Melissa Hutchison, Manager, Community Benefits * Allina Hospitals & Clinics
Schools *School Superintendents*	Paul Sterlacci, Safe Schools & Mental Health Coordinator* Intermediate District 287 Participating Alternate: Char Myklebust
Federally Qualified Health Centers *MN Assoc. of Community Health Centers*	Steven J. Knutson, Executive Director * Neighborhood HealthSource
Cultural Organization *Hispanic Health Network*	Victoria Amaris, Hispanic Health Network Member *
University of Minnesota *School of Public Health*	William Riley, Associate Dean * University of Minnesota School of Public Health

CHIP Collaborators

Many community stakeholders were invited to provide input into the CHIP community health assessment and planning efforts. The CHIP process intentionally targeted stakeholder organizations that could offer perspectives from a variety of population groups, health issues, and service needs and build a foundation for future collaboration on action. Targeted organizations included those with missions that have some aspect of health-related work. Stakeholders engaged in this process were drawn from different types of organizations from across the geography of the county and included representation from providers serving vulnerable or at-risk populations, communities experiencing health disparities, and cultural groups that live within our community.

The CHIP participants included stakeholder organizations from: public health, hospitals, health systems, health plans, clinics, schools, charitable organizations, the faith community, cultural groups, housing, social services, health policy, research, quality improvement, academic organizations and more. There were more than 2,000 stakeholders approached to provide input into the CHIP Plan. Nearly 2,000 contacts received an on-line CHIP Survey – with 239 respondents. Approximately 110 stakeholders attended one or more session of a 3-part CHIP forum series that was held March – May 2012. *A list of participating organizations is included in the Appendices.*

What the Partnership Developed

As a result of this collaborative work, the local Community Health Improvement Partnership now has a foundation for action. The main elements of the CHIP Plan that will guide the action phase are noted on the following pages.

- **The vision**: The partnership developed a vision for a healthy community that includes 10 characteristics they deemed important for community members to be healthy.

- **Guiding principles for action**: As the partners moved forward, they began to propose guidelines for collaborative action which are captured as principles for action.

- **Strategic health issues and goals**: Five strategic health issues have been selected for aligned and partnered efforts for which three targeted health improvement goals have been identified.

See CHIP Plan Development section and the Appendices for detailed information about: the community health assessment and data work, the survey, the forums, and the results of the MAPP assessments.

The Vision: Characteristics of a healthy community

Through stakeholder input from both the survey and discussions at the forums, the CHIP partnership identified 10 Characteristics of a Healthy Community. The themes that surround these characteristics are included here to provide context and demonstrate the breadth of the vision.

SAFETY

- Safe schools
- Safe housing • Safe neighborhoods
- Residents feel emotionally & physically safe
- Free of violence • Free from crime • Free from hazards
- People looking out for each other
- Respectful dispute resolution

ENVIRONMENTS THAT FOSTER HEALTH

- Spaces accessible by all
- Attractive & heartening spaces
- Clean air & water & land • Healthy indoor environments
- Planning & zoning that fosters health & clean environments
- Equitable access to healthy food • Accessible public transportation
- Community promotes green & sustainable environments
- Access to green spaces • Promotes physical activity
- Walkable & bike-able access to goods & services

COMMUNITY CONNECTEDNESS & ENGAGEMENT

- Respect & value for all
- Sense of belonging • Strong support systems
- Diversity is embraced • Cross cultural connectedness & pride
- Tolerant & accepting • Lack of isolation • Relationships thrive
- Intergenerational connectedness • Care and support for vulnerable persons
- Good community communication • Community gathering spaces
- Strong volunteer base • Opportunities to contribute to the community
- Residents, businesses & faith communities invested in community success
- Informed residents • Participation in community governance
- Schools are a part of & contribute to the community

EQUITABLY ACCESSIBLE HIGH QUALITY INFRASTRUCTURE

- Abundant, affordable, healthy housing
- Easy & affordable public transportation
- Quality & affordable pre-school & day care
- Sources for healthy & culturally diverse foods
- Accessible, affordable, culturally appropriate healthcare
- Options for healthy aging in your community of choice
- Quality educational opportunities for all ages exist - Pre-K through higher education
- Vocational & Employment re-training - Community education

BASIC NEEDS ARE MET

- All residents are able to meet their own basic Needs
- Residents have equitable access to resources & services
  to meet their basic needs:
- Food - Shelter & housing - Healthcare
- Transportation - Education - Employment
- Childcare - Special Needs Service

ECONOMIC VITALITY

- Economic security: able to meet basic needs & thrive
- Living wage jobs • Low unemployment • Child care options
- Economic justice – Equitable employment
- Business opportunities for all populations
- Economic development • Strong volunteer base
- Diversified & healthy business environment

ACTIVE PARTICIPATION IN CREATING HEALTH

- Have vision and values for their own health
- Promoting equitable social & political capital for all
- Individuals & families assume responsibility for their own health
- Have an active lifestyle • Focus on preventing illness & staying well
- Social & economic conditions that negatively impact health are addressed:
- Unemployment - Lack of education - Poverty - Unstable housing, etc.
- Make healthy choices • Consume healthy food • Alcohol, drug & tobacco free
- Modeling good behavior • Creating real opportunities to inspire people
- Seeing potential amidst risks • Replacing hopelessness with hope
- Culture of building on strengths & abundance
- Empowerment - Positivity - Individual potential
- Community is educated about factors that impact health
- Individuals & systems have a holistic approach to health
- Emotional - Mental - Physical - Dental
- Vision & values guide action to promote health

QUALITY EDUCATIONAL OPPORTUNITIES

- Community values lifelong learning
- Opportunities for lifelong learning exist • Libraries are available to all
- Early childhood services to prepare children for kindergarten are available
- Educational systems are successful at preparing their students for their next step
- Quality educational opportunities for all ages exist - Pre-K through higher education
- Vocational & Employment re-training - Community education
- Schools successfully support young adults to graduate from high school
- Education promotes health • Education supports gainful employment
- Educational systems support individual & community potential
- Social media supports education

MULTI-SECTOR LEADERS PROMOTE THE COMMON GOOD

- Accountable • Engaged • Aligned with others
- Policy makers understand how their decision-making impacts health
- Input from diverse members of the community is value and incorporated
- Leaders in all sectors of the community take ownership for promoting health
- Good & effective leadership that operate with vision & values that promote health
- Good policies that work for all • Infrastructure to make being healthy "easy"
- Policies protect most vulnerable • Public & private partnerships
- Establish policies & infrastructures that support people to:
- Meet basic needs - Reach their full potential
- Seamless systems & coordinated efforts across multiple sectors
- Efficient in delivery & administration of resources

GOOD PHYSICAL & MENTAL HEALTH

- Culturally competent services
- Preventive care is easily accessible & utilized
- Health equity: health disparities are eliminated
- Low incidence of disease & mortality • Chronic diseases are managed
- Equitable access to quality affordable health care & mental health services
- Comprehensive physical & mental health services that promote wellbeing
- Community is educated about mental health issues & services

In these lists:
Equitable is: affordable, culturally appropriate, geographically available, and accessible
High Quality is: comprehensive, culturally appropriate, available, and accessible

Guiding Principles for Action

As the stakeholders discussed vision and themes and actions – it became clear that they were also talking about guiding principles for our collaborative work. Themes throughout the CHIP discussions focused on prevention efforts and promotion of health; building on strengths and supporting strong beginnings; viewing health holistically as physical, mental, emotional and spiritual; engaging the community as we move forward; and the importance of addressing basic needs, health care access, and social conditions that impact health. The Guiding Principles for Action that were adopted by the Community Health Improvement Partnership follow.

Collaborative Guidance

- Develop a shared vision of community health.

- Collaborate across public and private organizations to achieve common goals.

- Partner with diverse communities.

- Engage local communities in grassroots solutions.

- Engage leadership at all levels to take ownership for creating health.

- Align and coordinate efforts for greater efficiency and effectiveness.

- Promote integration of systems & infrastructure that make being healthy easy.

Strategies Guidance

- Focus on creating health.

- Incorporate actions to address health equity & eliminate health disparities.

- Incorporate prevention work & improve access to services.

- Include policy, systems & environmental change strategies.

- Incorporate strategies to address social & economic conditions that affect health.

- Use evidence-based solutions & models that have worked effectively elsewhere.

- Use a holistic definition of health (including physical, emotional, mental & spiritual).

- Incorporate strengths-based and empowerment approaches.

- Incorporate frequent, multi-layered communication strategies.

Strategic Health Issues and Goals

The CHIP survey and the three-part CHIP forum series collected input on issues important to the community. The CHIP forums guided participants through several facilitated discussions that were used to identify five "Strategic Health Issues" and three "Targeted Health Improvement Goals" selected for focus for 2012 – 2015 as noted in the table below.

Strategic Health Issue	Targeted Health Improvement Goal 2012-2015
Maternal and Child Health	Increase childhood readiness for school
Nutrition, Obesity & Physical Activity	Increase regular physical activity and proper nutrition through improvements to the physical environment
Social & Emotional Wellbeing	Increase community and social connectedness
Health Care Access	Develop health care access strategies that will help achieve the targeted goals above
Social Conditions that Impact Health	Develop strategies to address social conditions that impact the targeted goals above

Because two of the strategic health issues selected can impact all aspects of health, addressing health care access and social conditions were selected to be cross-cutting goals. The partnership made a commitment to seek out strategies related to health care access and social conditions to incorporate into the work on the other three health issues and goals.

Moving into Action

The initial health assessment and planning phase of the partnership ran from January through June 2012. The evolution from the CHIP Leadership Group to the CHIP Steering Committee occured in July 2012. Three Action Teams will begin meeting in late summer: Maternal and Child Health; Nutrition, Obesity and Physical Activity; and Social and Emotional Wellbeing.

The first cycle for action will be September 2012 – December 2013. During the initial weeks of that work, specific measurable objectives and strategies and timelines for action will be identified. As needed, additional partners will be recruited. The action teams will also determine how to measure the impact of the aligned work. Most CHIP Leadership Group members are transitioning to the CHIP Steering Committee; 24 organizations have initially volunteered to join the action team work. As these action teams define the next steps of this partnership, a supplement will be added to the CHIP plan.

The table on the next page is a composite of what the partnership developed.

COMMUNITY HEALTH
IMPROVEMENT PARTNERSHIP
Convene ~ Catalyze ~ Collaborate

Characteristics of a Healthy Community

Safety

Environments that Foster Health

Community Connectedness & Engagement

Equitably Accessible High Quality Infrastructure

Basic Needs are Met

Economic Vitality

Quality Educational Opportunities

Multi-sector Leaders Promote the Common Good

Good Physical & Mental Health

Active Participation in Creating Health

Guiding Principles

Collaborative Guidance

- Develop a shared vision of community health.
- Collaborate across public and private organizations to achieve common goals.
- Partner with diverse communities.
- Engage local communities in grassroots solutions.
- Engage leadership at all levels to take ownership for creating health.
- Align and coordinate efforts for greater efficiency and effectiveness.
- Promote integration of systems & infrastructure that make being healthy easy.

Strategies Guidance

- Focus on creating health.
- Incorporate actions to address health equity & eliminate health disparities.
- Incorporate prevention work & improve access to services.
- Include policy, systems & environmental change strategies.
- Incorporate strategies to address social & economic conditions that affect health.
- Use evidence-based solutions & models that have worked effectively elsewhere.
- Use a holistic definition of health (including physical, emotional, mental & spiritual).
- Incorporate strengths-based and empowerment approaches.
- Incorporate frequent, multi-layered communication strategies.

Strategic Health Issues & Targeted Health Improvement Goals 2012-2015

Maternal & Child Health

Increase childhood readiness for school

Nutrition, Obesity & Physical Activity

Increase regular physical activity & proper nutrition through improvements to the physical environment

Social & Emotional Wellbeing

Increase community & social connectedness

Cross-cutting health issues:

- Health Care Access
- Social Conditions that Impact Health

Include strategies related to Health Care Access and Social Conditions that impact the targeted health issues

Strategic Health Issues & Goals

Highlighted Data

The following tables provide highlights of why a strategic health issue or targeted goal is important and what we know about how we are doing in the Hennepin community. In some cases, tables provide graphs or charts of sample data to illustrate what we know about this issue. For some of the goals, the data currently available is limited – or may not be available at this time.

Tables are provided for the following:

Maternal and Child Health
Increase childhood readiness for school

Nutrition, Obesity & Physical Activity
Increase regular physical activity and proper nutrition through improvements to the physical environment

Social & Emotional Wellbeing
Increase community and social connectedness

Health Care Access

Social Conditions that Impact Health

 At this time, there is not a data table for Social Conditions that Impact Health.

See also ATTACHMENT A: LOCAL DATA at the end of this document for relevant data from local communities in Hennepin.

Additionally, see the separate CHIP APPENDICES documents.

- Included is a PDF of data regarding 40 community health indicators for Hennepin County from which some of the data below has been extracted.

- There are also two documents with highlights from the SHAPE 2010 – Adult Survey and Child Survey that provides much more detail on many data topics.

This data site ***www.hennepin.us/PublicHealthData*** has the complete set of community health indicators and links to multiple data sites including Minneapolis and Bloomington health departments' data sites, the Minnesota Student Survey, Healthy People 2020, and the complete SHAPE 2010 Adult Survey and Child Survey data books.

Maternal & Child Health:
Childhood Readiness for School

Target Goal 2012-2015:
Increase childhood readiness for school

Healthy beginnings

Getting a good start in life is critical. By entering school ready to learn, children are more likely to graduate and become successful adults.

To be ready to learn, children need healthy development of their bodies, social skills, language, cognitive skills and more – all of them contribute to health.

And healthy children become healthy adults who then help create healthy communities.

"School Readiness" is an indicator of health in young children across a spectrum of developmental milestones.

The intent of this goal is to increase the proportion of children who are ready for school in all five domains of healthy development:

- Physical development
- Social-emotional development
- Approaches to learning
- Language
- Cognitive development

Why is this health issue important?

- Research shows that how a child develops in their first years has lifelong implications on physical, cognitive, and social-emotional health; learning; and overall wellbeing.

- During early childhood, children develop their language and motor skills as well as their abilities to attach with others and regulate their emotions. By age 3, the human brain has grown to 90 percent of its adult size.

- Healthy childhood development sets the stage for readiness for school - which influences success in life.

- A child's early and middle years are also foundational for health habits including: learning to make healthy choices, self-discipline, making good decisions about risky situations, and healthy eating habits.

- Environmental stressors and other negative risk factors can seriously compromise a child's ability to grow, play and learn – and affect physical, social-emotional, and cognitive growth and development.

- Research on a number of adult health and medical conditions suggest that they may have their beginnings in early and middle childhood.

- Unaddressed illnesses and conditions such as asthma, obesity, dental caries, child maltreatment, and developmental and behavioral issues all affect a child's ability to be healthy. It can delay their development, interfere with their education, and affect the health and wellbeing of the adolescents and adults they will become.

Percent of young children who meet basic milestones for school readiness
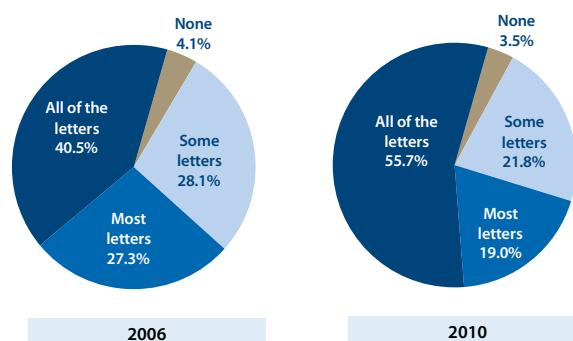Hennepin County Children Aged 3 to 5, 2006 & 2010

SHAPE
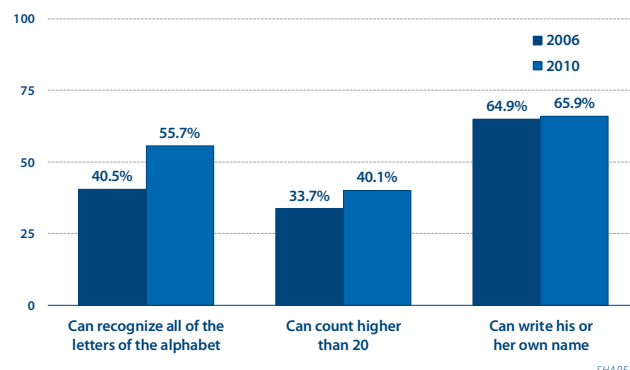
Percent of young children who meet basic milestones for school readiness, by household income level
Hennepin County Children Aged 3 to 5, 2010

SHAPE
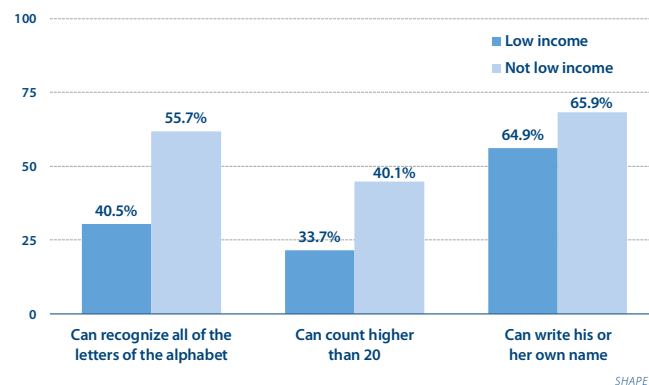
Percent of young children who can recognize the letters of the alphabet
Hennepin County Children Aged 3 to 5, 2006 & 2010

SHAPE

- Regular preventive care and developmental screenings play an important role in detecting and preventing significant health issues and provide opportunities to intervene early should a child show signs of growth or developmental delays or serious health conditions.
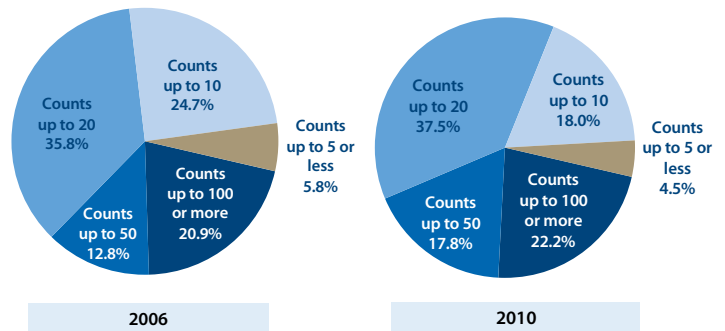
Data Sources: SHAPE[4] – Child Survey 2010 and Healthy People 2020[5].

How are we doing?

- There were over 90,000 children ages 0-5 in Hennepin County in 2010.

- A 2010 Minnesota Department of Education statewide sampling of approximately 5,800 kindergarteners found these rates of proficiency in the following performance areas (Defined as a score of 75% or greater):

  - 70% percent were considered proficient in physical development

  - 59% percent were considered proficient in personal and social development

  - 56% percent were proficient in language and literacy

  - 56% percent were proficient in mathematical thinking

  - 52% percent were proficient in the arts

- In Hennepin County in 2010, proficiency rates in three pre-school milestones ranged from a rate of 68% of students able to write their own names to a low rate of 21% of children able to count higher than 20.

- Within the county, overall improvements in alphabet recognition and basic counting skills have occurred since 2006. However, only four out of ten children aged 3 to 5 are currently able to count above 20.

- Nearly all parents report that they engaged in activities weekly that stimulate brain development and foster language and learning skills. However, some significant differences were noted in the number of times spent per week in these activities.

  - 54% of low-income households spent 4 or more times a week vs. 84% of households that were not low income.

Percent of young children who are able to count
Hennepin County Children Aged 3 to 5, 2006 & 2010

2006 — Counts up to 10 24.7%, Counts up to 5 or less 5.8%, Counts up to 20 35.8%, Counts up to 50 12.8%, Counts up to 100 or more 20.9%

2010 — Counts up to 10 18.0%, Counts up to 5 or less 4.5%, Counts up to 20 37.5%, Counts up to 50 17.8%, Counts up to 100 or more 22.2%

SHAPE

Percent of children whose parents tell stories or read books to them 4 or more times per week, by age and household income
Hennepin County Children Aged 3 to 5, 2010

0 to 2: 75.2%, 3 to 5: 77.5%, Low income: 54.2%, Not low income: 83.6%
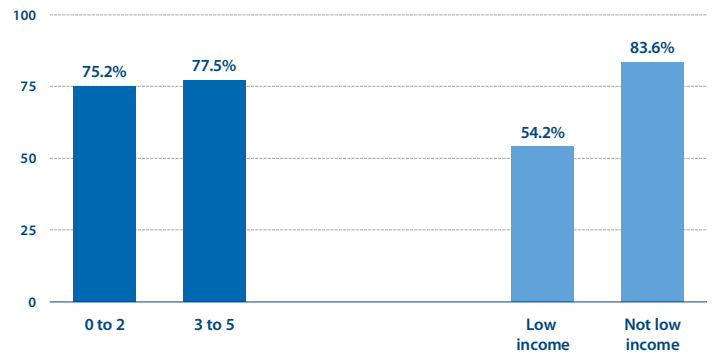
SHAPE

- Three out of four children in Hennepin (76.1%) met the standard for preventive care visits. However, only 55.0% of infants and toddlers aged 0 to 2 years old were "on track" for receiving all of the recommended visits for their age group.

- Kindergartners from lower income families and those whose parents have lower educational levels are more likely to not be ready for kindergarten. The gap in performance between low-income and not-low income families is nearly double in some milestones.

- A 2009, Wilder[6] Research study found that the estimated cost burden to Minnesota's K-12 system due to children entering kindergarten unprepared for school success is about $113 million dollars annually.

Data Sources: SHAPE – Child Survey 2010, Minnesota School Readiness Study 2010, Wilder Research – Cost Burden to Minnesota K-12 when Children are Unprepared for Kindergarten.

Percent of children who met the recommended guidelines for the number of preventive care visits, by age group

Hennepin County Children Aged 0 to 17, 2010

Population		Percent	C.I.
Hennepin County Children age 0 to 17		76.1%	± 3.3
Age Groups	0 – 2 years	55.0%	± 6.3
	3 – 5 years	93.7%	± 5.4
	6 – 9 years	84.7%	± 7.7
	10 – 13 years	76.0%	± 9.1
	14 – 17 years	66.3%	± 10.2
Gender	Male	74.9%	± 4.6
	Female	77.2%	± 4.6
Geographic Location	Minneapolis	78.1%	± 4.8
	Suburban Areas	75.2%	± 4.2
Household income level	Low income	70.1%	± 7.5
	Not low income	78.4%	± 3.5

SHAPE

Nutrition, Obesity & Physical Activity:
Nutrition*

Target Goal 2012-2015:
Increase regular physical activity and proper nutrition through improvements to the physical environment

Healthy eating

Too many of us just eat what's convenient, not what's good for us. We love fast food, super-sized portions and low cost food. Too much quickness and quantity. Not enough choices and quality.

When we don't eat enough of what our bodies need – fresh fruits, vegetables, whole grains and low fat dairy products – we miss vital nutrients and our health suffers for it. Changing what we eat – and making good food more convenient – is a job for communities.

*See separate sheets for Obesity and Physical Activity

Why is this health issue important?

Healthy growth and development

- To maintain healthy growth and development and to sustain health, a balanced diet that includes fruits and vegetables is important.

Healthy weight maintenance

- Fruits and vegetables are important sources of vitamins and dietary fiber, essential for maintaining healthy weight.To maintain a healthy weight and avoid other health problems, it is strongly recommended that children avoid all sources of "empty calories" (non-nutritive foods or beverages). Drinks, such as soda pop, fruit-ades, and other sweetened beverages often contain unnecessary amounts of added sugar.

How are we doing?

Fruit and vegetable consumption in adults

- Only 37% - just over one in three adults - consume five or more servings of fruits and vegetables daily.

Total servings of fruits and vegetables yesterday
Hennepin County adults 2010

5 or more servings
37.3%

0 servings
4.2%

1 serving
7.7%

2 servings
15.0%

3 or 4 servings
35.8%
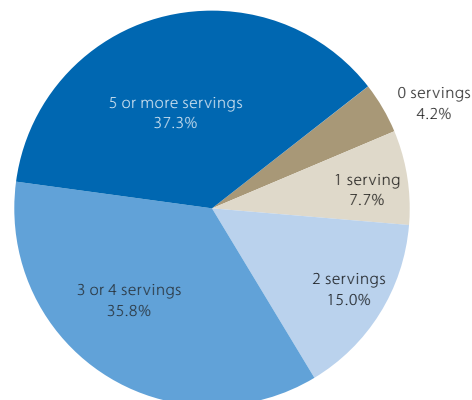
SHAPE

Percent of adults having 5 or more servings of fruits and vegetables yesterday by geographic areas
Hennepin County 2010

Minneapolis
N   Near-North, Camden
E   Northeast. University, Longfellow
      City of St. Anthony
C   Central, Phillips, Powderhorn
S   Calhoun-Isles, Southwest, Nokomis

Suburban Hennepin
NW1 Northwest Inner Ring Suburbs
W1   West Inner Ring Suburbs
S1   South Inner Ring Suburbs
NW2 Northwest Outer Ring Suburbs
W2   West Outer Ring Suburbs
S2   South Outer Ring Suburbs

29.5% - 31.5%
32.8% - 35.1%
37.8% - 39.7%
40.8% - 43.2%
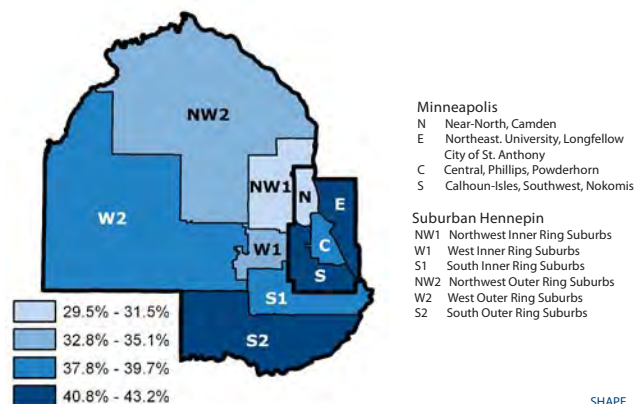
SHAPE

Percent of adults having 5 or more servings of fruits and vegetables yesterday by education and household income
Hennepin County 2010

18.9% — Less than high school
28.1% — High school
31.6% — Some college
42.6% — College or higher
27.9% — Low income
39.8% — Not low income

Education   Household income

SHAPE

Fruit consumption among children

- Hennepin County's young children aged 3 to 9, are most likely to meet the recommended standard for fruit on a daily basis.

  - Most children ages 3 to 5 (85.5%) get two or more servings of fruit each day.

  - Four out of five children aged 3 to 17 (79%) are currently eating the recommended two servings.

  - Adolescents aged 14 to 17 are less likely to meet the daily recommended standard at 70.2%.

  - Only 3.8% of Hennepin County children overall had no (zero) servings of fruit the day prior to the survey.

Vegetable consumption among children

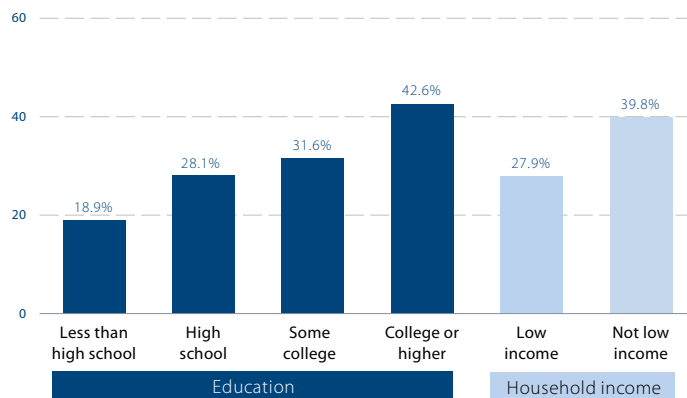- Only one in five children aged 3 to 17 (19%) is meeting the recommended guideline of eating three or more servings of vegetables each day.

  - One in seven Hennepin County children had no (zero) servings of vegetables the day prior to the survey (14.0%).Only one in four children aged 3 to 17 are meeting the daily recommended guideline for dairy products.

  - Children from low income households were significantly less likely to have met the recommended guidelines of four servings of dairy products per day.

Percent of children who met the daily guideline of having 2 or more servings of fruit, by age and household income
Hennepin County Children Aged 3 to 17, 2010

SHAPE

Percent of children who met the daily guideline of having 3 or more servings of vegetables, by age and household income
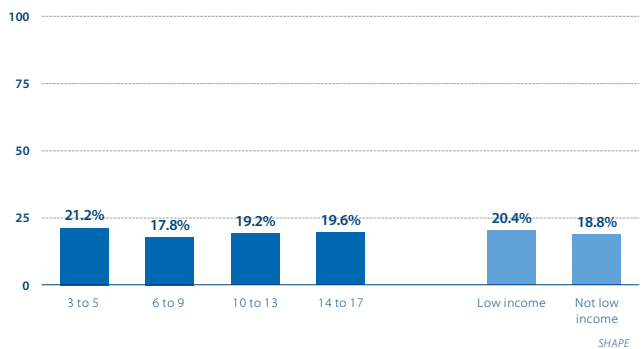Hennepin County Children Aged 3 to 17, 2010

SHAPE

Sugar-sweetened drinks among children

- Less than half of all Hennepin County children aged 3 to 17 met the recommended standard of avoiding sugar-sweetened drinks (48.1%).

  - Younger children, ages 3 to 5 years are doing well: 91.6% had zero or only one sugar-sweetened drink per day reported.

  - For youth 14 to 17, limiting sugar-sweetened drinks to zero or one per day drops to 68.4%.

  - Children from low income households were significantly more likely to have two or more sugar-sweetened drinks per day.

Understanding nutrition

- A large percentage of parents (more than 78%) talk with their children about good nutrition

Data Source: SHAPE 2010 – Child Survey, Hennepin County.

Percent of children who met the daily guideline of having 0 sugar sweetened drinks, by age and household income
Hennepin County Children Aged 3 to 17, 2010

SHAPE

Percent of children who met the daily guideline of having 4 or more dairy products, by age and household income
Hennepin County Children Aged 3 to 17, 2010

SHAPE
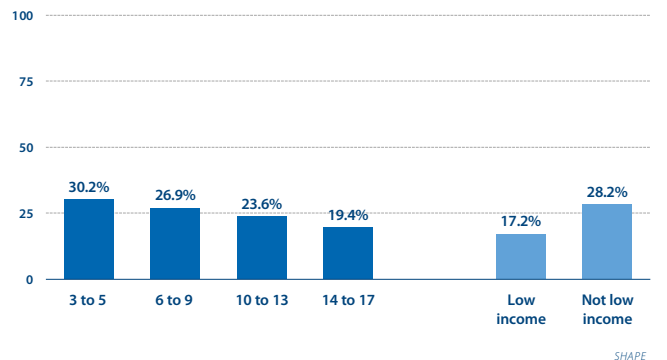
Nutrition, Obesity & Physical Activity:
Obesity

Target Goal 2012-2015:
Increase regular physical activity and proper nutrition through improvements to the physical environment

Healthy weight

Today's children may be the first generation of Americans to die younger than their parents. Obesity – both in children and adults – has reached epidemic proportions.

Simply by being obese, people are at high risk for many chronic diseases, including diabetes and heart disease.

The good news is the trend can be reversed. Through enhanced education; healthier, convenient food options; and developing options for physical activity, we can help people beat the bulge!

Why is this health issue important?

Adults

- Obesity and overweight are associated with increased risk of premature death and many chronic health conditions and diseases.

- It is one of the most common causes of diabetes and heart disease, which are more prevalent among low-income populations. These costly, preventable illnesses reduce quality of life and can cause disability and premature death.

- Over the past 30 years, the obesity rate among U.S. adults had increased dramatically and has reached an epidemic proportion.

- The overall medical cost related to obesity for U.S. adults in 2008 alone was estimated to be as high as $147 billion.

Children

- Obese children and teens have been found to be at increased risk for factors leading to cardiovascular diseases, including high cholesterol levels, high blood pressure, Type 2 diabetes, and abnormal glucose tolerance.

- Type 2 diabetes is increasingly being reported among children and adolescents who are overweight or obese.

- Asthma, hepatic steatosis (a liver enzyme disease) and sleep apnea are also health conditions associated with increased weight in childhood.

- Other consequences of being overweight or obese include social discrimination, psychological stress, low self-esteem, and social isolation.

Percent of adults being obese by geographic areas
Hennepin County 2010

Minneapolis
N   Near-North, Camden
E   Northeast. University, Longfellow
      City of St. Anthony
C   Central, Phillips, Powderhorn
S   Calhoun-Isles, Southwest, Nokomis

Suburban Hennepin
NW1 Northwest Inner Ring Suburbs
W1   West Inner Ring Suburbs
S1   South Inner Ring Suburbs
NW2 Northwest Outer Ring Suburbs
W2   West Outer Ring Suburbs
S2   South Outer Ring Suburbs

15.7% - 17.9%
18.0% - 19.9%
20.0% - 24.9%
25.0% - 30.3%

SHAPE
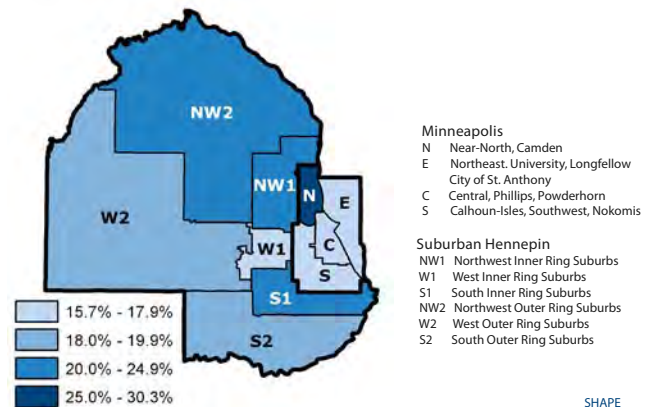
Number of adults who are obese
Hennepin County 1998-2010

SHAPE
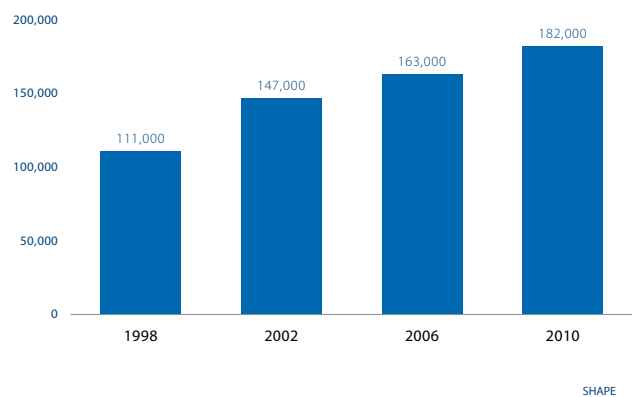
Percent of adults being obese by sexual identity
Hennepin County 2010

SHAPE
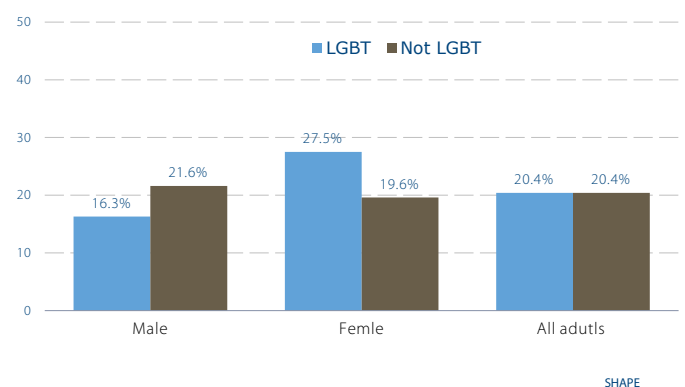
How are we doing?

Adults

- In 2010, at least half (53%) of Hennepin County adults were either overweight (33%) or obese (20%).

- Approximately 71,000 more adults were obese in 2010 than in 1998. The rate of obesity rose from 14% in 1998 to 20% in 2010 (a 43% increase).

- The 20% obesity rate for county adults is significantly lower than the national average (28%), but far exceeds the 15% Healthy People 2020 Objective.

- Obesity disproportionately affects many population groups including: older adults, seniors, residents with low income or low education, U.S.-born Blacks, Hispanics or Latinos, older residents with disabilities, and residents experiencing frequent mental distress.

- Obesity rates among females who are Lesbian, Bisexual or Transgendered are significantly higher than the rate among females who are not (46% vs. 20%) – though the obesity rate for the full LGBT community is no higher than county adults overall.

- Obesity rates vary widely across the geographic areas of the county with north Minneapolis having the highest rate (30%).

Data Source: SHAPE 2010 – Adult Survey.

Adult weight status
Hennepin County adults 2010
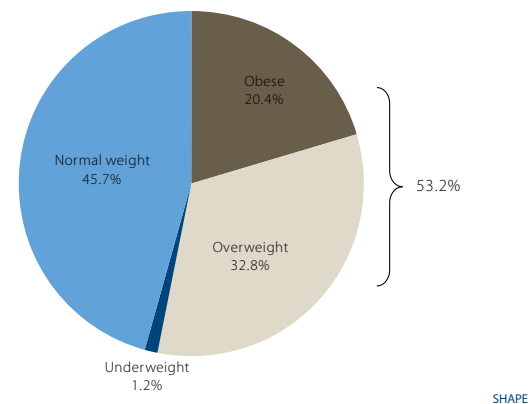
- Obese 20.4%
- Normal weight 45.7%
- Overweight 32.8%
- Underweight 1.2%
- 53.2%

SHAPE

Percent of adults being obese by race and ethnicity
Hennepin County 2006

White	US-born Black	African-born Black	Southeast Asian	Hispanic/Latino	All adults
18.4%	38.5%	19.8%	8.5%	29.5%	19.1%

SHAPE
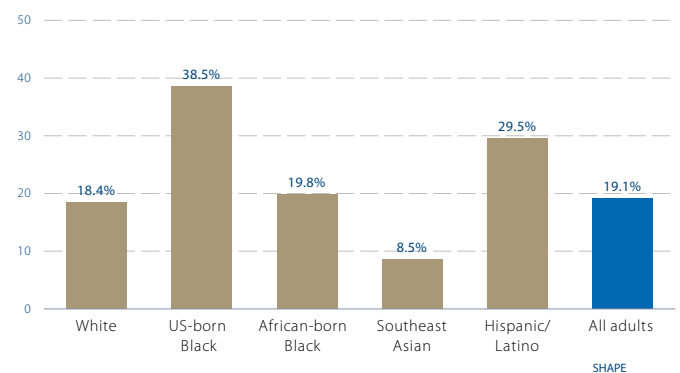
Percent of adults being obese by education and household income
Hennepin County 2010

Less than high school	High school	Some college	College or higher	Low income	Not low income
26.4%	31.4%	25.5%	15.9%	26.4%	19.1%

Education   Household income

SHAPE
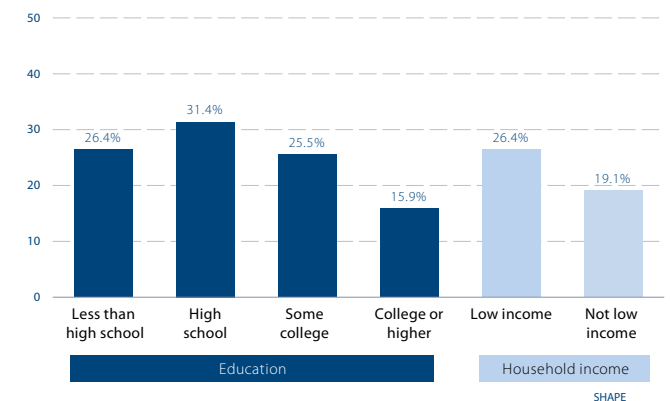
Children

- One out of five 9th and 12th graders in Hennepin County schools reported a weight and height that would place them in either the overweight or obese weight status group (19%).

- For 9th graders, the highest combined overweight and obesity rates were reported among African American and Hispanic/Latino students (28.4 and 31.5%) compared to 19.7% for all county 9th graders.

- Adolescents from low income households are more likely to be overweight or obese (29.0%) compared to those who are not low income (16%).

Data Source: Minnesota Student Survey [7] - 2010, Minnesota Department of Health.

Percent of child patients who were overweight or obese by age group
Hennepin County Medical Center Patients, Aged 2 to 17, January to June 2011

Legend:
- Overweight, but not obese
- Obese

Age group	Overweight, but not obese	Obese
2 to 5	16.6%	15.9%
6 to 11	18.8%	20.2%
12 to 17	20.0%	19.7%
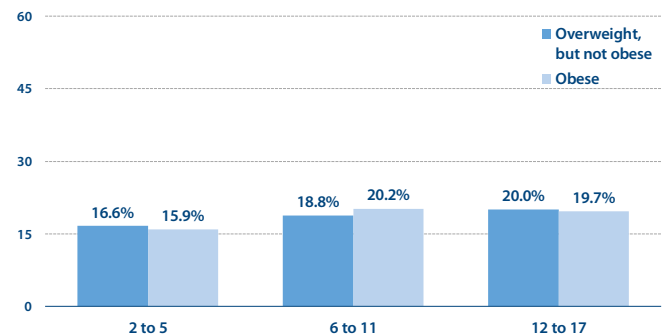
HCMC - EPIC

Nutrition, Obesity & Physical Activity:
Physical Activity

Target Goal 2012-2015:
Increase regular physical activity and proper nutrition through improvements to the physical environment

Healthy bodies

As our society has become focused on computer and TV screens, we're not moving! Bodies that don't move become weak and vulnerable.

It's time to reverse the trend. By being active, you improve your physical and mental health, decrease your risk of chronic disease and improve your overall quality of life.

Movement doesn't have to be extreme sports. Simply walking, taking the stairs, or standing up while watching TV can have a huge impact on physical health.

Endorsing and enabling increased activity leads to us becoming a better and healthier community.

Why is this health issue important?

Adults

- Physical activity can help control weight, reduce the risk of heart disease and some cancers, strengthen bones and muscles, and improve mental health.

- Being physically activity is one of the most important steps that Americans of all ages can take to improve their health.

- Physical inactivity can lead to obesity and Type 2 diabetes.

- Healthy People 2020 aims to reduce the proportion of adults who engage in no Leisure Time Physical Activity (LTPA) by 10%.
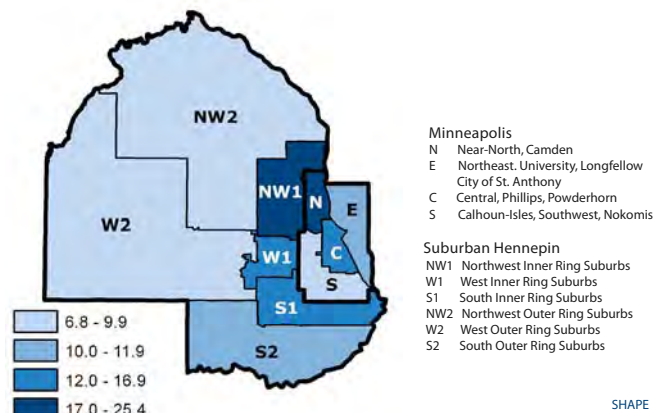
Children

- To maintain a healthy weight and avoid other health problems, it is strongly recommended that school-aged children grades 1-12 engage in regular physical activity every day for at least one hour or more.

- Increasing children's levels of physical activity is a modifiable health behavior that could lead to significant reductions in obesity and overweight among children.

Adolescents

- To maintain a healthy weight and avoid other health problems, it is strongly recommended that adolescents regularly engage in moderate physical activities for at least 30 minutes on five or more days per week and vigorous activities for at least 20 minutes on three or more days each week.

- Inactivity in adolescence is associated with increased risk for factors leading to cardiovascular diseases, including high cholesterol levels and high blood pressure.

- Other consequences of inactivity include an increased risk of being overweight or obese which, in turn, can lead to systematic social discrimination. The psychological stress of social stigmatization can cause low self-esteem, and hinder academic performance and social functioning.

Percent of adults engaging in no leisure time physical activity by geographic area
Hennepin County 2010

Minneapolis
N   Near-North, Camden
E   Northeast. University, Longfellow
       City of St. Anthony
C   Central, Phillips, Powderhorn
S   Calhoun-Isles, Southwest, Nokomis

Suburban Hennepin
NW1   Northwest Inner Ring Suburbs
W1   West Inner Ring Suburbs
S1   South Inner Ring Suburbs
NW2   Northwest Outer Ring Suburbs
W2   West Outer Ring Suburbs
S2   South Outer Ring Suburbs

- 6.8 - 9.9
- 10.0 - 11.9
- 12.0 - 16.9
- 17.0 - 25.4

SHAPE

Percent of adults engaging in no leisure time physical activity by education and household income
Hennepin County 2010
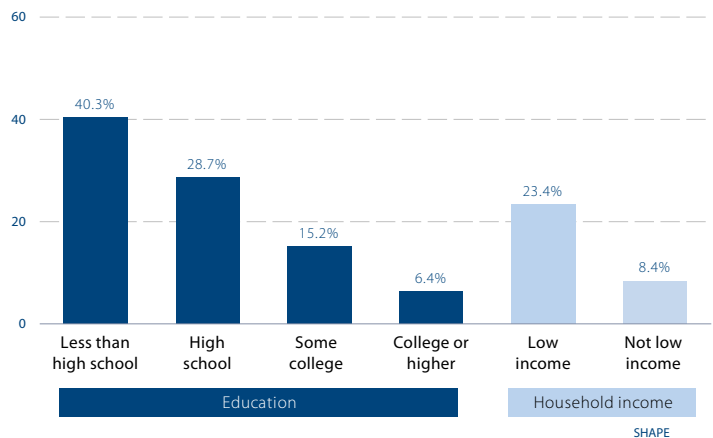
40.3% Less than high school
28.7% High school
15.2% Some college
6.4% College or higher
23.4% Low income
8.4% Not low income

Education   Household income

SHAPE

Percent of adults being obese by race and ethnicity
Hennepin County 2006

18.4% White
38.5% US-born Black
19.8% African-born Black
8.5% Southeast Asian
29.5% Hispanic/Latino
19.1% All adults

SHAPE
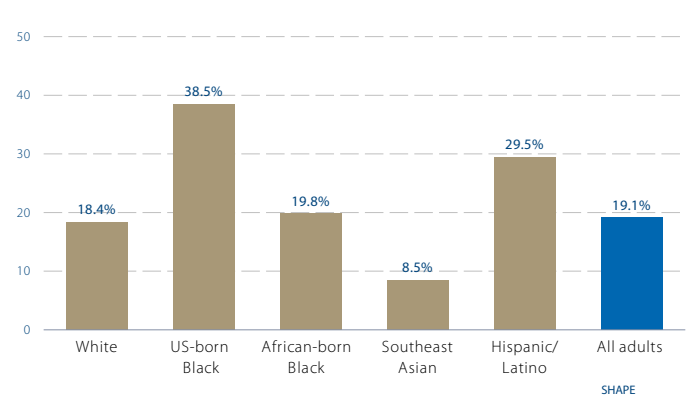
How are we doing?

Adults

- In 2010, 12 % of Hennepin County adults engaged in no Leisure Time Physical Activity (LTPA), which is better than the state average (19%) and the national average (24%). It is also a significant decrease from what it was in 2006 (16%).

- The low rate of no LTPA among Hennepin County adults is not equally distributed across the county's populations. Significantly higher rates of no LTPA are found among senior residents, residents of racial and ethnic minorities, those who experience frequent mental distress and older residents with a disability.

- Geographic variation in the rates of no LTPA is evident, ranging from 7% in South Minneapolis to 25% in North Minneapolis.

- Social conditions matter: Residents with low household income are three times more likely to report no LTPA compared to those with higher household income. Residents with less than high school education are six times more likely to report no LTPA than compared to residents with college or higher education.

- Increased social connectedness, as measured by community involvement and getting together or talking to friends/neighbors, is found to be significantly related to increased rates of physical activity.

- The higher the perceived safety of a neighborhood, the lower the rate of no LTPA.
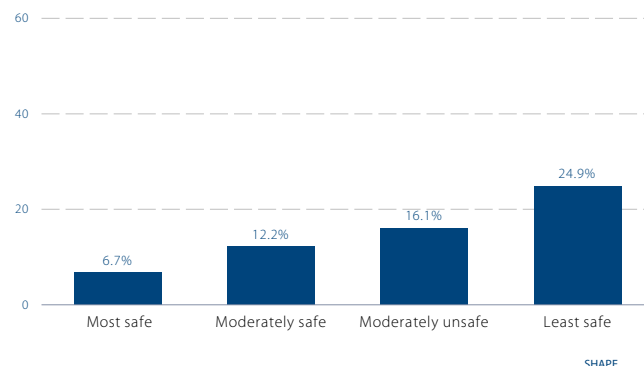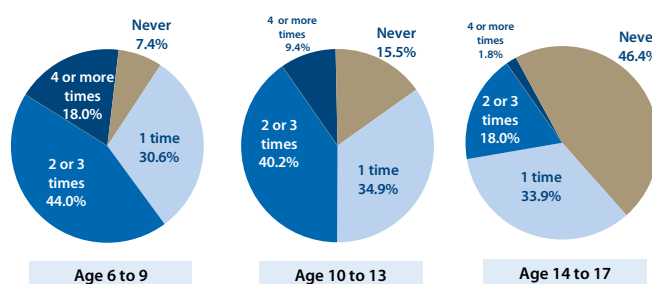
Percent of adults engaging in no leisure time physical activity by level of perceived community safety
Hennepin County 2010

SHAPE

Percent of parents who play sports or do physical activities with their child during a typical school week, by child's age
Hennepin County Children Aged 6 to 17, 2010

| Age 6 to 9 | Age 10 to 13 | Age 14 to 17 |

SHAPE

Percent of students who met the recommended guidelines for moderate physical activity, by grade level
Hennepin County Students, 2010

Population		Percentage	
		9th graders	12th graders
Hennepin County students attending school in public school districts		56.0%	42.6%
Gender	Boys	62.7%	51.5%
	Girls	49.6%	34.4%
Race / Ethnicity	Asian / Pacific Islander	40.5%	25.7%
	Black / African American	44.0%	32.6%
	Native American / American Indian	**	**
	White	62.9%	47.6%
	Hispanic / Latino	38.9%	28.7%
Household income level	Receives free or reduced price lunches	41.9%	30.2%
	Does not receive free or reduced price lunches	61.7%	48.0%

MSS

Children

- Less than a quarter of all Hennepin children aged 6 to 17 met the recommended standard of weekly physical activity (24.1%). No significant differences were found by household income or geographic location.

- In 2010, only 28% of Hennepin children aged 6 to 13 were meeting the guideline of getting at least 60 minutes of daily physical activity. This drops even further to 15.7% for adolescents aged 14 to 17. No differences were observed by residence (urban vs. suburban).

- A large percentage of parents talk with their children about getting regular exercise (73% or more).

- Most parents play or engage in physical activities with their pre-schoolers four or more times per week (more than 73%). That percentage drops significantly by the time their children are teenagers (to 2%) - with nearly half of the parents spending no time in physical activities with their adolescent.

Adolescents

- Fewer girls are getting the recommended level of activity each day. In 2010, 31.2% of boys were meeting the guideline of getting at least 60 minutes ofdaily physical activity, as compared to only 16.8% of girls. Only one out of three 12th grade girls (34.4%) is currently meeting the recommended levels for moderate physical activity.

- Students of color are less likely to meet the recommended standards for moderate physical activity than others; their rates are 15% to 20% lower than their peers who are White.

- Three out of four 9th grade boys (76.6%) are meeting the recommended levels of vigorous physical activity. However, the percentages for each of the other grade/gender groups are notably lower.
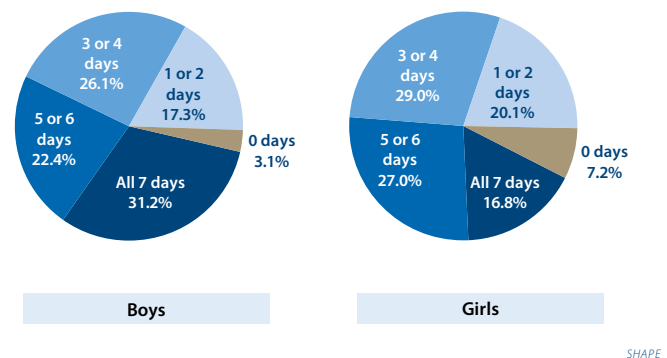
- Trend data suggest that, there have been gradual increases in the physical activity levels for boys, but the rates for girls have remained relatively stable.

Data Source: SHAPE 2010 – Child Survey & Minnesota Student Survey - 2010, Minnesota Department of Health.

Percent of children whose parents do physical activities with them 4 or more times per week, by age and household income
Hennepin County Children Aged 0 to 5, 2010

SHAPE

Percent of children who were physically active for at least 60 minutes a day during the past week, by gender
Hennepin County Children Aged 6 to 17, 2010

Boys — 3 or 4 days 26.1%, 1 or 2 days 17.3%, 0 days 3.1%, All 7 days 31.2%, 5 or 6 days 22.4%

Girls — 3 or 4 days 29.0%, 1 or 2 days 20.1%, 0 days 7.2%, All 7 days 16.8%, 5 or 6 days 27.0%

SHAPE

Social & Emotional Wellbeing:
Community & Social Connectedness

Target Goal 2012-2015:
Increase community & social connectedness

Healthy connectedness

Do you feel "at home" in your community? Do you feel like your neighbors are willing to help you when needed, that your neighbors can be trusted, and that this is a good place to raise your children?

How connected we feel to our communities affects our sense of wellbeing and health. Healthy communities help people live healthier lives! And we strengthen each other. Communities can get healthier together.

The intent of this goal is to increase the wellbeing and mental health of residents of Hennepin County. Limited data is available specific to "Community and Social Connectedness". As an alternative, proxy data and recommendations will be shown.

Why is this Issue Important?

The Storytelling Project of the City of Minneapolis found this information about mental health:

- Family networks and social interaction promote health.

- People are resilient despite great hardships.

- Health is viewed holistically.

- Access to physical activities is important to health.

- Cultural pride and maintaining cultural traditions are important to good health.

- Culturally-competent services are essential.

- Stigma surrounds mental illness.

- Residents need more help dealing with a range of emotions.

- More resources are available for mothers than fathers.

- Women and men both want group sessions for education, skill-building, and social support.

The Minnesota Department of Health's "Social Connectedness Project"[8] describes social connectedness as: ". . . an individual's engagement in an interactive web of key relationships, within communities that have particular physical and social structures that are affected by broad economic and political forces."

National and international studies have documented that people who have strong social connectedness and healthy relationships have higher quality lives and contribute to better functioning and vibrant communities.

Healthy social environments promote health for individual as well the broader community.

Percent of adults with selected mental health conditions
Hennepin County 2010
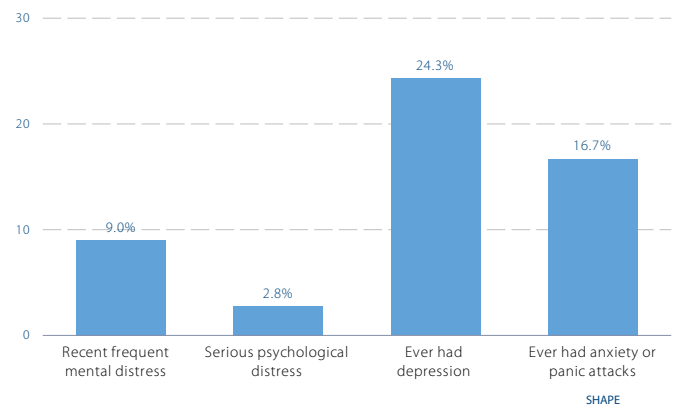
Percent of adults with frequent mental distress by geographic area
Hennepin County 2010

Minneapolis
N   Near-North, Camden
E   Northeast. University, Longfellow
     City of St. Anthony
C   Central, Phillips, Powderhorn
S   Calhoun-Isles, Southwest, Nokomis

Suburban Hennepin
NW1 Northwest Inner Ring Suburbs
W1   West Inner Ring Suburbs
S1   South Inner Ring Suburbs
NW2 Northwest Outer Ring Suburbs
W2   West Outer Ring Suburbs
S2   South Outer Ring Suburbs

7.0% - 7.9%
8.0% - 8.9%
9.0% - 9.9%
10.0% - 17.9%

SHAPE
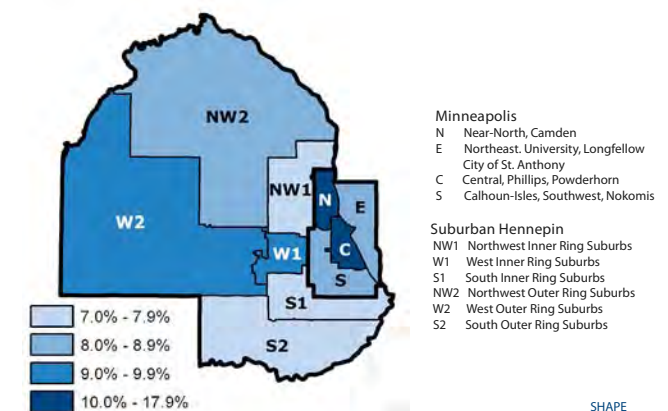
Community and social connectedness impacts social and emotional wellbeing and health of adults of all ages and is an indicator of health across a spectrum of developmental milestones in children.

Social connectedness is linked to the economy, employment, education, neighborhood safety, transportation, environmental protection, faith communities, and technology.

For children, mental health is a significant factor in determining overall wellbeing. Chronic mental or emotional health problems (issues lasting one year or more) may affect or limit an adolescent's physical health, their intellectual growth, and their social development. Episodes may include serious self-harming behaviors, suicidal thoughts, or suicide attempts.

The Search Institute's[9] work on what kids need to succeed lists several Developmental Assets® related to social connectedness: family support, positive family communication, caring relationships with other adults, a caring neighborhood, a caring climate in care and educational settings, parent involvement, service to others, and engagement in creative activities (e.g. arts, music).

Mental health is a state of successful performance of mental function, and is essential to personal wellbeing, family and interpersonal relations, and ability to contribute to community or society.

Burden of mental illness in the U.S. is among the highest of all diseases, and mental disorders are among the most common causes of disability.

Frequent Mental Distress (FMD) has been commonly used as a proxy for poor mental health in state and national population health surveys. Serious psychological distress (SPD) estimates serious mental illness in general population.

Data Sources: Minnesota Department of Health's "Social Connectedness Project", SHAPE 2010, Search Institute, City of Minneapolis Story Telling Series

Percent of adults with frequent mental distress by education and household income
Hennepin County 2010

Category	Percent
Less than high school	20.1%
High school	16.3%
Some college	12.1%
College or higher	5.9%
Low income	19.5%
Not low income	6.2%

Education — Household income

SHAPE
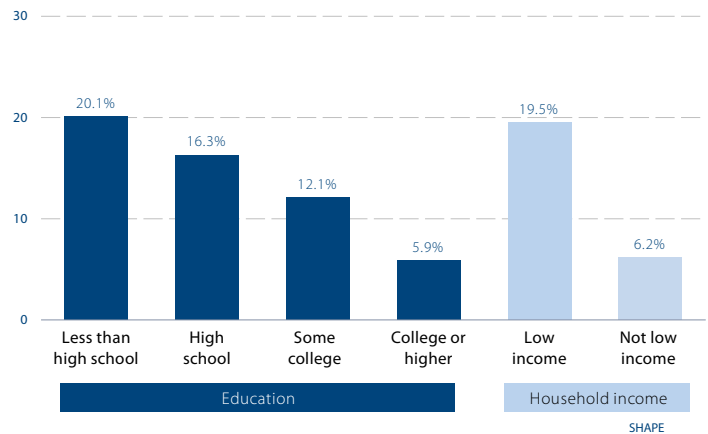
How are we doing?

We do not have direct data about community and social connectedness. Below is proxy data to give us an idea of the social and emotional wellbeing of our residents.

Adults

- In 2010, close to one in ten (9.0%) Hennepin County adults experienced Frequent Mental Distress (FMD).

- While the prevalence of FMD in 2010 (9.0%) is similar to the rate in 2006 (9.7%), it has significantly increased from the rate in 2002 (5.6%).

- FMD is more common among adult females (10.2%) than among adult males (7.6%) and less common among seniors (5.3%) than among younger adults.

- A large geographic variation in FMD rates is observed with the highest rates in North and Central Minneapolis (greater than 10%).

- Members of the Lesbian, Gay, Bisexual and Transgender (LGBT) community reported a rate of FMD twice as high as the rate reported by adults that are not (16.3% vs. 8.4%); the rate is highest for women in the LGBT community (19.3%).

- Obese adults have a significantly higher rate of FMD (13.9%) than adults that are not obese (7.7%).

- Adults with diabetes also have a significantly higher rate of FMD (13.2%) than adults without (8.8%).

- The rate of FMD is significantly higher among current smokers (19.8%) than among those who don't (7.3%).

- Adults who lack leisure time physical activity have significantly higher rates of FMD (13.8%).

- FMD is significantly higher among adults who are heavy alcohol users (11.5%) than those who aren't.

- The rate of FMD is significantly higher among adults with low income (19.5%), or low education (20.1% for less than high school education vs. college educated at 5.9%)

- FMD is also significantly higher among U.S.-born Blacks (20.7%) and Asians (13.9%). The most prominent disparities in FMD rates are found among older adults with disabilities (23.1%) and those with functional limitations (36.6%).

Percent of adults with frequent mental distress by sexual identity
Hennepin County 2010

SHAPE
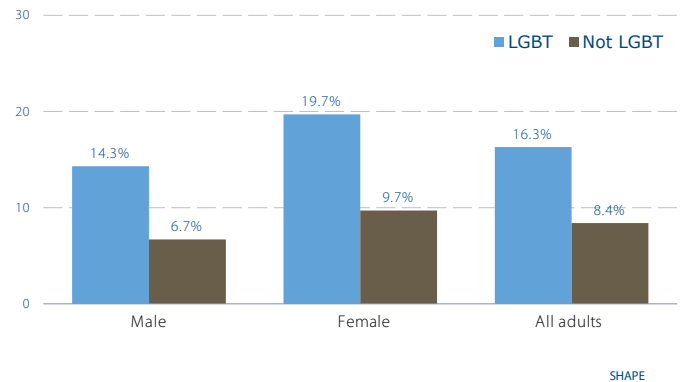
Percent of adults who frequently felt unaccepted due to race ethnicity or culture by geographic area
Hennepin County 2010

Minneapolis
N   Near-North, Camden
E   Northeast. University, Longfellow
     City of St. Anthony
C   Central, Phillips, Powderhorn
S   Calhoun-Isles, Southwest, Nokomis

Suburban Hennepin
NW1 Northwest Inner Ring Suburbs
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NW2 Northwest Outer Ring Suburbs
W2   West Outer Ring Suburbs
S2   South Outer Ring Suburbs

1.7% - 4.1%
4.9% - 7.0%
10.6%
21.0%

SHAPE
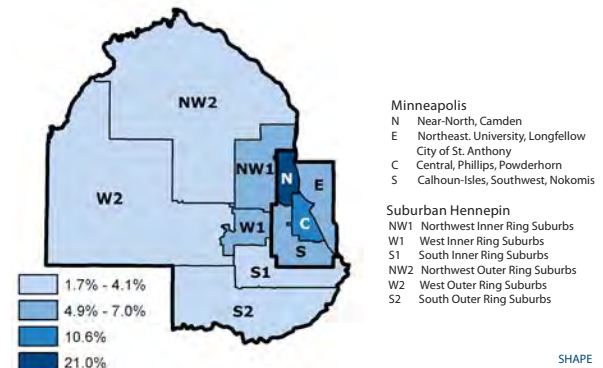
- In 2010, 2.8% of Hennepin County adults experienced Serious Psychological Distress (SPD); another 13% experienced mild to moderate psychological distress. Disparities for SPD mirror those for FMD.

- About half of all adults in the county are regularly involved in school, neighborhood or community activities.

- One in five adults is afraid to go out at night due to violence in their neighborhood.

- One in three residents experience situations at least once a year where they feel unaccepted due to their race, culture or ethnicity.

Data Source: SHAPE 2010 – Adult Survey; 2012 Community Health Indicators, Hennepin County

Children

- Nearly half of Hennepin County children have at least one meal with their families on all 7 days per week.

- About two thirds of parents talk with their school-aged children about their daily activities most days of the week.

- Approximately 10% of children spend more than one hour per week participating in leisure time activities such as fine arts, drama, dance or choir.

- Nearly half of school aged children spend one or more hours each day playing electronic games, watching TV or using computers for recreation.

- More than 50% of youth ages 10-17 volunteer some time each week; approximately one in four of those volunteer two or more hours per week.

- In 2010, 19.3% of school-aged child experienced fear of going to school at some point in the past year because of being picked on, teased or bullied by other children (compared to 11.4 % in 2006). That percentage is significantly higher for low-income children (27.2%) as compared to their non-low-income peers (15.4%).

- Nearly three quarters of 9th and 12th graders in Hennepin County schools report that their parents care about them very much. However, only one in four considered themselves to be strongly connected to both parents (26.1% and 26.6%).

Frequency of adults involved in school, community or neighborhood activities
Hennepin County adults 2010

Never 23.8%
Weekly 15.5%
Monthly 12.3%
Several times a year 22.5%
One a year or less 25.9%
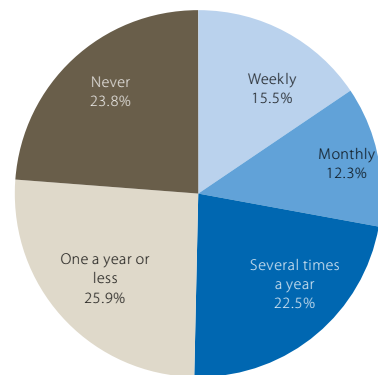
SHAPE

Percent of children who were afraid to go to school during the past school year because of being picked on, teased or bullied
Hennepin County Children Aged 6 to 17, 2006 & 2010

Never 88.6%
Rarely 7.8%
Sometimes 2.9%
Usually or Always 1.6%

Never 80.7%
Rarely 11.9%
Sometimes 6.0%
Usually or Always 1.4%

2006   2010
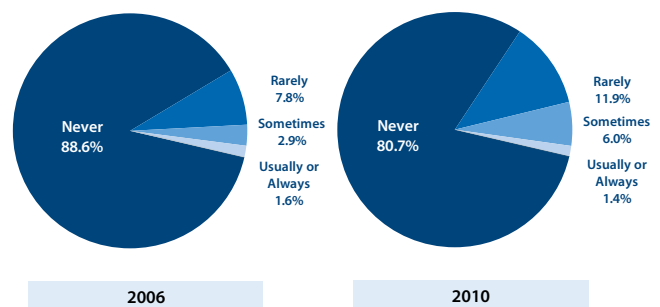
SHAPE

- One in three 9th or 12th graders in Hennepin County schools see themselves as not well connected to caring adults (33.8% and 38.4%). One in four see themselves as not well connected to their school.

Adolescents

- Mental health concerns were reported for one out of seven adolescents in Hennepin County.

- One out of ten 9th graders (9.9%) and nearly 12% of 12th graders report that they have a mental or emotional health problem that has lasted for one year or more.
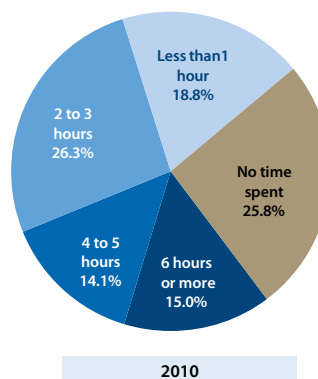
- Chronic mental or emotional health problems were more likely to be reported by White students in 9th grade (10.5%) and in 12th grade (12.5%) than their non-White peers.

- Girls have notably higher rates for mental health problems than boys. 14.6% of girls in 9th grade reported self-harming behaviors (vs. 6% in boys) and 18.1% reported suicidal thoughts (vs. 11.2% for boys). By 12th grade the disparity remains but the rates drop. By12th grade the difference for chronic mental health problems for girls was 14.3% vs. 9.2% in their male peers.

- More than one in ten students of all racial and ethnic backgrounds report serious self-harming behaviors or suicidal thoughts.

- Students of color in both 9th and 12th grades report higher rates of serious self-harming behaviors and suicidal thoughts with rates dropping by 12th grade. By grade 12, the rates of these behaviors remain highest in Hispanic/Latino students (9.6% and 14.1% respectively) when compared to their peers.

- Nearly 40% of 9th graders and more than one third of 12th grade students report experiencing bullying behavior.

- Nearly three quarters of adolescents 10-17 spends time each week with an adult role model, tutor coach or mentor with approximately 55% spending 2 or more hours per week.

- More than 9 in 10 students report feeling safe in their neighborhood.

Data Sources: Minnesota Student Survey - 2010, Minnesota Department of Health.

Percent of youths who spend time with an adult role model, tutor, coach or mentor, by amount of time per week
Hennepin County Children Aged 10 to 17, 2010

Less than1 hour 18.8%

2 to 3 hours 26.3%

No time spent 25.8%

4 to 5 hours 14.1%

6 hours or more 15.0%

2010   *SHAPE*

Percent of 9th grade students who reported having chronic mental or emotional health problems
Hennepin County Students, 2010

No chronic mental or emotional health problems reported 90.1%

Mental or emotional health problems lasting at least one year or more 9.9%
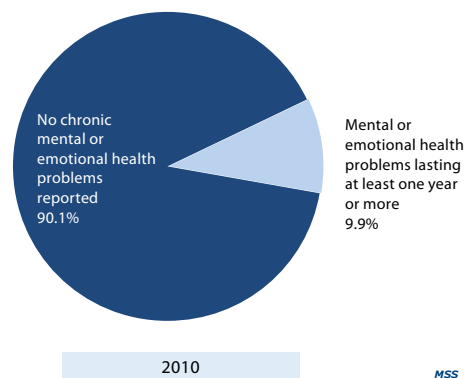
2010   **MSS**

Health Care Access:

Cross-cutting Health Issue

Target Goal 2012-2015:
Develop health care access strategies that will help achieve the targeted goals for increasing childhood school readiness, social and community connectedness, and regular physical activity and proper nutrition.

Access to health care

"Health care access" is NOT about the availability of quality local health care. Minnesota has plenty of first-rate hospitals, clinics and medical practitioners. Access is about barriers to getting needed care. There are still many people, including children, who lack adequate medical insurance to cover the costs of today's care. As a very real consequence, kids get raised without appropriate preventive and remedial medicine. Their folks just can't afford it. Some in our community don't get care because there aren't affordable clinics in their neighborhood or they haven't found a doctor that speaks their language or understands their culture.

Absent appropriate medical intervention, treatable ailments – at all ages – can easily become serious, chronic and even life-ending conditions. Developing effective health care access solutions will significantly boost our chances to achieve all of our other community health improvement goals.

Why is this health issue important?

- A person's ability to access health services has a profound effect on every aspect of his or her health.

- Health insurance in one of the best known and most common means used to obtain access to health care.

  - People without medical insurance are more likely to lack usual sources of medical care, and more likely to skip routine medical care due to cost, thus increasing their risk for serious and disabling health conditions.
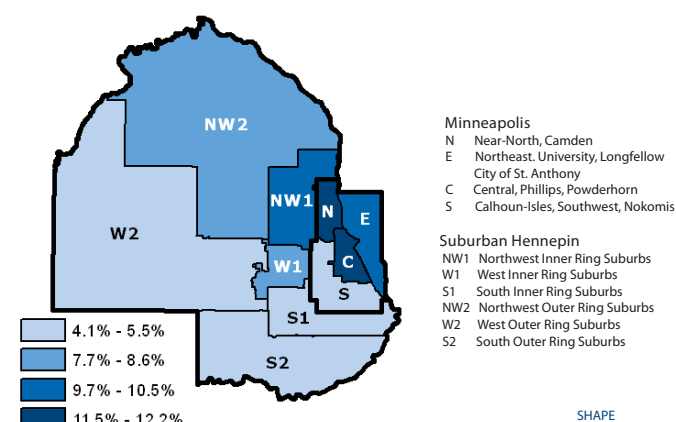
  - Health People 2020 set a goal of 100% coverage for Americans under age 65.

  - Coverage for health care increases the likelihood that a child is regularly seen by a doctor or health professional.

  - Regular health care visits are important for: monitoring healthy growth and development; accessing preventive screenings and immunizations; and, for diagnosing or treating serious health conditions.

  - The lack of adequate health care coverage is a considered a significant risk to a child's overall health and wellbeing.

- Usual place of care is an important measure for access to health care. A medical home is a doctor's office or clinic where a person usually goes when a person is sick or needs medical care.

  - Persons without a usual place of care are less likely to receive preventive care, more likely to have unmet health care needs, more hospitalizations, and higher costs of care.

  - It is important for children to have a consistent source of medical care, where their health concerns can be monitored by health professionals who know their conditions and where the child can receive any needed follow-up care.

Percent of adults under age 65 currently uninsured by geographic area
Hennepin County 2010

Minneapolis
N   Near-North, Camden
E   Northeast. University, Longfellow
     City of St. Anthony
C   Central, Phillips, Powderhorn
S   Calhoun-Isles, Southwest, Nokomis

Suburban Hennepin
NW1   Northwest Inner Ring Suburbs
W1   West Inner Ring Suburbs
S1   South Inner Ring Suburbs
NW2   Northwest Outer Ring Suburbs
W2   West Outer Ring Suburbs
S2   South Outer Ring Suburbs

- 4.1% - 5.5%
- 7.7% - 8.6%
- 9.7% - 10.5%
- 11.5% - 12.2%

SHAPE

Percent of adults under age 65 currently uninsured by education and household income
Hennepin County 2010

Less than high school	High school	Some college	College or higher	Low income	Not low income
35.2%	17.2%	11.5%	4.2%	19.7%	4.6%
Education				Household income	

SHAPE
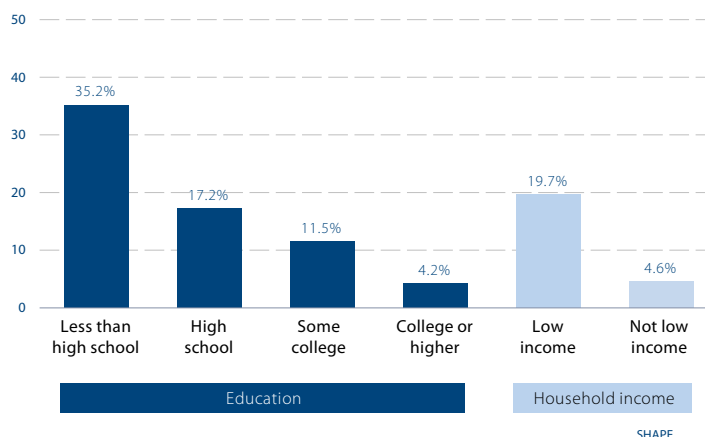
Percent of adults under age 65 currently uninsured by race and ethnicity
Hennepin County 2006

White	US-born Black	African-born Black	Southeast Asian	Hispanic/ Latino	All adults
6.2%	14.7%	18.4%	9.9%	40.0%	8.6%

SHAPE
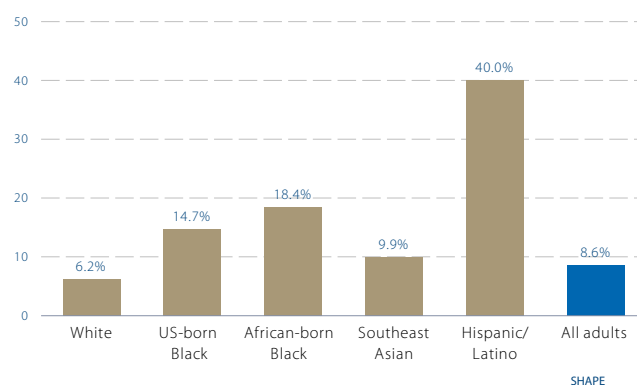
How are we doing?

Adults

- The rate of currently uninsured among county working age adults (7.8%) compares favorably to the rates among their peers in the state (10.5%) and in the nation (22.3%).

  - The great majority (92%) of Hennepin County working age adults (age 18-64) currently have health insurance coverage.

  - 11% of working adults are covered through public programs; 81% are covered through private health plans.

  - The current rate of uninsured adults (7.8%) is an equivalent to about 60,000 working age adults who lack health insurance coverage at any point of time.

  - Almost twice that many working age adults (110,000 persons, or 14.4%) lack health insurance at least some time during the past the year.

  - Social and economic status matters.

  - Those who reported a disproportionately higher rate of being currently uninsured include working age adults who were: male, low income, unmarried, lesbian or from a racial or ethnic minority group.

  - While the young adults (age 18-24) still reported the highest currently uninsured rate (11.8%) among all adults, this rate represents a 114% reduction from the rate in 2006 (25.3%). This reduction may largely be due to the new Minnesota Law that was effective in January 2008 to cover dependents under their parents' policy up to age 25.

  - Significant geographic variation in rates is also observed.

Unmet medical care needs by household income
Hennepin County adults 2010

Measure	All Adults	Low income	Not low income
Needed medical care during the past 12 months	68.2%	67.3%	68.7%
Unmet medical care needs - either delayed or did not get the needed medical care (among those who needed medical care)	23.9%	44.0%	18.5%
Unmet medical care needs - due to cost or lack of insurance (among those who had unmet medical care needs)	75.2%	81.3%	72.5%

Unmet mental health care needs by household income
Hennepin County adults 2010

Measure	All Adults	Low income	Not low income
Needed mental health care during the past 12 months	24.9%	35.3%	22.6%
Unmet mental health care needs - either delayed or did not get the needed mental health care (among those who needed mental health care)	60.8%	67.5%	58.2%
Unmet mental health care needs - due to cost or lack of insurance (among those who had unmet mental health care needs)	54.8%	66.2%	48.9%

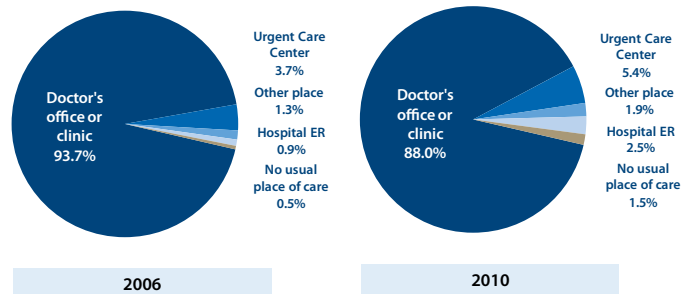### Percent of adults by usual place of medical care
Hennepin County adults 2010

Doctor's office, clinic, public health or community clinic 77.4%

Hospital emergency room 2.6%

Urgent care center 8.4%

Minute clinic 3.1%

Other 2.5%

No usual place 6.0%

SHAPE
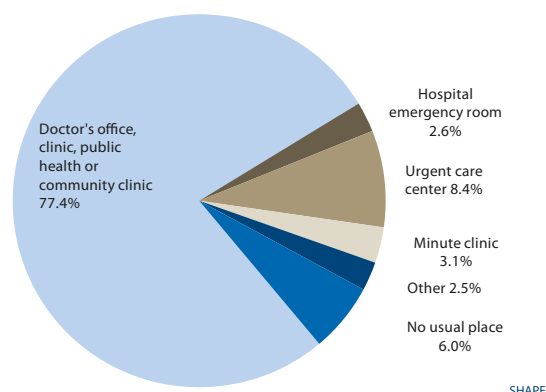
- Working age adults in North Minneapolis have a current uninsured rate almost three times as high as the rate for their counterparts in west and south suburb outer rings (11.5% vs. 4.1% or 4.2%).

• In 2010, a great majority (78%) of Hennepin County adults had a usual place of care.

  - However, over one-fifth of county adults (22%) have no usual source of care. This means when they are sick or need medical care, they either have no place to go, or use an emergency room, urgent care or minute clinic. This rate far exceeds Healthy People 2020 aims to reduce persons (all ages) without usual place of care to 5% or lower.

  - The rate of adults without usual place of care has increased from 14% in 2006 and in 1998 to 22% in 2010.

  - The rate of no usual source of care is 3.5 times higher among those currently uninsured than among those currently insured (64% vs. 19%).

  - Young adults and adult males have sizable higher rates of no usual place of care than older adults and adult females.

  - Adults with low income, low education, being U.S.-born Blacks, Hispanics or Latinos, experiencing recent frequent mental distress, or being lesbians, reported a higher rate of no usual place of care.

  - Wide variation in rates across geographic areas is also observed with the lowest rate (13%) in south suburban outer ring and the highest (29%) in North Minneapolis.

Data Source: SHAPE 2010 – Adult Survey and 2012 Community Health Indicators, Hennepin County

Percent of children by place the child usually receives his or her medical care
Hennepin County Children Aged 0 to 17, 2006 & 2010

Doctor's office or clinic 93.7%
Urgent Care Center 3.7%
Other place 1.3%
Hospital ER 0.9%
No usual place of care 0.5%
2006

Doctor's office or clinic 88.0%
Urgent Care Center 5.4%
Other place 1.9%
Hospital ER 2.5%
No usual place of care 1.5%
2010

SHAPE

Percent of children with health insurance coverage by source of coverage
Hennepin County Children Aged 0 to 17, 2006 & 2010

Private source of health insurance 76.5%
Public source 18.2%
Uninsured 3.9%
2006

Private source of health insurance 74.7%
Public source 20.4%
Uninsured 4.5%
2010

SHAPE

Children

- Most Hennepin County parents (95.1%) report that their child currently has insurance coverage that pays for his or her health care. Yet, nearly one out of twenty Hennepin County children (4.5%) is currently uninsured.

    - Three quarters (74.7%) of children were insured by a private source (down from 76.5% in 2006).

    - 20.4% were insured under a public program (compared to 18.2% in 2006).

    - 4.5% were uninsured (compared to 3.9% in 2006).

    - Hispanic/Latino children were significantly less likely to have access to health insurance coverage than Hennepin County children overall (29.2 % are currently uninsured).

    - Children from urban areas (Minneapolis) appeared to be somewhat more likely to be uninsured; however, the difference in the rates reported by location of residence is not statistically significant.

- Some children were experiencing gaps in their health coverage:

    - 7.2% did not have health coverage for at least part of the year (compared to 5.4% in 2006).

    - 2.7% were uninsured for the entire year (compared to 2.1% in 2006).

- Most Hennepin County parents report that their child has a regular medical home (88.8%), as compared to 93.7% in 2006, listing a doctor's office or clinic as their usual place to receive medical care.

    - The number of low income children who used emergency rooms or urgent care centers and had "no usual place of care" more than doubled (from 2.4% to 6.8%).

    - Children from low income households were significantly less likely to have a usual medical home as compared to the rate for all Hennepin County children overall (80.9% compared to 88.8%).

- A schedule of recommended preventive care visits, based on the child's age, provides a "standard" for determining if the child has received adequate preventive care in the past 12 months.

    - Three out of four children in Hennepin County (76.1%) met the standard for preventive care visits.

    - Infants and toddlers, aged 0 to 2 years old were likely to have had some preventive visits, but only 55.0% were "on track" for receiving all of the recommended visits for their age group.

    - There were no significant differences reported by income level or geographic location.

Data Source: SHAPE 2010 – Child Survey, Hennepin

Social Conditions that Impact Health:
Cross-cutting Health Issue

Target Goal 2012-2015:
Develop strategies to address social conditions that impact the targeted goals of increasing childhood school readiness, social and community connectedness, and regular physical activity and proper nutrition.

Healthy communities

Employment opportunities. Parks. Sidewalks. Safe neighborhoods. Low-crime rates. Good public schools. Diversity embraced. Music. Art. Libraries. Good mass transit. Safe after-school options. Clean air and water.

These examples represent just a fraction of the wide and varied range of social determinants of our individual and collective health. Our challenge is to identify and address those that pose barriers to achieving other health goals.

Why is this health issue important?

The quality of the social and physical environments in which we live can directly impact the health of an individual, family or community. Healthy People 2020 of the U.S. Department of Health and Human Services highlights the importance of addressing the social determinants – or social conditions – that impact health[10]. These conditions include such things as social and economic opportunities; resources and supports; quality education; safety at home and at work; a clean environment including clean air and water; and social interactions and relationships. Many of these social conditions were also identified by the CHIP stakeholders as important characteristics of a healthy community.

One of four overarching goals identified for this decade by Healthy People 2020 is the goal to "create social and physical environments that promote good health for all". The Community Health Improvement Plan for Hennepin has also identified social conditions that impact health as a strategic health issue and specifically identifies it as a cross-cutting issue that needs to be incorporated into strategies to address all other strategic health issues and goals.

How are we doing?

We are not providing a snapshot of how we are doing in Hennepin County on this strategic issue due to its complexity in scope. Please see the various data appendices or link to the Hennepin County Public Health Data website ***www.hennepin.us/PublicHealth-Data*** to search a variety of sites on a variety of social, demographic and health data.

CHIP Plan Development

CHIP Process Overview

Timeline of Actions

The Community Health Improvement Partnership began in December 2011. During January through June, 2012, considerable activity focused on engagement of community stakeholders in the Assessment and Planning phase of this work. We have completed the selection of strategic health issues and identified goals for focused work. We are now preparing for engagement of the CHIP action teams, which will be convened fall of 2012 for the three selected strategic health issues. The first cycle for action will be September 2012 – December 2013. A quick visual of the steps undertaken during the CHIP assessment and planning process follows.

Community Health Improvement Partnership

2012 Timeline

12/1/2011
CHIP Process Initiated

1/15/2012
Community Health Assessment Begun

2/16/2012
CHIP Survey Distributed

2/24/2012
1st CHIP Leadership Group Meeting

3/12/2012
Leadership Group Meeting

3/28/2012
CHIP Forum 1

3/30/2012
Leadership Group Subcommittee
Local Public Health System

4/2/2012
Leadership Group Meeting

4/18/2012
CHIP Forum 2

4/23/2012
Leadership Group Subcommittee
Action Phase Planning

4/29/2012
Leadership Group Meeting

5/2/2012
CHIP Forum 3

5/15/2012
Leadership Group Meeting

5/29/2012
Leadership Group Subcommittee
Goals Recommendations

6/12/2012
Final Leadership Group Meeting

6/30/2012
CHIP Assessment & Planning Phase ends

12/1/2011   6/30/2012

MAPP and ToP® Processes

Mobilizing for Action through Planning and Partnership (MAPP)

The CHIP partners followed the Mobilizing for Action through Planning and Partnership (MAPP) process to guide their planning. MAPP is a nationally recognized process for improving community health that was developed by the National Association of County and City Health Officials (NACCHO). It offers a framework and a set of tools for convening community-wide strategic planning for improving community health. Details about the MAPP Process and how it was used are included in the MAPP Appendix.

Technology of Participation (ToP®)

Trained Technology of Participation (ToP®) facilitators from Hennepin County and the City of Minneapolis guided the CHIP consensus workshop discussions held at the three CHIP forums. This trademarked method of facilitation has been proven effective in "empowering people, communities and organizations to re-imagine their future and realize that vision." It is described as nurturing a culture of participation, building capacity for change, sparking individual creativity, and recognizing and honoring all contributions. It is designed to help groups and teams deal with large amounts of data in a short period of time, foster an emphasis on common ground, deal effectively with diversity, avoid conflict and polarization, and build commitments for effective action.

Two ToP® facilitators from Hennepin worked with CHIP project staff to design and coordinate the consensus workshops for the three CHIP stakeholder forums. A team with four pairs of facilitators attended each forum to lead discussions ranging from characteristics of a healthy community to environmental scans to actions and goals discussions. ToP® facilitators will convene facilitated "Action Planning Workshops" this fall as the action teams begin their work in the next phase of this initiative.

Building on Past Successes

This community has a long and rich history of working to improve the public's health.

Community health assessments and health improvement initiatives are not new, and each partner in the CHIP initiative brings a solid background of work in and with the community to improve health. Community engagement and collaborative planning is regularly used to move forward gains in health status and public health planning. Multiple organizations are currently engaged in a variety of works related to the strategic health issues and targeted goals selected for action. The CHIP's promise is the opportunity to strengthen what is already strong and address where we have gaps – together. During the action phase of the CHIP work the partners will begin to inventory and catalogue these works to identify opportunities for greater collaboration and synergy.

Community Health Assessment:
Data review

The CHIP assessment and planning work focused on two tracks:

- Compiling recent assessment data collected by the three partner public health departments and drawn from other state and national sources.

- Adding to these assessments from the stakeholder engagement work done through the CHIP Survey and the CHIP Forum Series.

Together, these efforts provide a picture of current health issues in Hennepin and factors that could impact health moving forward.

This section will describe the Community Health Assessment Data Review process and provide an overview of the data reviewed as well as a brief profile of Hennepin County's jurisdiction, people and overall health. The Data and MAPP appendices provide expanded details. A link to the data sources used or created in this work can be found on the Hennepin County Public Health Data website **www.hennepin. us/PublicHealthData**. This site provides links to the following data sites:

- The Community Health Assessment Indicators (PDF file also in APPENDICES)
- *SHAPE - Survey on the Health of All the Population and the Environment*
- Minneapolis Department of Health and Family Support
- *Results Minneapolis*
- Bloomington Public Health
- Minnesota Department of Health's Data and Statistics
- *Minnesota Student Survey*

- *Healthy People 2020*
- MN Dept of Health Statistics & Data
- MN Dept of Education Data Center
- CDC Data & Statistics
- Census Bureau

Community Health Assessment

Local public health entities regularly do community health assessments and identify strategic goals and objectives. Community health assessments identify factors that affect the health of a population, describe the health status of the community, and provide a basis for decision making as communities develop priorities, identify resources, and mobilize to improve health of the public.

In Minnesota, community health assessments are performed for the geographic regions covered by community health boards. These assessments are often done in partnership with other organizations. Targeted partners include those who will provide a broad range of perspectives; represent a variety of groups, sectors, and activities within the community; and bring the necessary resources and enthusiasm to the table for action.

The CHIP Community Health Assessment

The five health boards serving the geographic area of the jurisdiction used a shared process that included the assessment needs of the hospitals and health systems.

The three health departments jointly

- Identified sectors and organizations to engage as partners in planning.
- Activated a three-agency assessment workgroup to review data, execute a survey, and present assessment information to the convened community partners.

Each agency took responsibility for different aspects of the community health assessment activities. The Hennepin County Human Services and Public Health Assessment Team pulled data from multiple sources to create a set of 60 community health assessment indicator fact sheets – which reflect current health status in Hennepin.

Assessment and Data

Staff from the data and assessment areas of the three health departments reviewed recently collected quantitative and qualitative health data from a variety of sources, including local, state and federal. They created, executed and analyzed a CHIP survey that was distributed to community organizations. (See Data Appendix for survey questions.)

SHAPE

A primary source for the CHIP Community Health Assessment data was the 2010 Survey of the Health of All the Population and the Environment (SHAPE)[4] which is Hennepin's fourth survey of residents and the factors that affect their health. SHAPE, a nationally recognized survey, provides data on a broad range of health topics from nutrition and exercise to feelings of safety, for many local geographic areas and demographic subgroups within the County.

The SHAPE 2010 - Adult Data Book summarizes the responses of the more than 7,000 respondents from the SHAPE 2010 - Adult Survey. Results in this data book are presented for Hennepin County as a whole and for ten geographic areas.

The SHAPE 2010 – Child Data Book summarizes the responses from nearly 2,200 participants in the SHAPE 2010 – Child Survey. Results in this data book are presented for Hennepin as a whole and for two geographic areas within the county. The data are also reported by demographic variables including gender, age, grade level and household income.

Since 1998, SHAPE has collected information on the following health topics or domains:

- Overall health
- Health care access and utilization
- Healthy lifestyle and behaviors
- Social-environmental factors

In 2006 the SHAPE project expanded to include a survey of children, including questions about chronic conditions, nutrition and physical activities, use of community amenities, school- and community-based educational and enrichment activities, and family connectedness and communication.

Community Health Assessment Indicators

Along with SHAPE, Hennepin County's Public Health Assessment team has built a set of on-line community health assessment indicators about health in the county. Using data extracted from SHAPE, the Minnesota Student Survey, and vital records information, staff drew comparisons to state and national data including Healthy People 2020 and Minnesota's Behavioral Risk Factor Survey.

These indicators follow 12 Healthy People 2020 health domains and include data sets for which there are county or local data. To the right is a list of the 12 domains followed by a sample of one of these indicator summaries. The indicators are posted on the Hennepin County Public Health Data website: **www.hennepin.us/ PublicHealthData**. A table listing the indicator data sets found on this site can be found in the DATA Appendix as well as a PDF file with all of the current indicators. As the information on these indicators change over time, they will be updated.

Community health assessment data domains

- Access to health services
- Demographic information
- Environmental quality
- Injury and violence
- Maternal and child health
- Mental health
- Nutrition, physical activity, and obesity
- Overall health
- Preventive services
- Reproductive and sexual health
- Social determinants
- Tobacco and substance abuse

Sample indicator summary

The following screen shot highlights the first page of a sample indicator.
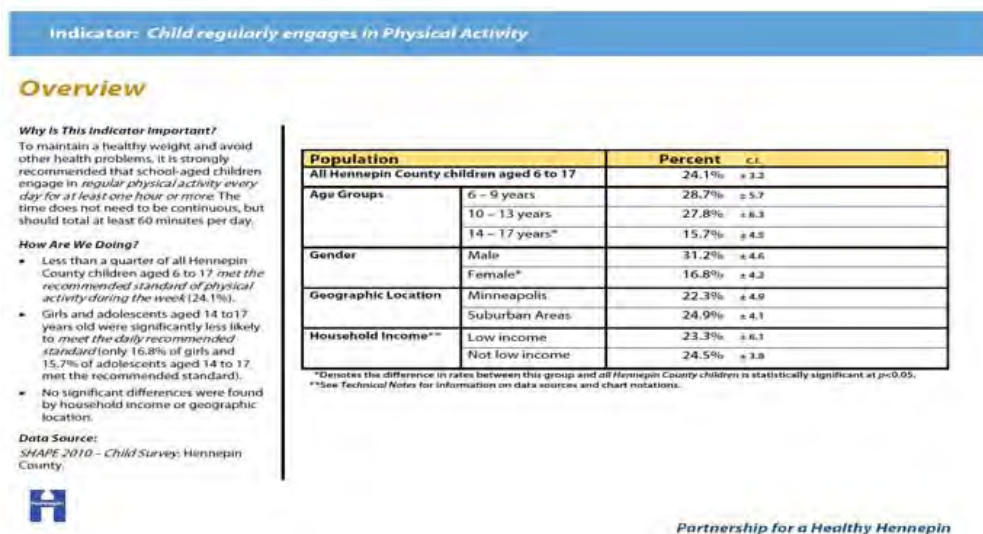
Other Data Sources

The CHIP Community Health Assessment included many local, state and national data sources: SHAPE, Healthy People 2020, the Minnesota Student Survey, America's Health Rankings (United Health Foundation), County Health Rankings (Robert Wood Johnson), data sources from the Minnesota Department of Health, and local data collected by the Minneapolis Department of Health and Support and the Bloomington Division of Public Health.

Presentations to Community Stakeholders

Data highlights were provided to CHIP forum participants, including county demographics and health status of residents in a variety of health areas.

Forum 1 Data Presentation

Staff from each of the three local health departments (Hennepin County, Minneapolis, and Bloomington) presented data from different sources to the CHIP forum 1 participants in order to:

- Introduce the different types of health indicators – national and local.

- Share some foundational data about health status in the community.

- Inform participants about the types of data available - quantitative data vs. qualitative sources.

- Educate them on the many aspects of data to consider when attempting to set community health priorities.

- Provide resources to help them locate different types of data.

Data included trends, geographic distributions, racial and ethnic differences, and numbers of people affected. Copies of the slide presentation are included in the DATA APPENDIX.

In addition, forum participants were given a demonstration on how to access the Hennepin County Public Health Data website to review indicators and link to other data sites, including:

- Community health assessment indicators

- *SHAPE*

- Minneapolis Department of Health and Family Support

- *Results Minneapolis*

- Bloomington Division of Public Health

- Minnesota Department of Health's Data and Statistics

- *Minnesota Student Survey*

- *Healthy People 2020*

Besides receiving the *SHAPE* Adult and Child Data Books, participants received a Public Health Assessment Data Sources reference document which was prepared by the Metro Public Health Analysts Network. This working group includes representatives from public health assessment personnel from the health departments in the Twin Cities metro area. It was formed and operates under the leadership and direction of the Metro Local Public Health Association (MLPHA). This document shared at the forum lists publicly available data sources that help tell the story of the health of children and adults who live in the seven-county metro area in Minnesota.

**Public Health Assessment Data Sources
MPHAN – March 2012**

At the end of the presentation, forum participants were asked to complete some "homework" prior to forum 2. They were asked to review local health data related to their organization's primary mission AND to review at least two OTHER health issues that interested them. They were also asked to prepare to discuss the following questions at the next forum:

- What needs to change in the next four to five years to create or improve health in our community?
- What needs to change to address health issues that are most important to you?
- How can your organization contribute to improvements in the community's health?

Forum 2 had no data presentation.

Forum 3 data presentation

Participants received health data information about proposed strategic health issues: maternal and child health; nutrition, obesity and physical activity; social and emotional wellbeing (mental health) and health care access and utilization. Copies of the slide presentation are included in the DATA Appendix.

Hennepin Profile

About the Jurisdiction

Hennepin County is the most populous and diverse county in Minnesota with 1.2 million residents. It covers approximately 611 square miles and contains 46 cities. It forms part of the 16th most populated metropolitan areas in the country and is the largest of Minnesota's 87 counties with a quarter of the state's population. The City of Minneapolis, one of the "Twin Cities," is its largest city and the county seat. Bloomington is the 2nd largest city in the County and the 4th largest city in the state. Hennepin is composed of urban, suburban, exurban, and rural areas. Fourteen school districts operate in the county. Although containing the largest population of any Minnesota county, Hennepin still has 18% of its area under farm cultivation.

The high-quality services and opportunities available in Hennepin County contribute to making this a place where people choose to live and work. Hennepin has a broad-based economy with sizable manufacturing, financial, governmental, trade, health care, and entertainment sectors. One third of the state's employers -- including 11 Fortune 500 companies-- operate within the county's boundaries. The diversity of this base has typically provided some level of insulation against economic downturns. Employment remains relatively stable, and the unemployment rate has typically remained below the national average.

We have an excellent network of quality and diverse health care providers. Eleven hospitals serve the county as well as several health plans, and multiple community-based not-for-profit clinics – including eight Federally Qualified Health Centers.

Hennepin County is home to the University of Minnesota, a land-grant university with an Academic Health Center and School of Public Health that are actively involved with public health initiatives in the community. Minnesota residents are very civic-minded and generous; multiple non-profit and corporate foundations regularly support health-related initiatives in the community.

About the People

The citizenry in Hennepin is well educated: more than 88 percent of Hennepin County residents over age 25 are high school graduates – but not across all racial and ethnic groups.

The population is aging – with a large swell of 45-65 year olds approaching retirement and the life changes associated with aging. The community is fortunate to have an almost equal number of younger adults following behind that will continue to keep this community strong and our elders supported.

The population is growing more diverse and is home to Minnesota's largest foreign-born population: one in eight Hennepin residents were born in a different country. The largest number of Somali refugees in Minnesota lives in the county. Hennepin is a highly linguistically diverse county with ninety different languages spoken. This is the eighteenth highest number recorded in any county in the United States.

Income levels tend to exceed the national average. Although 93% of the population lives above the poverty level, this percentage differs among racial and ethnic groups – with nearly 30% of the American Indian, African American and Latino communities living with incomes below the federal poverty level. Lower income communities are mostly located in the city center and first ring suburbs.

Hennepin County Population 2010
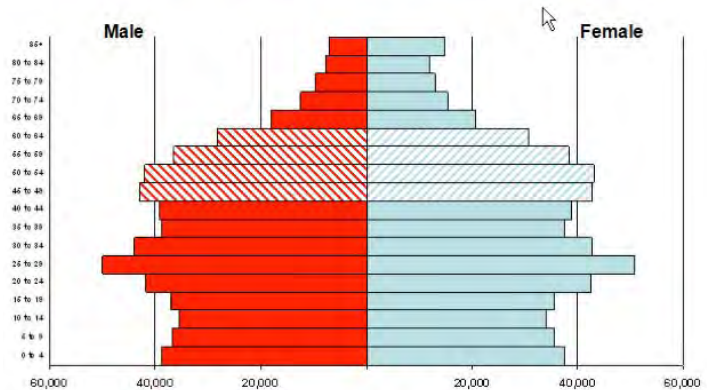
Hennepin County Population Change by Race/Ethnicity 2000-2010

Race/Ethnicity	2000	2010	Percent Change
Hispanic/Latino	45,439	77,676	70.9%
White not Hispanic	881,016	826,670	-6.2%
Black or African American not Hispanic	98,698	134,240	36.0%
American Indian not Hispanic	10,212	8,848	-13.4%
Asian/PI not Hispanic	53,702	71,966	34.0%
Some other race not Hispanic	2,115	2,321	9.7%
Two or more races not Hispanic	25,018	30,704	22.7%
Total	1,116,200	1,152,425	3.2%

Hennepin County Poverty Distribution

Percentage of the Population in Poverty, 2000
Data Displayed by Census Tract
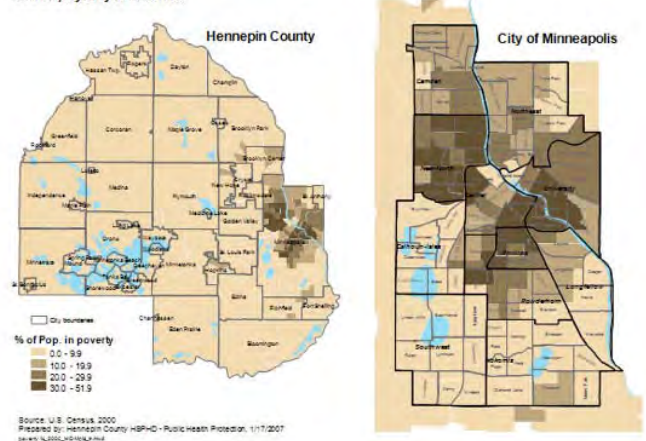
About Health in the Community

Overall, our residents are very healthy. However, disparities in health remain – particularly for those with lower incomes or education levels.

- County adults enjoy better health than adults nationwide, with 63% reporting excellent or very good health.

- The smoking rate continues to decline (from 21% in 1998 to 12% in 2010) and is lower than the national average.

- Like the rest of the country, our population is getting heavier.
  - More than half of county adults are either obese (20%) or overweight (33%).
  - The current obesity rate (20%) is as high as it was in 2006, and is notably higher than the rate in 1998 (14%) and the rate in 2002 (17%).

Percent of children reported to be in *excellent health* by household income level
Hennepin County Children aged 0 to 17, 2006 & 2010

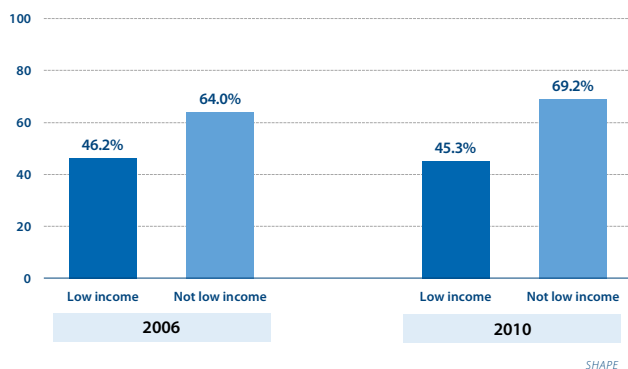Hennepin County children are also in good health, overall. Most are on the right path to establishing habits and patterns that promote healthy growth and development, as well as establishing a strong foundation for life-long health and wellbeing.

- Hennepin County infants, toddlers and children up to age 9 are doing very well.

- However, many of the key health indicators begin to "flatten out" or decline for youth aged 14 to 17.

- Serious health conditions affect about one in ten children in Hennepin.

- The incidence of asthma attacks has increased in children over the past few years.

- Mental health concerns were reported for one out of seven adolescents in Hennepin.

- Children from low-income families were significantly lower on many important measures of health and wellbeing than their peers.

Good health is not shared equally across populations in Hennepin, however. Disparities in health status persist between genders, across racial and ethnic groups, by age groups, across geographic areas, or at different educational attainment and across income levels.

The following series of charts and graphs will give you a picture of health in our community. The data outlined in the Highlights are not repeated here. Additional Health Data can be found in the Data Appendix and on-line at the Public Health Data site ***www.hennepin.us/PublicHealth-Data***. Local data is available in Attachment A.

Percent of adults by self - rated health status

Hennepin County adults 2010

Good
27.4%

Very good
43.7%

Fair
7.7%

Poor
1.7%

9.4%

Excellent
19.5%

SHAPE
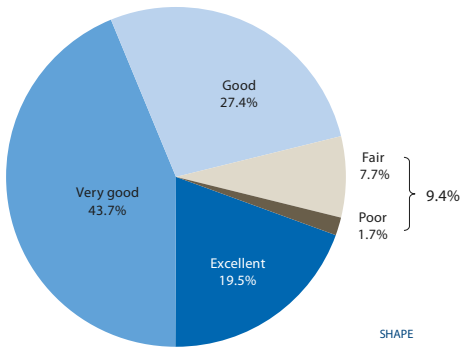
Percent of adults with selected chronic disease and conditions

Hennepin County 2010

Any of these four	40.0%
High blood cholesterol	32.4%
Cardiovascular disease	4.9%
Hypertention	16.7%
Diabetes	5.3%

SHAPE

Percent of adults reporting poor or fair health by education and household income

Hennepin County 2010

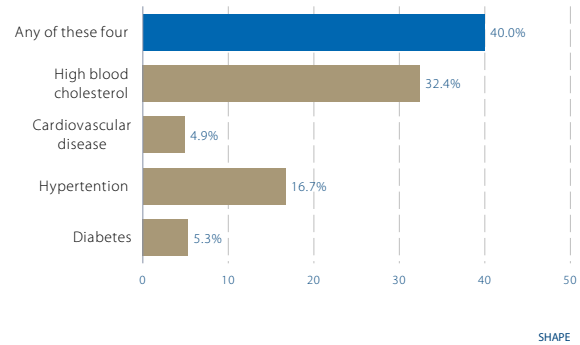|		
Less than high school	34.5%	
High school	20.7%	
Some college	13.6%	
College or higher	4.6%	
Low income	21.6%	
Not low income	5.9%	

Education   Household income

SHAPE
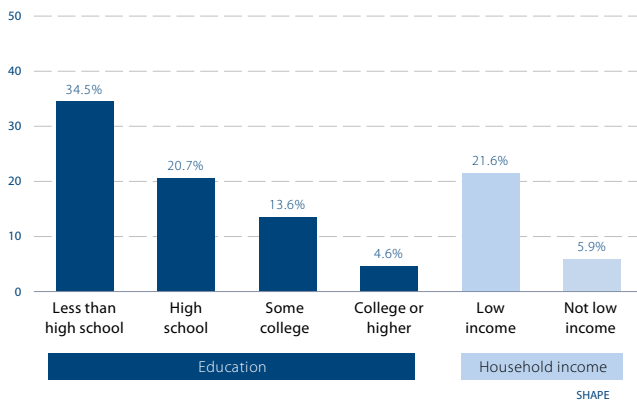
Percent of adults with diabetes by geographic area

Hennepin County 2010

3.3 - 4.9
5.0 - 5.9
6.0 - 6.9
7.0 - 7.9

Minneapolis
N   Near-North, Camden
E   Northeast. University, Longfellow
      City of St. Anthony
C   Central, Phillips, Powderhorn
S   Calhoun-Isles, Southwest, Nokomis

Suburban Hennepin
NW1 Northwest Inner Ring Suburbs
W1   West Inner Ring Suburbs
S1   South Inner Ring Suburbs
NW2 Northwest Outer Ring Suburbs
W2   West Outer Ring Suburbs
S2   South Outer Ring Suburbs
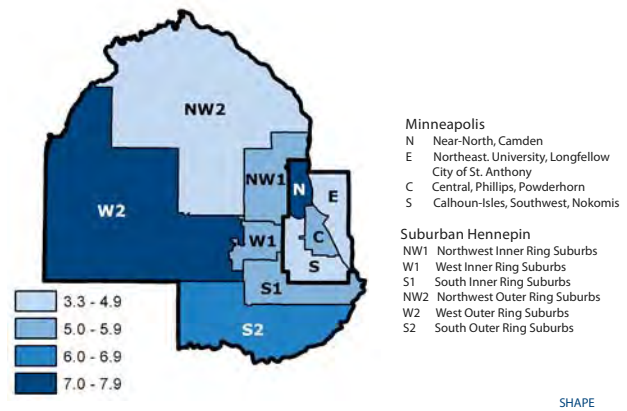
SHAPE

Percent of adults reporting poor or fair health by geographic area

Hennepin County 2010

5.4% - 7.9%
8.0% - 9.9%
10.0% - 19.9%
20.0%

Minneapolis
N   Near-North, Camden
E   Northeast. University, Longfellow
      City of St. Anthony
C   Central, Phillips, Powderhorn
S   Calhoun-Isles, Southwest, Nokomis

Suburban Hennepin
NW1 Northwest Inner Ring Suburbs
W1   West Inner Ring Suburbs
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S2   South Outer Ring Suburbs
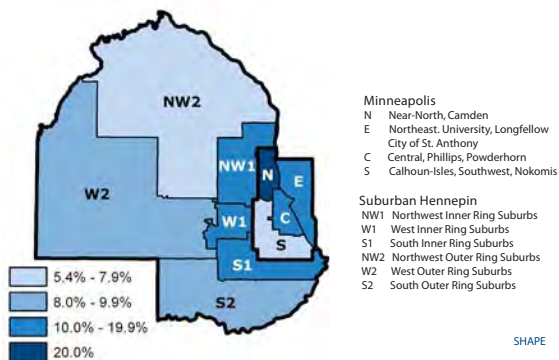
SHAPE

Percent of adults with diabetes by education and household income

Hennepin County 2010

Less than high school	13.4%	
High school	11.4%	
Some college	6.4%	
College or higher	3.4%	
Low income	9.2%	
Not low income	4.1%	

Education   Household income
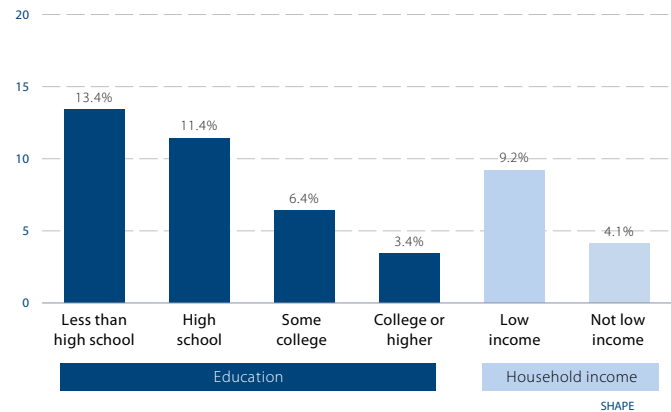
SHAPE

Current smoking status

Hennepin County adults 2010
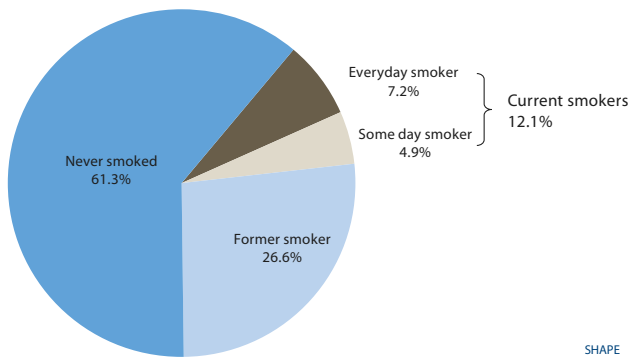
Never smoked
61.3%

Former smoker
26.6%

Everyday smoker
7.2%

Some day smoker
4.9%

Current smokers
12.1%

SHAPE

Percent of adults with selected mental health conditions

Hennepin County 2010

9.0% — Recent frequent mental distress
2.8% — Serious psychological distress
24.3% — Ever had depression
16.7% — Ever had anxiety or panic attacks
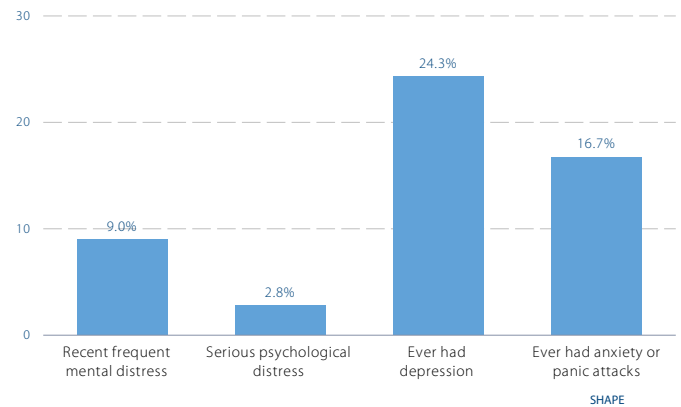
SHAPE

Percent of adults currently smoking

Time trend 1998-2010, Hennepin County adults
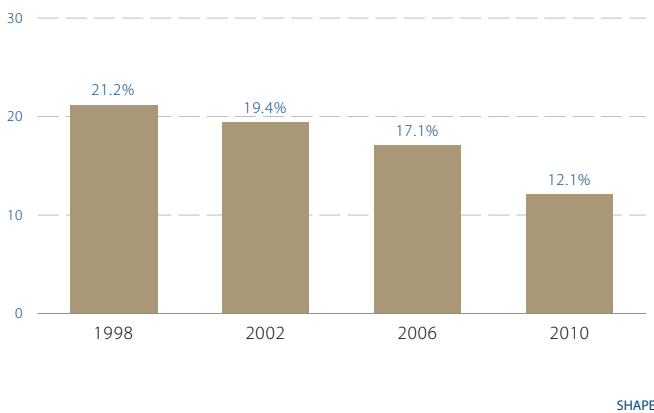
21.2% — 1998
19.4% — 2002
17.1% — 2006
12.1% — 2010

SHAPE

Percent of adults with frequent mental distress by geographic area

Hennepin County 2010

Minneapolis
N   Near-North, Camden
E   Northeast. University, Longfellow
     City of St. Anthony
C   Central, Phillips, Powderhorn
S   Calhoun-Isles, Southwest, Nokomis

Suburban Hennepin
NW1 Northwest Inner Ring Suburbs
W1   West Inner Ring Suburbs
S1   South Inner Ring Suburbs
NW2 Northwest Outer Ring Suburbs
W2   West Outer Ring Suburbs
S2   South Outer Ring Suburbs

7.0% - 7.9%
8.0% - 8.9%
9.0% - 9.9%
10.0% - 17.9%
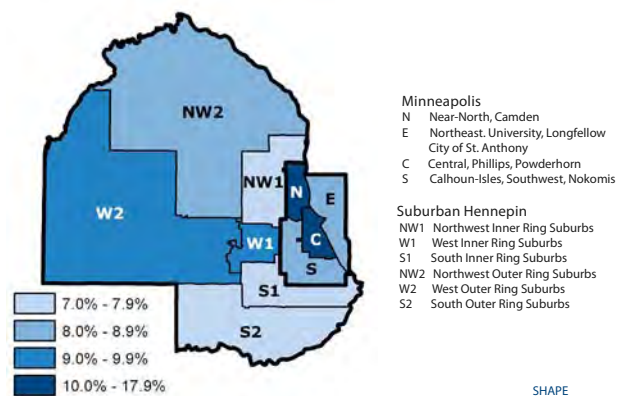
SHAPE

Community Health Assessment:
Stakeholder engagement & planning

Overview

Between February and May 2012, nearly 2,500 stakeholder organizations and individuals were invited to provide input into the local CHIP planning process, including stakeholders from across the geography of the county, from a variety of sectors, and that served different population groups.

Most were contacted to participate in an on-line survey. Of the nearly 2,000 agencies that received the survey, 239 organizations responded. Survey respondents who were interested in the forum series were also invited to participate in a three-part CHIP forum series. Others were added to the forum invitation list by health department staffs and CHIP Leadership Group members. Of approximately 260 organizations invited to the forums, 110 individuals participated at one or more of the three CHIP forum sessions.

To encourage participation, survey reminders were emailed to the survey recipients, multiple invitations and reminders were sent to each forum invitee, and phone calls were made to community stakeholders who had not come. Follow-up emails were sent to all invitees after each forum with information so that interested individuals were able to follow the CHIP assessment and planning progress.

Additionally, Hennepin established a dedicated email address for communicating with CHIP participants: *HennepinPublicHealth@co.hennepin.mn.us*. A follow-up survey was distributed to non-participants to identify ways to make future gatherings more inviting or accessible. Follow-up information has been sent to forum participants to keep them abreast of activities associated with the action phase of the CHIP process.

The information gathered from these efforts provided the input into the Community Health Assessment and the assessments outlined in the MAPP process: Community Themes and Strengths, Forces of Change, and Public Health System Assessment. Details about how these assessments were incorporated into the CHIP process can be found in the MAPP Appendix.

The CHIP Survey

In February 2012, nearly 2,000 stakeholder organizations received the on-line CHIP survey: 239 responded. Recipients were drawn from stakeholder organizations across the county doing health-related work. The CHIP survey sought information about these areas:

- Characteristics of a healthy community.
- Changes that need to be made to improve the health of the community.

Respondents were also asked for basic information about their organization, any current involvement they have in addressing any of 27 health issues listed on the survey, and their interest in participating in other CHIP-related activities. Survey results were incorporated into the stakeholder feedback provided by the forum participants and input from the respondents was ultimately reflected in the summary documentation and products of this process.

The three characteristics of a healthy community most frequently identified were:

- Access to affordable quality health care.
- Access to affordable opportunities to be physically active.
- Safe Places / reduced crime.

They were followed closely by these three:

- Access to affordable healthy foods.
- Social and community connectedness.
- Engaged, committed, motivated, and informed residents.

The top three issues cited as needed to improve the health of the community were:

- Improve local access to affordable health care.
- Improve local opportunities to affordable physical activities.
- Improve local access to affordable healthy foods.

The survey questions and summary results can be found in the APPENDICES.

The Three CHIP Forums

A series of three community stakeholder forums were convened by the Community Health Improvement Partnership during March, April and May of 2012. The forum series goals were to develop a shared vision for a healthy community, identify potential actions that could be taken to reach the vision, establish guiding principles for partnered efforts, and propose priorities for initial action. The forums were attended by 110 individuals from multiple sectors serving our community:

Behavioral health / chemical health

Business

Charitable organizations

Childcare

Clinics

Community coalitions

Community leaders

Cultural groups or leaders

Dependent adult services

Early childhood

Environmental health

Faith based

Food providers

Health plans

Health promotion

Health research & quality

Home care

Hospitals & health systems

Housing

Human services

Local government

Long-term care

Mental health

Policy or advocacy groups

Public health

Public health advisory

Schools

Services to seniors or disabled

Social services

Visiting nurses

Wellness programs

The forum sessions were a combination of assessment and data sharing and stakeholder feedback via focused discussions and consensus workshops facilitated by Hennepin County ToP® - trained facilitators. Each forum had multiple consensus workshops occurring simultaneously (three to four conversations). Convening parallel conversations allowed the process to mine tremendous amounts of input in very short time periods.

Forum 1

Forum 1 was devoted to the sharing of the Community Health Assessment information and development of a shared community vision for health (MAPP Phases 2 & 3). The MAPP assessment questions participants were to help answer were:

- What is important to our community and our stakeholders?
- How is quality of life perceived in our community?

Following the forum the CHIP Leadership Group synthesized the lists and identified 10 characteristics of a healthy community identified by our stakeholders.

The 10 Characteristics of a Health Community that were developed at Forum 1 and finalized at Forum 2 are below. The supporting themes associated with those characteristics can be found in the CHIP Highlights section.

Shared Vision of Characteristics of a Healthy Community

Safety
Environments that foster health
Community connectedness & engagement
Economic vitality
Equitably accessible high quality infrastructure
Basic needs are met
Quality educational opportunities
Good physical & mental health
Multi-sector leaders promote the common good
Active participation in creating health

Forum 2

Forum 2 was focused on two areas of discussion:

1. Factors in the community's environment that could impact health.
2. Proposed ideas for change that would move us closer to our vision of a healthy community (MAPP Phase 3).

These discussions were all lead by ToP® facilitators and addressed MAPP assessment questions:

- What assets do we have that can be used to improve community health?
- How can we improve and better coordinate public health activities?
- What forces are or will be influencing the health and quality of life of the community and the work of the local public health system?

Environmental scan

Forum participants were asked to look beyond health indicators and data to the environment of our community - to think about community factors that could impact health – positively or negatively. They were asked to think about strengths and assets, gaps or areas in need of strengthening, current or anticipated opportunities, potential threats or stressors and expected changes in our environment. Some of the areas they were to consider included external forces, community trends and demographic shifts, systems and policies (or the lack of them), and social, economic, political, technological, environmental, legal and other dynamics that could impact health in our community. The MAPP Appendix has summary details regarding these discussions.

Contributors to Our Local Community Health System

Local community health system

Forum participants were asked to think about potential contributors to public health and health improvement in the community. They were introduced to the idea that these contributors together make up an informal network or interconnected web of providers and resources that currently contribute to our community's health. They were then asked to identify the top contributors to this network that would be the local Community Health System for the county.

The Word Cloud on the previous page is a merging of their ideas (created in WORDLE[11] on-line) – which represents the more frequently identified contributors in larger text. This visual illustrates how the CHIP forum participants see the contributors to our local Community Health System.

Ideas for change

The consensus workshops at Forum 2 focused on what needs to be in place or changed over the course of the next few years to move towards the healthy community vision created in Forum 1. The specific question discussed was:

- What innovative, substantial actions will move us closer to our vision of a healthy community?

The top issues for change identified included the following. A detailed list of the ideas for change generated at Forum 2 is included in the MAPP Appendix

- Invest in Early Childhood
- Develop Equitable Opportunities
- Promote Healthy Choices
- Get Leadership Support
- Engage the Community
- Address Healthcare Access
- Implement Policy, System & Environmental Changes
- Collaborate & Coordinate

Forum 3

Forum 3 focused on the following topics:

- Selecting strategic health issues for priority focus
- Reviewing health data related to targeted strategic issues
- Identifying priority goals under each strategic issue
- Introduction of the CHIP Action Phase

Strategic health issue selection

Between Forums 2 and 3, public health staff analyzed themes from the CHIP survey results and the previous forum consensus workshops to find strategic health issues most frequently mentioned. Using the 11 *Healthy People 2020* health domains that framed the health data in Forum 1 and in the Community Health Assessment indicators, these five strategic health issues received top ratings.

- Maternal & Child Health
- Mental Health –changed to "Social and Emotional Wellbeing "
- Nutrition, Obesity & Physical Activity
- Health Care Access
- Social Determinants – changed to "Social Conditions that Impact Health"

The CHIP Leadership Group reviewed the findings of staff and recommended approval to use these strategic health issues as the CHIP health priorities. They further recommended approval of addressing Health care Access and Social Determinants as cross cutting strategic health issues and recommended that strategies related to these be identified to impact the other three strategic health issues. These strategic health issues were supported by the CHIP Forum 3 participants and officially adopted as the focus areas for future action.

Identifying priority goals for action

Forum participants reviewed Healthy People 2020 goals that relate to the targeted strategic health issues that were adopted. They rated the strategic importance and ability to implement corrective strategies for each of the goals using the matrix below. The expectation was that goals rated as high in importance and high in ease of implementation might be goals to target for action.

This process was not as easy as it might have been. In part, goal statements from Healthy People 2020 did not easily match the words and themes that forum participants had been identifying in their previous discussions. Many of the goal statements were disease focused and less prevention oriented. And social conditions that impacted health were mostly absent. The findings from the consensus workshops were forwarded to the CHIP Leadership Group to finalize goals for action.

At the June Leadership Group meeting, three goal statements were adopted:

1. Increase childhood school readiness.

2. Make changes to our environment that will foster regular physical activity and good nutrition.

3. Increase community & social connectedness.

They also re-affirmed the strategic health issues related to Health Care Access and Social Conditions that impact Health – but determined to not select specific goals for these. They have asked each CHIP action team to include strategies for these cross-cutting issues across the CHIP work.

Community Health Improvement Partnership
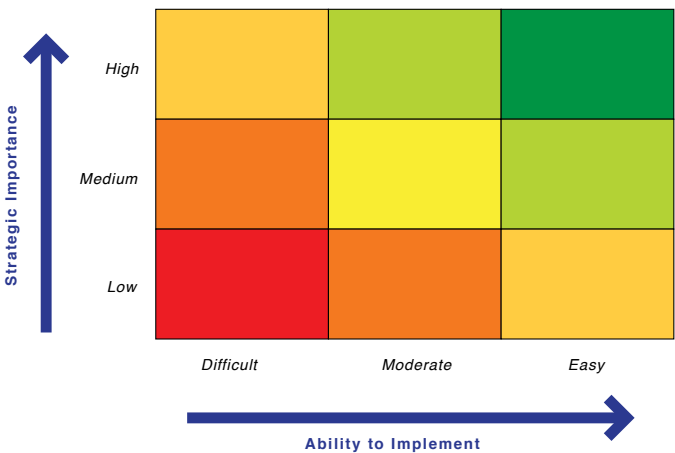
Moving Into Action

Three action teams will begin meeting in early fall 2012:

- Maternal and Child Health Action Team
- Nutrition, Obesity and Physical Activity Action Team
- Social and Emotional Wellbeing Action Team

At the end of the spring CHIP Forums, 24 organizations indicated a commitment to continue participating on one or more of the action teams. More participants will be recruited as these teams identify their strategies for action. ToP® facilitators will assist these teams through an Action Planning Workshop to help them select priorities for action.

With support from CHIP project staff and representatives from the partner health departments and hospitals, these teams will evaluate opportunities for alignment across organizations, assess gaps, and identify policy issues and opportunities that if addressed together, could make a difference. They will develop a plan that will move them quickly to action – and ideally to success within the first year. Measurable objectives with time-framed targets and improvement strategies will be identified for the initial CHIP action cycle September 2012 – December 2013. The initial cycle of action will be evaluated at the six month and one year mark – using performance targets set by the action teams and CHIP Steering Committee.

Nearly all members of the CHIP Leadership Group have committed to transition to the CHIP Steering Committee that will guide the action phase of the CHIP initiative. Several of these leaders will also be joining the CHIP action teams. Hennepin County Human Services and Public Health will serve as the facilitator of the next phase of the CHIP work under the guidance of the Steering Committee.

If you are interested in learning more about or becoming involved in the CHIP work in Hennepin, please contact:

Kathryn Richmond
CHIP Project Coordinator
612. 543-5262
Kathryn.Richmond@co.hennepin.mn.us

For more details about the work done in the CHIP Planning Process, please see the attached MAPP Process Details and Data Detail Appendices.

Local Data

CHILDREN			
Indicator	ALL Hennepin	Minneapolis	Suburban Hennepin
SCHOOL READINESS - Basic Milestones - age 3 to 5 years			
Recognizes all letters of the alphabet	55.7%	45.6%	59.7%
Counts higher than 20	40%	27.1%	45.3%
Writes his/her first name	65.9%	61.8%	67.6%
Parents tells stories or reads books 4 or more times/week	76.4%	70.5%	79.3%
Children receiving recommended preventive care visits	76.1%	78.1%	75.2%
NUTRITION			
Children age 3 to 17 years			
Eats recommended fruit servings per day (2+)	79.1%	79.3%	79.0%
Eats recommended vegetables servings per day (3+)	19.3%	21.7%	18.3%
Eats recommend dairy servings per day (4+)	24.9%	24.6%	25.0%
Zero sugar-sweetened drinks	48.1%	44.2%	49.8%
PHYSICAL ACTIVITY			
Children 6 to 17 years			
Physically active 60 minutes every day	24.1%	22.3%	24.9%

Data Source: SHAPE 2010 – Child Survey

ADULTS						
	ALL Hennepin	Minneapolis	Suburban	Northwest Suburban	West Suburban	South Suburban
NUTRITION						
Fruit & Vegetable servings per day (5+)	37.3%	30.9%	36.4%	33.8%	37.0%	39.7%
OBESITY						
Obese Adults	20.4%	18.7%	21.3%	23.9%	18.4%	19.8%
PHYSICAL ACTIVITY						
No leisure time physical activity	11.9%	12.8%	11.4%	12.1%	9.5%	11.8%
Meets moderate physical activity guidelines (30min / 5+ days)	34.8%	38.0%	33.2%	31.5%	32.6%	35.9%
Meets vigorous physical activity guidelines (20min / 3+days)	42.1%	45.4%	40.2%	38.7%	42.6%	40.7%
SOCIAL & EMOTIONAL WELL-BEING						
Frequent mental distress	9.0%	10.7%	8.0%	7.9%	9.5%	7.2%

Data Source: SHAPE 2010 – Adult Survey

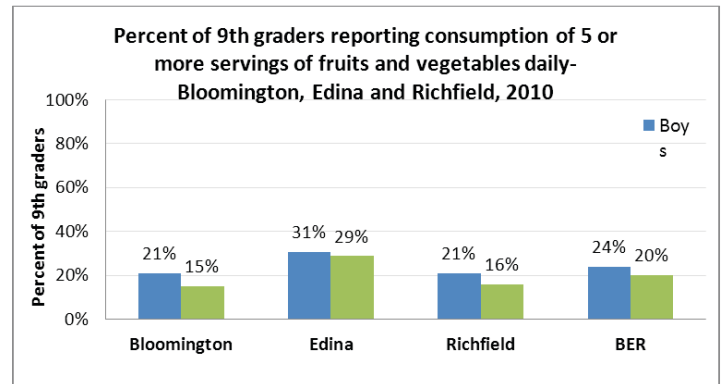## Data from Bloomington, Edina and Richfield Health Boards

Nutrition, Obesity and Physical Activity
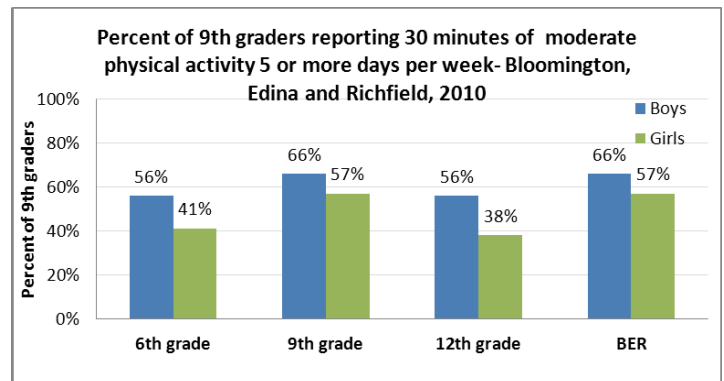*Nutrition, Obesity and Physical Activity data: Adults in BER region-see SHAPE.*

From Minnesota Student Survey data: Consumption of fruits and vegetables is still relatively low with less than one quarter of 9th graders consuming the recommended amount in BER. This percentage has been relatively stable in the last 10 years, not dramatically increasing or decreasing.

Physical activity for adults per SHAPE - see comments on nutrition above. From the 2010 MSS, a higher percentage of boys report 30 minutes of physical activity 5 or more days per week compared to girls for each city. The trend has been increasing since 2001 for each city in terms of percentage of 9th graders meeting the recommended amount of physical activity.

PER the Minnesota Student Survey, students that receive "free or reduced lunches" (per self-report on the survey) were less likely to report consuming 5 servings of fruits and vegetables, more likely to consume 3-plus servings of pop and more likely to be classified as overweight/obese.

Percent of 9th graders reporting consumption of 5 or more servings of fruits and vegetables daily- Bloomington, Edina and Richfield, 2010

Boys

	Bloomington	Edina	Richfield	BER
Boys	21%	31%	21%	24%
	15%	29%	16%	20%

Data Source: Minnesota Student Survey 2010

Percent of 9th graders reporting 30 minutes of moderate physical activity 5 or more days per week- Bloomington, Edina and Richfield, 2010

Boys / Girls

	6th grade	9th grade	12th grade	BER
Boys	56%	66%	56%	66%
Girls	41%	57%	38%	57%

Data Source: Minnesota Student Survey 2010

Student Free and Reduced Lunch and Nutrition Data: All grades combined for Bloomington Edina and Richfield Students, 2010

	5 servings of F&V yesterday	Consume 3+ servings of pop yesterday	Overweight/Obese
Receive FR Lunch	18%	18%	27%
Do not receive FR lunch	24%	10%	17%

Data Source: Minnesota Student Survey 2010

Social and Emotional Well-Being: Youth

- 42% of youth (6, 9th and 12th) in BER reported volunteering at least 1 hour per week.

- Nearly 1/3 (31.9%) of youth (6, 9th and 12th) in BER reported spending 11+ hours per week watching TV, playing video games or playing on the computer (screen time).

- 9% of 9th graders and 11% of 12th graders in BER reported that they have had a mental health or emotional health problem that has lasted for one year or more.

- 17% of 9th grade girls in BER reported suicidal thoughts in the past year compared to 11% of boys. For 12th graders these percentages are more similar with 13% of boys and 12% of girls reporting suicidal thoughts in the past year.

- Students that reported they were connected to their community, to a caring adult or to school were less likely to report using tobacco, alcohol or marijuana in the past 30 days (13% were using) compared to students who did not report they were connected to their community, to a caring adult or to school (25% were using).

- In 2010, 29% of Richfield 9th graders, 35% of Bloomington 9th graders and 41% of Edina 9th graders reported being bullied in the past 30 days.

- In 2010, 41% of Richfield 9th graders, 45% of Bloomington 9th graders and 42% of Edina 9th graders reported bullying others in the past 30 days.

Data Source: Minnesota Student Survey 2010

Social and Emotional Well-Being data: Adults in BER region-see SHAPE

CITATIONS

Websites & Works Consulted

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3. Technology of Participation - ToP Facilitation (2012). "Collaborative Approaches;" and "Facilitative Leadership." ToP. Retrieved May 1, 2012, from *http://topfacilitation.net/* Please note: this site is no longer available.

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8. Search Institute. (2012). "What Kids Need to Succeed." Search Institute. Retrieved May 1, 2012, from *http://www.search-institute.org/*

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10. U.S. Department of Health and Human Services. (2011, November 15). "Determinants of Health." Healthy People 2020. Retrieved May 1, 2012, from *http://www.healthypeople.gov/2020/about/DOHAbout.aspx*

11. WordleTM (2011). " Beautiful Word Clouds – Create your own Word Cloud." Wordle. Retrieved May 1, 2012, from *http://www.wordle.net/*

CHIP APPENDICIES INFORMATION

CHIP APPENDICIES are in a separate document and includes the following:

APPENDIX 1: CHIP Participants

- CHIP Leadership Group
- CHIP Forum Participants
- CHIP Survey Participating Organizations

APPENDIX 2: The MAPP Process Details

- Overview of the MAPP process and how it was utilized in this planning process.
- Tables of summary info from forum discussions: Healthy Characteristics + Themes, and SWOT & Forces of Change

APPENDIX 3 - PART A: Data Detail

3.A.1. Hennepin Public Health Data Web Site information

3.A.2. 2012 CHIP Survey Questions and Summary Results

3.A.3. Data PowerPoints from the CHIP Forums
    a. Forum 1 PowerPoint
    b. Forum 3 Power Point

3.A.4. Key findings from the 2010 SHAPE Adult Survey

3.A.5. Key findings from the 2010 SHAPE Child Survey

3.A.6. List of Community Health Assessment Indicator Fact Sheets from the Hennepin Public Health Data website

APPENDIX 3 - PART B: Data Detail - Indicator Fact Sheets

This appendix is in a stand-alone document due to its size.

SEE SEPARATE FILE.

Appendix E

Justification Worksheet

Community Health Needs Assessment
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Please use the Facilitation Questions, Part 2 – Choosing Final Priorities, as a guide to complete this worksheet.

Health Priority	Justification for Why a Priority was or not Chosen
1.Physical Activity and Nutrition	1. Not Chosen—one of the Hennepin County CHIP goals, within the West region, this issue can be more effectively addressed by Abbott Northwestern
2. Community and social connectedness	2. Not Chosen—one of the Hennepin County CHIP goals, many of the programs in the region are already looking at this issue, such as Neighborhood Health Connection, the Backyard Initiative; outside of the scope of PEI's core competencies.
3. Health Care Access	3. Chosen— one of the Hennepin County CHIP goals; access to healthcare is an important value at PEI and Allina Health; as a healthcare provider, as the only hospital focus on eye-care in state PEI should be leader in this area; addressing this issue also gives PEI a chance to look at this issues related to health disparities.
4. Increasing childhood readiness for school	4. Chosen -- One of the Hennepin County CHIP goals—the goal was chosen because stakeholders felt that PEI could readily collaborate, utilize assets and implement interventions beyond clinical services in addressing these needs in the community. Also, PEI stakeholders felt that the work done by PEI's Early Youth Eye ware (EYE) program effectively addresses this issue.
5. Social Conditions that impact health	5. Not chosen—One of the Hennepin County CHIP goals, but as a healthcare provider, stakeholders felt that addressing this issue fell out of the scope of what PEI could effectively and competently address.
6. Homelessness	6. Not Chosen—Homelessness was not one of the Hennepin County CHIP selected issues, but stakeholders brought up this issue multiple times during meetings as an important issue in their communities. Although this is not an issue that stakeholders felt PEI could address directly, stakeholders felt that by looking at health care access as a priority, PEI could help improve this health of this community.

Health Priority	Justification for Why a Priority was **NOT** Chosen
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Appendix F

Framing CHNA
Health Disparities

Community Health Needs Assessment
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Framing CHNA's in the Context of Healthcare Equity

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

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

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

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

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

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

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

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

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

State Level

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

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

Metro Area

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

Hennepin County

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

Allina Health

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

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

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

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

What are healthcare systems doing to eliminate healthcare disparities?

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

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

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

Identifying Healthcare Disparities within the Hospital and Clinic Setting

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

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

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

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

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

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

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

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

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

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Appendix G
Community Dialogue Report

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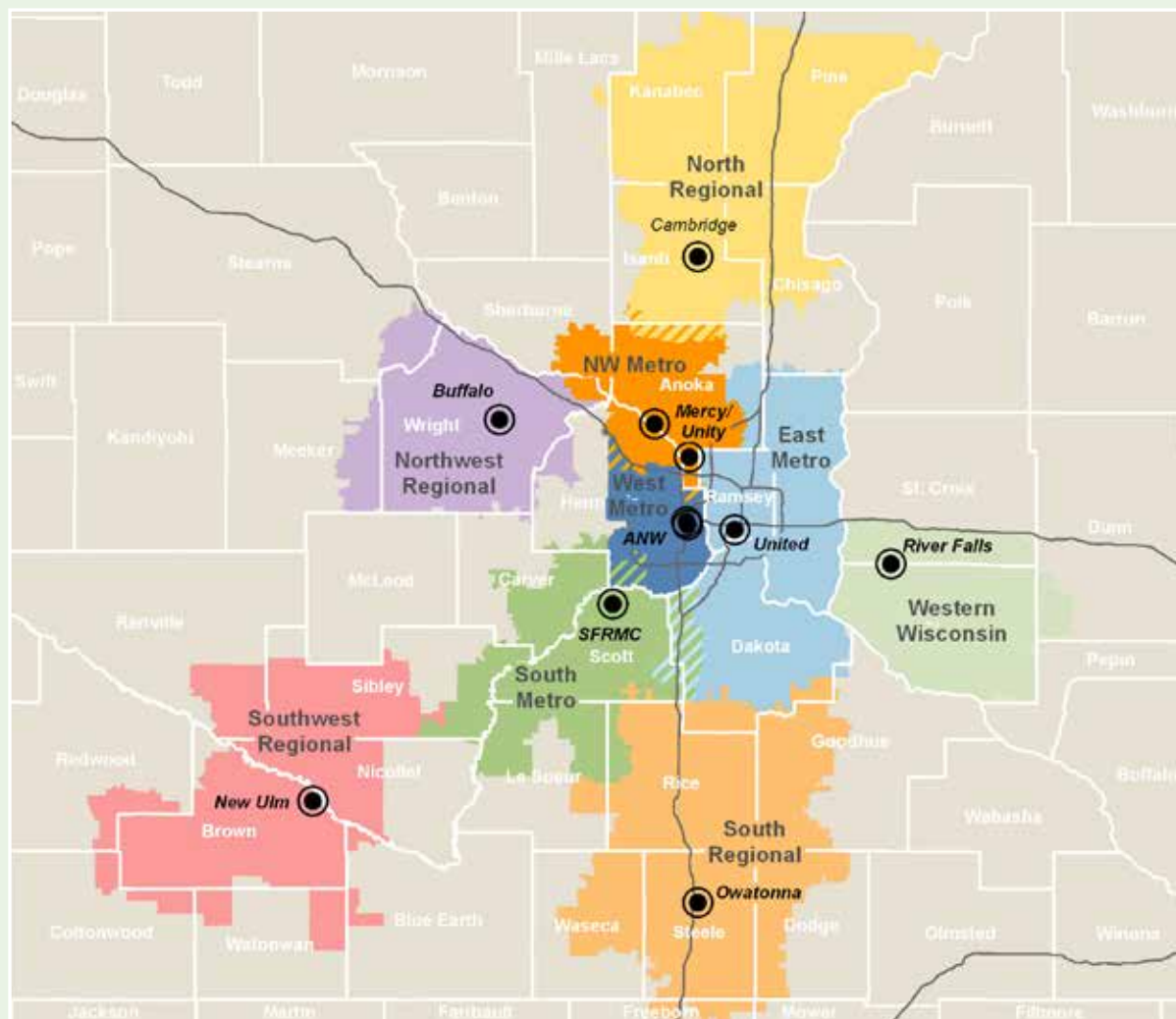
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Allina Health

Improving health in our community

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

Allina Health Community Benefit & Engagement Regional Map

Introduction

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

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

The needs assessment at Abbott Northwestern Hospital and Phillips Eye Institute, part of the West Metro Region, identified three priority health issues to focus on from 2014–2016 (see **allinahealth.org** for the full community health needs assessment report). They included:

- **OBESITY,**

- **MENTAL HEALTH THROUGH COMMUNITY AND SOCIAL CONNECTIONS,**

- **AND CHILDREN'S HEALTH THROUGH SCHOOL READINESS.**

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

This summary highlights the findings from the 2013 dialogues in the West Metro Region, which includes Abbott Northwestern Hospital and Phillips Eye Institute.

In February 2013, Abbott Northwestern Hospital, Phillips Eye Institute and Allina Health convened two Community Dialogues in the West Metro Region.

Participants were asked to share their knowledge about the local health concerns that are most pressing among residents and their ideas about what works and what needs to be done to improve health in their community. Participants engaged in a World Café or participatory dialogue facilitated by members of Wilder Center for Communities. Participants moved through different rounds of conversation focused on obesity, mental health through community and social connections, and children's health through school readiness.

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 West Metro region. Allina Health believes the community members included in the dialogues conveyed useful information and insight, and they continually seek to develop an understanding of the diverse experiences and opinions of community residents.

COMMUNITY DIALOGUE PARTICIPANTS

Plymouth

Eight community members participated in the Plymouth community dialogue. The majority were between 45 and 64 years of age. Half of the participants reported living in a suburban community; others noted living in a small town or metropolitan city. Participants indicated representing a variety of sectors including: healthcare, faith-based organizations, nonprofits, education, government, law enforcement, parks and recreation, and education. They also cited an array of expertise in health topics including: chronic disease management/treatment/ prevention, human services, drug abuse, senior care, obesity, physical activity, integrative/ complementing health therapies, and drug abuse. All participants reported representing and/or working with adults and white residents.

In addition, many participants indicated working with and/or representing African-Americans and individuals with physical disabilities and mental health concerns.

Minneapolis

Twelve community members participated in the Minneapolis community dialogue. Half of the participants were between 45 and 64 years of age. Many participants indicated representing the heath care, education, and nonprofit sectors. They also identified an array of expertise in health topics, such as: obesity prevention, nutrition, physical activity, and health disparities. Several participants also cited working with and/or representing adults (25-64) and children/ youth (6-17).

Community impact

OBESITY

Participants were asked to reflect on how obesity impacts people in their community. They indicated the adverse effects of obesity on physical health such as diabetes, high blood pressure, and the elevated expense of accessing medical resources. Participants also cited a low rate of exercise and physical activity stemming from sedentary lifestyles, an absence of incentives to lose weight, and limited opportunities to participate in physical activities or exercise. Participants shared that some people are unable to access healthy foods due to a lack of economic resources or education regarding nutritious eating. Participants highlighted the positive impact on of the Loring School community garden, the Minneapolis Nutrition Center, and the Midtown farmers market.

MENTAL HEALTH THROUGH COMMUNITY AND SOCIAL CONNECTIONS

Participants were asked to reflect on how mental health through community and social connections impacts people in their community. Participants referenced the isolation, alienation, and stigma people experience when they have a mental illness. Other participants cited a lack of resources/programs to help people contend with mental illness, language barriers, racial/cultural disparities, the difficulty of accessing long-term care, and the challenge to quantify mental health prevention. Some participants cited importance of current school-based mental health programs and felt that could expand to further help children and families.

CHILDREN'S HEALTH THROUGH SCHOOL READINESS

Participants were asked to reflect on how children's health through school readiness impacts people in their community. Participants noted that children who are unhealthy or hungry have difficulty learning and that children's health through school readiness is a critical priority. Participants referenced the services that some schools currently provide, such as developmental screening and a partnership between Minneapolis Public Schools and Phillips Eye Institute for vision screening. In addition, participants noted that some parents encounter language and cultural barriers when care is administered to their children through the schools.

Addressing health concerns in the community

OBESITY

Participants were asked to reflect on what should be done to address obesity. Participants shared a range of ideas focused on the importance of increased access to healthy foods and physical activity, including the following:

- Ensuring access to nutritious food in schools and grocery stores
- Expanding farmers markets
- Improving infrastructure for biking and walking
- Expanding opportunities for physical activity, such as affordable gym memberships
- Increasing access to the outdoors

MENTAL HEALTH THROUGH COMMUNITY AND SOCIAL CONNECTIONS

Participants were asked to reflect on what should be done to address mental health through community and social connections. Participants suggested a variety of approaches to addressing mental health, such as:

- Increasing reimbursement for providers
- Increasing funding and collaboration between schools, nonprofits, and mental health providers
- Training community health workers on mental health issues
- Establishing mental health and services which can travel to meet people

CHILDREN'S HEALTH THROUGH SCHOOL READINESS

Participants were asked to reflect on what should be done to address children's health through school readiness. Participants shared the importance of supporting parents, possibly through a "mentor mom" program in which volunteer moms support single moms. Participants highlighted the importance of strengthening the health services provided at schools, such as screenings and nutrition. They also cited increased collaboration between children's parents, doctors, and school-based health providers.

How Allina Health can help address health concerns

OBESITY

Participants were asked to reflect on how Allina Health could help address obesity. Participants reported that Allina Health could help address obesity through promoting nutrition/ access to healthy foods, creating more opportunities for exercise and physical activity, and more community-based education focused on physical health. Participants specifically suggested:

- Supporting local health foods initiatives in schools and grocery stores
- Establishing community owned bikes
- Offering free opportunities for exercise in partnership with local community centers and churches
- Creating educational programing focused on healthy eating and community gardens
- Assembling an incentive program to encourage weight loss
- Funding the placement of community health workers in local clinics to focus on nutrition and health eating

MENTAL HEALTH THROUGH COMMUNITY AND SOCIAL CONNECTIONS

Participants were asked to reflect on how Allina Health could help address mental health through community and social connections. Participants shared that Allina Health could help address mental health through community and social connections by facilitating access to mental health resources and convening community members to focus on local mental health issues. Participants specifically noted:

- Establishing "mobile" mental health practitioners who can travel to community centers and satellite clinics
- Holding community forums to discuss and define mental health illness
- Organizing community events through the Backyard Initiative to address isolation among community members
- Providing online access to mental health professionals

CHILDREN'S HEALTH THROUGH SCHOOL READINESS

Participants were asked to reflect on how Allina Health could help address children's health through school readiness. Participants indicated that Allina Health could help address children's health through school readiness by expanding services currently offered in schools and increasing collaboration with community organizations. Participants specifically referenced:

- Sustaining the Phillips Eye vision screening and extend it to other schools
- Creating incentives for families who attend school fairs or parent teacher conferences
- Supporting school readiness health screenings
- Partnering with local academic and nonprofit groups to focus on children's holistic health and establishing strong health behaviors early in a child's life

Conclusion

The community dialogues were an opportunity for Abbott Northwestern Hospital and Phillips Eye Institute 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 Abbott Northwestern Hospital and Phillips Eye Institute for FY 2014–2016.

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

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Appendix H
Video Ethnography

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Qualitative Analysis & Results

To augment the Phillips Eye Institute CHNA process, the Division of Applied Research videotaped interviews of community members to help the hospital and Allina Health understand the unmet health needs of the community, solicit how Phillips Eye Institute could most effectively address the selected priority issues, and inform action planning.

A total of nine community members were interviewed and filmed for approximately one hour each. Videography was completed by Allina's Media Services, an internal resource for electronic media production, meeting and event support, and technical consultation. Transcription, editing and processing was outsourced to a qualified and experienced transcription consultant meeting industry standards. Each participant was asked key questions within each selected priority.

Key Questions

 School Readiness:
1. What does being ready for school mean to you?
2. What do you think is important for kids getting ready for school?
3. What should be done in our community to address these health concerns?

Physical activity and nutrition:
1. What makes it harder/easier to make healthy choices?
2. What leads you to make the choices you make?
3. Where do you get your information?
4. How is this happening in your community?
5. Who do you exercise with and eat with and where?

 Community and social connectedness:
1. How do you find and maintain your emotional & mental balance?
2. In particularly stressful times, who and where do you turn?
    a. What is the role of the community in providing support?
    b. Is there someone that provides you support?

Each participant was asked the following questions about each selected priority:
1. What makes it hard for you/your community?
2. What would be helpful that's not there?
3. What should be done in our community to address these health concerns?
4. What is the role of Abbott Northwestern in providing support for these health concerns?
5. What should the role of Allina Health be in providing support across the system?
6. What else would you like to share?

Analysis
Qualitative analysis was conducted on each interview and analysis was complete in September.

Results

The Division of Applied Research will present preliminary results to the Community Engagement leads in October. Final results will be reported through a video which conveys identified actionable opportunities to Phillips Eye Institute, Allina Health, and the community. The draft video will be shown to interviewees in November to obtain feedback, and the final video will be finished in November or December. Final results will be integrated into the action planning process for Phillips Eye Institute and Allina Health where applicable.

In the meantime, the following themes are emerging as a result of the data analysis:

Emerging Themes:

Respect for Religious Diversity
- Creating prayer spaces for all religions to practice their rituals and ceremonies.
- Establishing parking for non-Western healers as a concrete way to respect and invite non-Western healers into Abbott Northwestern Hospital.

Making Allina Health Approachable:
- Building community spaces centered on health and wellness within Abbott Northwestern Hospital that are open to community members.
- Creating more opportunities for Allina Health employees and community members to connect at community events and community spaces to dialogue about how to stay healthy.

Cultural Health Outreach:
- Utilizing culturally relevant activities for the whole family, such as American Indian ceremonial dancing, to promote physical health.
- Utilizing culturally relevant traditional foods, such as eating wild rice, to promote nutrition.

Art as Healing:
- Utilizing a variety of creative mediums (such as painting, photography, storytelling, music and dance) to promote health and healing and to create a venue for exploring difficult topics together.

Appendix I
Community Assets Inventory

Community Health Needs Assessment
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Abbott Northwestern Hospital CHNA Community Program Inventory

Issues	Key Goals	Objectives/ Indicators	Strategies/ Programs	Target Populations	Location	Current State of Programs (Existing, Enhancement or New)	Allina Health Role (Leader, Supporter, Partner)	Budget Impact (Low, Medium, High)	Partners
Obesity	Reduce childhood obesity	Increase physical activity Improve nutrition	Health Powered Kids	Youth (ages 3-14)	System-wide	Existing	Leader	Medium	Schools After-School Programs YMCA CampFire
Obesity	Reduce overweight and obesity	Increase physical activity	Support fitness events in the community	All	System-wide	Existing	Supporter, Partner	Medium	Cause associations
Obesity	Reduce overweight and obesity	Increase physical activity Improve nutrition	Neighborhood Health Connection	All	System-wide	Existing	Leader	Medium	Community Non-profit agencies Churches
Obesity	Reduce overweight and obesity	Increase physical activity	Free Bikes 4 Kidz	Children	System-wide	Existing	Leader	Medium	Non-profits FB4K

Obesity	Reduce overweight and obesity	Improve nutrition	Healthy Corner Store Program	All	Minneapolis	Existing	Observer	None	Mpls Dept of Health Appetite for Change
Obesity	Reduce overweight and obesity	Improve nutrition	EBT at Farmers Markets program	All	Minneapolis, Suburbs	Existing	Observer	None	Mpls Dept of Health
Obesity	Reduce overweight and obesity	Improve nutrition Improve social connections	Community Gardening initiatives	All	Minneapolis, suburbs	Existing	Observer, partner	Low	Local Health Departments Suburban cities Backyard Initiative
Obesity	Reduce overweight and obesity	Improve nutrition	Healthy Food Shelf Network	All	Minneapolis	Existing	Observer	None	Mpls Dept of Health
Obesity	Reduce overweight and obesity	Improve nutrition	Community Food Assessments to identify gaps and barriers to accessing healthy food	All	Bloomington, Edina, Richfield	Existing	Observer	None	Bloomington Public Health
Obesity	Reduce overweight and obesity	Improve nutrition	Work with preschools and childcare settings to improve food choices	Children	Bloomington, Edina, Richfield	Existing	Observer	None	Bloomington Public Health

Obesity	Reduce overweight and obesity	Improve nutrition	SHIP programs work with schools to improve the nutritional status of foods in schools	Children	Minneapolis, suburbs	Existing	Observer	None	Local health departments
Obesity	Reduce overweight and obesity	Increase physical activity	Complete Streets Policies	All	Minneapolis, Suburbs	Existing, new	Observer, partner	None	Local health departments Public works
Obesity	Reduce overweight and obesity	Increase physical activity Increase social connections	Safe Routes to Schools policies	Children, parents	Minneapolis, Suburbs	Existing	Observer	None	Local health departments School districts
Obesity	Reduce overweight and obesity	Increase physical activity	School-based opportunities for physical activity	Children	Minneapolis, Suburbs	Existing, new	Observer	None	Local health departments Schools

Obesity	Reduce overweight and obesity	Improve nutrition Increase physical activity	Clinic-based systems for screening, counseling, referrals and follow-ups to help patients achieve healthy weight	All	Minneapolis, Suburbs	Existing	Observer	None	8 community Clinics in Mpls 29 Primary care clinics in suburban Hennepin County 5 Partners in Pediatrics offices
Obesity	Reduce overweight and obesity	Increase physical activity	Installation of bike racks and fitness equipment	All	Minneapolis, Suburbs	Existing, new	Observer, partner	Low	Public Works Park & Rec Schools
Obesity	Reduce overweight and obesity	Increase physical activity	Improve bike-related infrastructure	All	Minneapolis, Suburbs	Existing, new	Observer, partner	Low	Cities County State
Obesity	Reduce overweight and obesity	Increase physical activity Improve nutrition	National Diabetes Prevention Program	Adults	Minneapolis, Suburbs	Existing	Observer	None	YWCA
Social Connections	Increase social and emotional wellbeing	Increase social connections	Early Childhood Family Education programs	Young children, parents	Minneapolis, Suburbs	Existing	Observer	None	Schools

Social Connections	Increase social and emotional wellbeing	Increase social connections	Minneapolis Way To Grow program	Young children, parents	Minneapolis	Existing	Observer, partner	None	Minneapolis Youth Coordinating Board
Social Connections	Increase social and emotional wellbeing	Increase social connections	Helping Us Grow	Young children, parents	New Hope, Golden Valley, Plymouth, Robbinsdale	Existing	Observer	None	Robbinsdale Area Schools
Social Connections	Increase social and emotional wellbeing	Increase social connections	Senior Center-based programs	Seniors	Minneapolis, Suburbs	Existing	Observer, partners	Low	Volunteers of America Cities Non-profits
Social Connections	Increase social and emotional wellbeing Reduce overweigh and obesity	Increase social connections Increase physical activity	Silver Sneakers Program	Seniors	Minneapolis, Suburbs	Existing	Observer	None	Non-profit Senior centers YWCA/YMCA

Column Definitions:

- **Issue** = priority issue
- **Key Goal** = broad population-based aim (e.g., reduce obesity).
- **Objective** = specific, measurable goal that leads directly to the key goal/aim (e.g., increase access to healthy foods).
- **Strategy/Program** = evidence supported practice to achieve objective.
- **Target Population** = what group will be impacted by the strategy.

- **Location** = where within Hennepin County is this strategy/program implemented.
- **Current State of strategy** = Is this program existing, an enhancement to a current program or a new endeavor. Should be derived from community inventory, community benefit reporting.
- **Budget Impact** = Is this program a low, medium or high budget item.
- **Partners** = who will be involved in the strategy/program. Should be derived from community inventory, community benefit reporting.

Appendix J

CADCA's Seven Strategies
for Community Change

ALLINA HEALTH
PHILLIPS EYE
INSTITUTE

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).