ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Community Health Needs Assessment and Implementation Plan 2014–2016

St. Francis
Regional Medical Center

SOUTH METRO

Identifying and Responding to Community Needs

ST. FRANCIS REGIONAL MEDICAL CENTER

1455 St. Francis Ave.
Shakopee, MN 55379-3380

St. Francis Regional Medical Center is jointly owned by Essentia Health Critical Access Group, Allina Health and Park Nicollet Health Services. Its Catholic identity is sponsored by the Benedictine Sisters of the St. Scholastica Monastery in Duluth. This unique structure enables St. Francis to combine the caring and compassion of a community hospital with the modern medical technology, specialties and services found in the metro area. St. Francis provides a full range of inpatient, outpatient and emergency care services on a collaborative medical campus with more than 30 other clinics and health care providers. The St. Francis Regional Medical Center service area includes the following affiliated clinics: Burnsville, Chanhassen, Chaska, Dean Lakes, St. Francis Health Services in Jordan, Lakeville, Savage and Shakopee.

St. Francis Regional Medical Center has a history of working to improve health in the community it serves through both charitable giving and direct programming efforts which address health needs in the community. Some recent examples include supporting the River Valley Nursing Center, the Esperanza summer program and the St. Mary's Health Clinic located in Shakopee.

Saint Francis Regional Medical Center conducted its community health needs assessment (CHNA) as part of Allina Health, a not-for-profit health system dedicated to the prevention and treatment of illness through its family of clinics, hospitals, care services and community health improvement efforts in Minnesota and western Wisconsin.

LEAD PARTIES ON THE ASSESSMENT

Tamara Severtson, manager, Mission Integration and Community Benefit Lead, South Metro Region

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	1996*	2005	2012
Hospital rooms (all private)	39	62 (70 licensed)	86 (93 licensed)
Medical/surgical rooms	25	33	57 (Care North 24, Care South 33)
Special care unit rooms	4	8	8
Family birth rooms	10	17	17
Children's care pediatric rooms	0	4	4
Same-day surgery rooms	13	18	19
Operating rooms	3	5 (and 1 C-section)	8 (and 1 C-section)
Emergency Department treatment bays	8	16	21
Endoscopy rooms	0	2	2

*New Campus

	1996	2012	% Increase
Inpatient admissions	2,636	5,675	115%
Surgical procedures	2,578	4,370	70%
Births	661	1,311	98%
Emergency Department visits	10,069	27,964	178%
Urgent care visits (Chaska closed in 2008)	1,248	9,122	631%

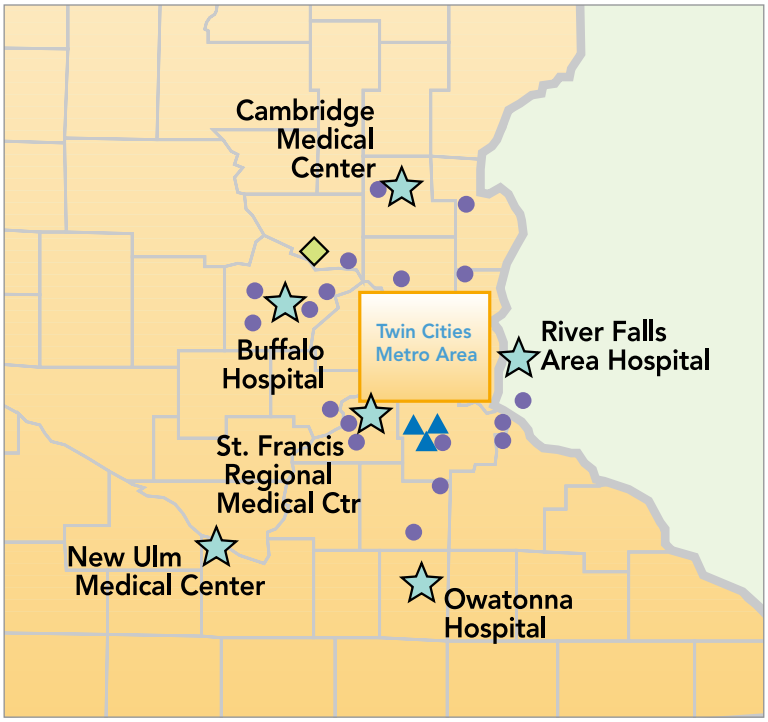
	2007	2012
Outpatient encounters – New in 2007	109,717	110,974

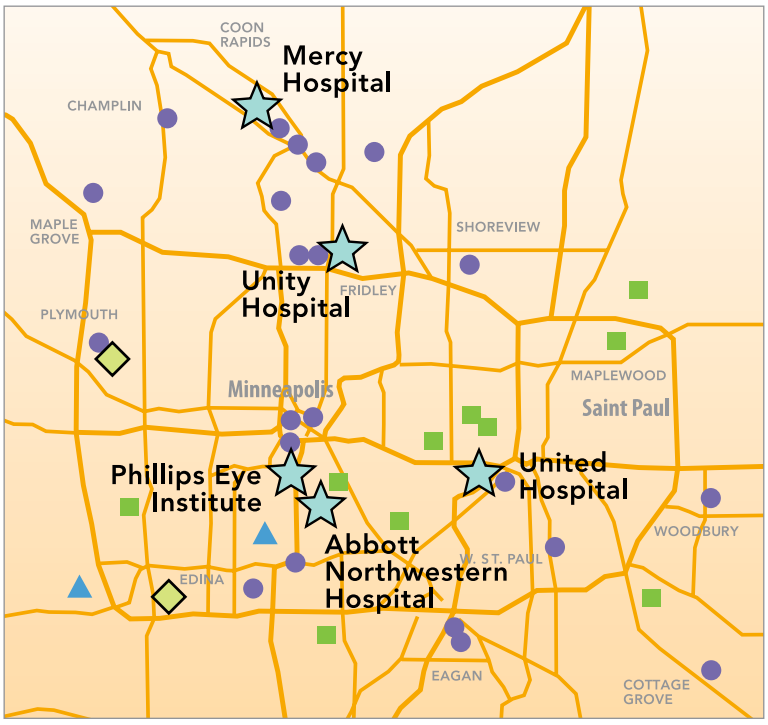
Allina Health and St. Francis Regional Medical Center Service Area

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

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

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



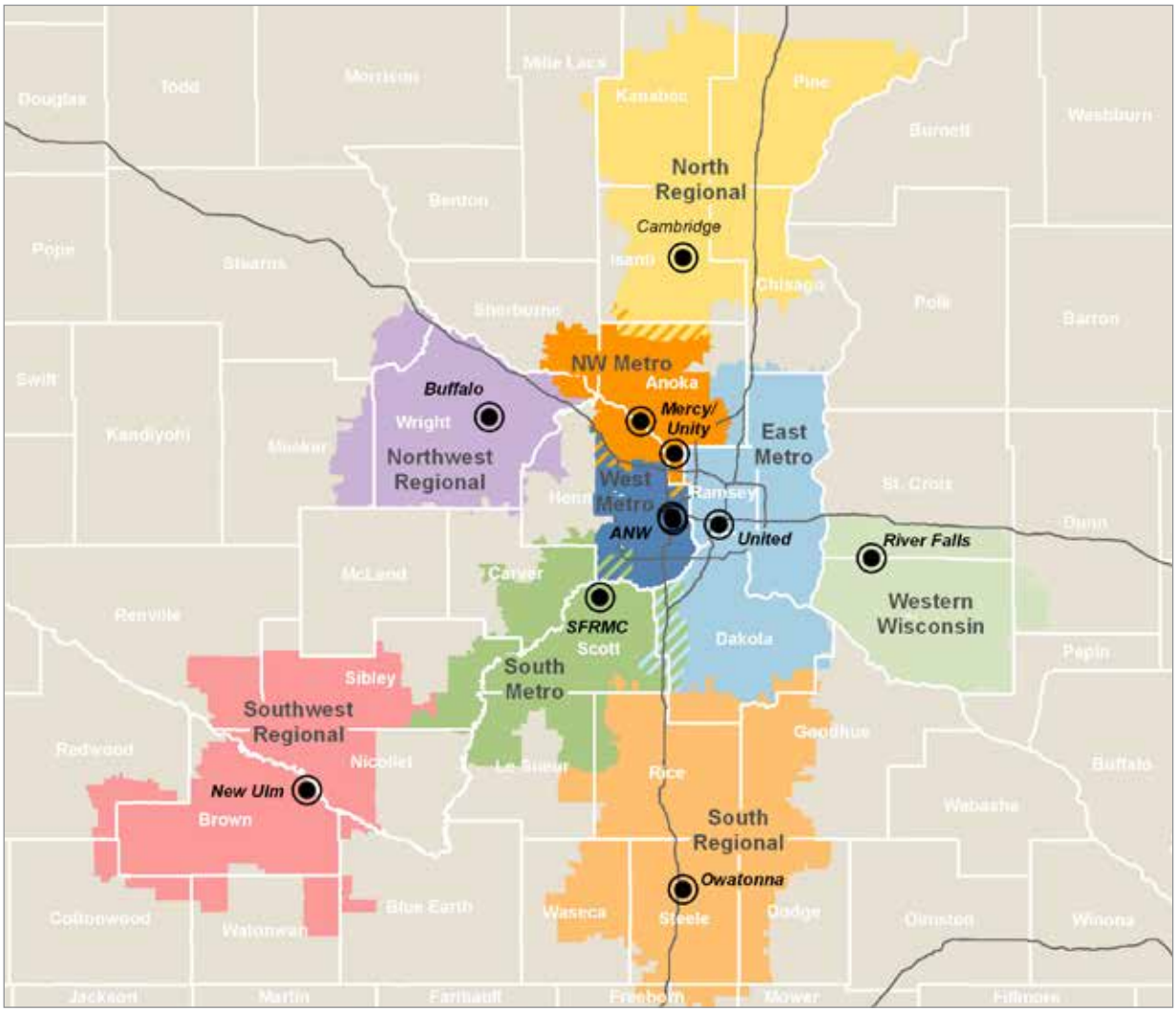


- Allina Health Hospital
- Allina Health Ambulatory Care Center
- Allina Medical Clinic
- Aspen Medical Group
- Quello Clinic

Description of Community Served by St. Francis Regional Medical Center

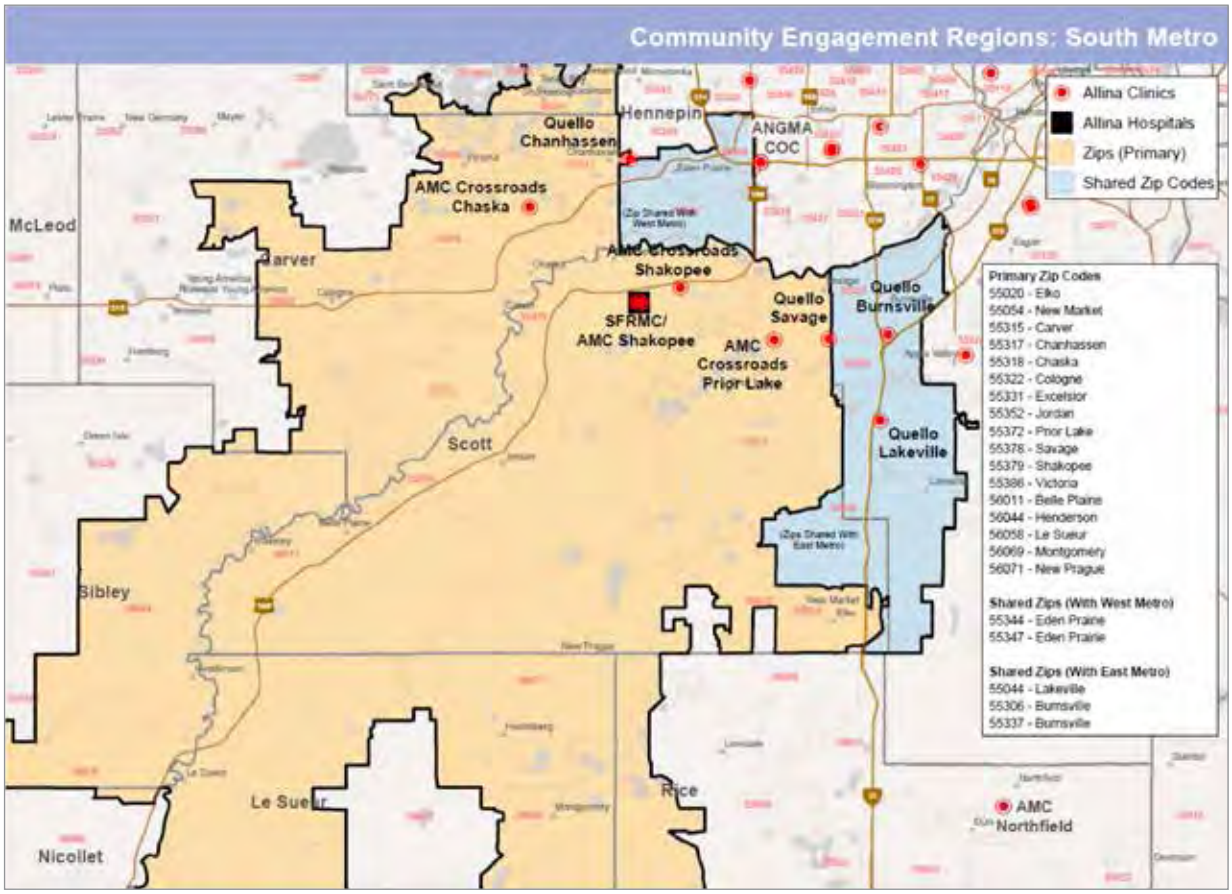
For the purposes of community benefit and engagement, Allina Health divides its service area into nine regions.

FIGURE 1: COMMUNITY BENEFIT & ENGAGEMENT REGIONAL MAP



For the South Metro Region Community Health Needs Assessment (CHNA), the focus of inquiry was Scott County and Eastern Carver County. See appendices A and B detaileds report on Carver and Scott Counties, prepared by Stratis Health. All appendices can be found on the Allina Health website (**allinahealth.org**).

FIGURE 2: SOUTH METRO REGION MAP



Assessment Partners

The St. Francis Regional Medical Center CHNA was conducted in collaboration and partnership with community members, community organizations, stakeholders from local public health and internal stakeholders at Saint Francis Regional Medical Center and affiliated clinics. These partners assisted in the development of the hospital priorities as well as in building the implementation plan. In addition, St. Francis Regional Medical Center partnered with Wilder Research, a branch of the Amherst H. Wilder Foundation, to conduct the community health dialogues in the South Metro region. Wilder Research developed the dialogue plan and materials, provided technical assistance related to recruitment strategies, facilitated the dialogues and synthesized the information into a report. See Appendix C 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 South Metro Region Community Engagement Lead guided the effort for St. Francis Regional Medical Center.

The St. Francis Regional Medical Center assessment was conducted in three stages: data review and setting priorities, community health dialogues and action planning. The process began in April 2012 with the development of the CHNA plan and was completed in August 2013 with the final presentation of the assessment and action plan to the St. Francis Regional Medical Center Mission and Strategy Committee and Board of Directors. The following is a description of the assessment steps and timeline created by the CHNA Team.

PHASE 1 — DATA REVIEW AND PRIORITY-SETTING

MAY – JULY 2012

DATA COLLECTION

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

SEPTEMBER 2012

DATA REVIEW

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

OCTOBER 2012

ISSUE PRIORITIZATION

Reviewed revised data packet and completed formal prioritization process with stakeholders

PHASE 2 — COMMUNITY HEALTH DIALOGUES

FEBRUARY – MARCH 2013

DATA COLLECTION

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

APRIL 2013

REPORT PRODUCTION

Developed report of findings from needs assessment and community dialogues

PHASE 3 — ACTION PLANNING

APRIL – JUNE 2013

IMPLEMENTATION/PLAN

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

AUGUST 7, 2013

APPROVAL

Presented implementation plans to local boards/committees/leaders for approval

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, St. Francis Regional Medical Center did not collect primary data, but instead compiled existing public health data to create a set of indicators specific to health in Scott and Carver Counties. Stakeholders were given this set of indicators, which they reviewed to gain a sense of current health needs. These datasets included:

MINNESOTA COUNTY PROFILES: STRATIS HEALTH

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

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

MINNESOTA COUNTY-LEVEL INDICATORS FOR COMMUNITY HEALTH ASSESSMENT

The Minnesota County-level Indicators for Community Health Assessment is a list of indicators across multiple public health categories and from various data sources. This list of indicators was developed by the Minnesota Department of Health to assist local health departments (LHD) and community health boards (CHB) with their community health assessments and community health improvement planning processes. The indicators were placed in six categories: People and Place, Opportunity for Health, Healthy Living, Chronic Diseases and Conditions, Infectious Disease, and Injury and Violence. (http://www.health.state.mn.us/divs/chs/ind/) The main data sources for County-level Indicators were:

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

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

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 Scott and Carver County and comparison data for other counties in the state.

Based on the review of data over the course of these meetings, the St. Francis Regional Medical Center community health assessment group identified five issues to be considered in the next step of the prioritization process.

1. Access to care
2. Mental health
3. Nutrition/physical activity
4. Preventive services
5. Substance abuse

Prioritization Process

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

THE HANLON METHOD

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

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

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

Component A = Size of the problem

Component B = Seriousness of the problem

Component C = Estimated effectiveness of the solution

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

DISCUSSION QUESTIONS

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

- Does work on this issue fit within the St. Francis/Allina Health mission? Does this fit within work we're already doing?
- What is the role for St. Francis/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 St. Francis/Allina Health efforts on this issue?
- Does work on this issue provide an opportunity to address the health needs of vulnerable populations? Can St. Francis/Allina Health impact barriers to health for groups around this issue?
- Are there legal implications involved in addressing the health issue?

Notes from this discussion can be found in Appendix G.

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

Priority Health Needs for 2014–2016

Upon completion of the prioritization process, St. Francis Regional Medical Center determined three community health priority needs:

1. Mental health/substance abuse

Focusing on mental health and substance abuse as a single priority combined two of the top five priorities issues. Focusing on these issues fits with the mission of St. Francis as a faith-based hospital. St. Francis's role in this area will be primarily as a partner and supporter of existing efforts. Mental health and substance abuse impact the whole community and can be viewed on a continuum, from social connection and emotional support to severe and persistent mental illness. Mental health and substance abuse issues impact and exacerbate each other, and addressing these issues will create an increase in costs initially and will require many partnerships and overall community support.

2. Nutrition/physical activity

As health care shifts focus from acute care to prevention, improving nutrition and increasing physical activity become even more vital. Lack of physical activity and poor nutrition are associated with a number of health-related issues including high morbidity and mortality including heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death. Also, rates of obesity are generally higher in minority and low-income persons. Health care may act as supporter or partner for other organizations and the community. Efforts in this area must have a long-term view.

3. Access to care

Access to care received the second-highest score in the Hanlon Prioritization Process. Specifically, stakeholders discussed that this issue again fit with the mission of St. Francis as a faith-based hospital. There is a high cost related to increasing access, but the stakeholders believe the cost of doing nothing is much higher, such as untreated chronic disease. Lack of access to healthcare has a high impact on vulnerable populations.

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

IDENTIFIED HEALTH NEEDS NOT SELECTED AS PRIORITIES

Preventive services: Although this need was the top-ranked priority according to Hanlon, it was moved to the bottom of the list due to the fact that there are already existing structures to effectively address this issue. While preventive clinic-based services are effective, people with access to primary care clinics are already receiving these services. Focusing instead on access as a top priority will bring people into these preventive services.

Community Health Dialogues

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

Invitations were sent via email or in-person by St. Francis Regional Medical Center'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 diverse populations 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 24 people participated in the two community health dialogues in the South 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 St. Francis Regional Medical Center, as part of Allina Health, in addressing this issue in your community?

KEY FINDINGS

Mental health/substance abuse: Dialogue participants felt that St. Francis Regional Medical Center, as part of Allina Health, could help address mental health/substance abuse through providing education and outreach, expanding services and supports, and collaborating with the community. Participants specifically suggested:

- Increasing communication with schools, community centers and public entities
- Creating an onsite counseling center that addresses adolescent mental health and substance abuse
- Having walk-in crisis care for teens
- Collaborating with Park Nicollet/Health Partners, the Shakopee Mdewakanton Sioux Community and other community organizations.

Nutrition/physical activity: Dialogue participants felt that St. Francis Regional Medical Center, as part of Allina Health, could help address physical activity and nutrition through outreach and increased collaboration with the local community. Participants specifically noted:

- Having trailers with games and activities that could be circulated around different neighborhoods
- Creating partnerships with local leaders and community groups that would align Allina Health wellness and health care expertise with the group's social connections to maximize exposure
- Supporting community food programs that provide whole foods
- Increasing access to health clubs and fitness centers.

Access to care: Dialogue participants felt that St. Francis Regional Medical Center, as part of Allina Health, could help address access to care by expanding services and supports. Participants specifically referenced:

- Supporting free clinics that are needed in the community
- Continuing free training activities
- Creating a community paramedic program focused on community health prevention.

For a full copy of the report see Appendix I.

Community Assets Inventory

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

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

See Appendices J for full inventory of hospital and community-based programs.

Action Planning

The final phase of the CHNA process was to develop the implementation plan for Saint Francis Regional Medical Center. The implementation plan is a set of actions that the hospital will take to respond to the needs identified through the community health needs assessment process. St. Francis Regional Medical Center used its Community Advisory Council to engage with internal and external stakeholders including representatives from Carver and Scott County Public Health, to develop the implementation plan for FY 2014–2016.

THE PROCESS INCLUDED FOUR STEPS:

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

STEP 1: Identifying key goals, objectives and indicators

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

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

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

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

STEP 3: Selecting evidence-based strategies

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

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

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

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

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

STEP 4: Assign roles and partners for implementing each strategy

When selecting the strategies, St. Francis Regional Medical Center 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 St. Francis Regional Medical Center plans to do to address priority issues in the community. Yearly work plans will be developed to provide detailed actions, accountabilities, evaluation measures and timelines.

Mental health/ substance abuse

GOAL: Create a sustainable framework for improving mental health

INDICATORS

- Lower the suicide rate per 100,000 people
- Increase the proportion of adults and children with mental health disorders who receive treatment
- Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

St. Francis Regional Medical Center's strategy to address the issue of mental illness and substance abuse on will focus on strengthening mental health services in the community and increasing the number of people impacted by mental health and substance abuse programs supported by St. Francis. Planned programs include:

- Participating fully in county-wide consortiums that address mental health in the community. *Partners: public health, mental health providers, local government*
- Maintaining and promoting hospital and clinic-based support groups for patients and community members who need support related to their mental health as a part of a holistic approach to chronic disease. *Partners: clinics, mental health providers*
- Piloting programs that address the mental health needs of adolescents and at-risk populations. *Partners: community diversity groups, schools*
- Continuing support of mental health crisis teams in the regions. *Partners: public health, community mental health providers*
- Developing and enhancing the mental health service line at St. Francis. *Internal stakeholders*

Nutrition/physical activity

GOAL: Reduce obesity and hunger insecurity

INDICATORS

- Reduce the proportion of adults and children who are obese or overweight
- Reduce household food insecurity
- Increase the variety and contribution of fruits and vegetables to the diets of the population aged two years and older
- Increase the proportion of new mother who breastfeed their infants
- Reduce the proportion of adults who engage in no leisure time exercise
- Increase the proportion of adults and adolescents who meet current federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity.

St. Francis Regional Medical Center's strategy to increase address the issue of physical activity and nutrition in will focus on strengthening the ability of people in the community to engage in healthy behaviors, concentrating on two key areas: reducing obesity and hunger. Planned programs include:

- Supporting and encouraging breast-feeding programs internally and in the community. *Partners: local public health, community health organizations, clinics, employers and providers*

- Promoting and developing programs that will promote healthy eating, active living and life balance. *Partners: local public health, community health organizations, clinics, and providers*
- Supporting the adoption of policies that promote healthy eating and active living in the community. *Partners: local public health, community health organizations, clinics, providers*
- Continuing to support community programs that increase physical activity and nutrition with a focus on reaching diverse populations. *Partners: local public health, community health organizations, local community organizations, clinics, and providers*
- Providing financial support to community partners. *Partners: local public health, community health organizations, clinics, and providers*
- Supporting local food shelves and hunger-fighting initiatives though employee volunteerism and charitable giving. *Partners: local public health, community health organizations, clinics, and providers*

Access to care

GOAL: Increase access to healthcare in the community, especially among vulnerable populations

INDICATORS

- Increase the percentage of persons with a usual primary care provider
- Reduce the percentage of persons who are unable to find or delay seeking necessary medical care, dental care or prescription medicines

St. Francis Regional Medical Center's strategy to increase access to care in its community will focus on one key area, strengthening the ability of uninsured persons in the community to access the full continuum of care. Planned programs include:

- Partnering with local health consortiums and developing community partnerships to assess the ability of members of the community to access the full range of health-care related services. *Partners: local public health, community health organizations, clinics, providers*
- Providing financial support to local entities that provide care and services to people without insurance. *Partners: local public health, community health organizations, charity care providers*

Conclusion

As a faith-based, not-for profit hospital, St. Francis Regional Medical Center 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 St. Francis Regional Medical Center will indirectly address these priority issues along with other needs, such as through the provision of charity care, support of Medicare and Medicaid programs, discounts to the uninsured and others. St. Francis Regional Medical Center will continue to engage with the community to ensure that the work in the plan is relevant, effective and to modify its efforts accordingly.

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ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix A

Carver County Profile

Community Health Needs Assessment
and Implementation Plan 2014–2016

St. Francis Regional Medical Center

Carver County

(Twin Cities Region)

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

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

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

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

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

Demographics Age • Gender • Race • Foreign Born

Demographic data reveal the following state-level trends:

- Minnesota's population is projected to grow substantially by 2035, with slight growth in the younger age groups and substantial growth in the older age groups. These changes will influence the overall age composition of the state.
- Gender is evenly distributed across age groups, with notable exception in the older age groups which have larger proportions of females.
- Minnesota's population continues to become more diverse. Between 2000 and 2007, the Asian, black, and Hispanic/Latino populations increased at a faster pace than the white population.

StratisHealth

CULTURE CARE CONNECTION

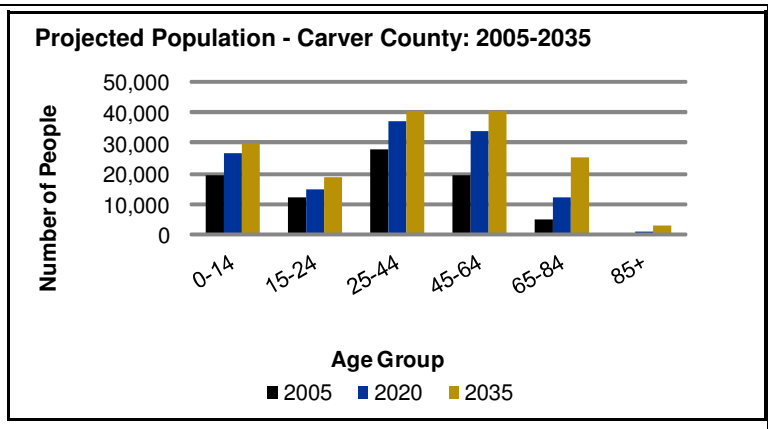
Funding provided by UCare

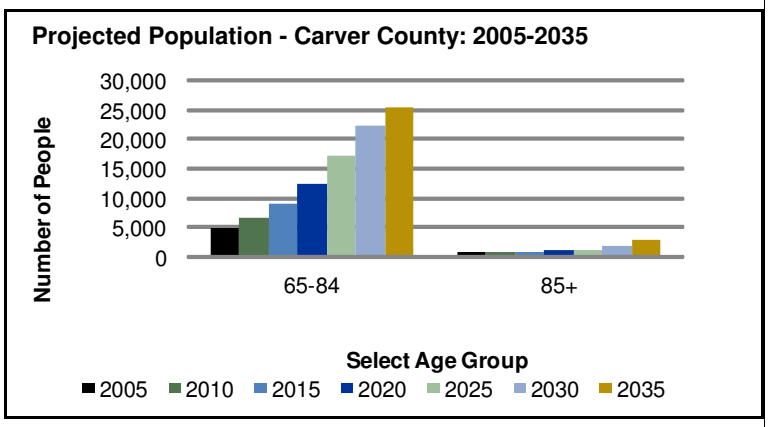
Age

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

Population projections:

- 14 and under to rise 55%
- 15 to 24 to rise 57%
- 25 to 44 to rise 46%
- 45 to 64 to rise 107%
- 65 to 84 to rise 384%
- 85 and above to rise 202%





What providers need to know:

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

Suggestions:

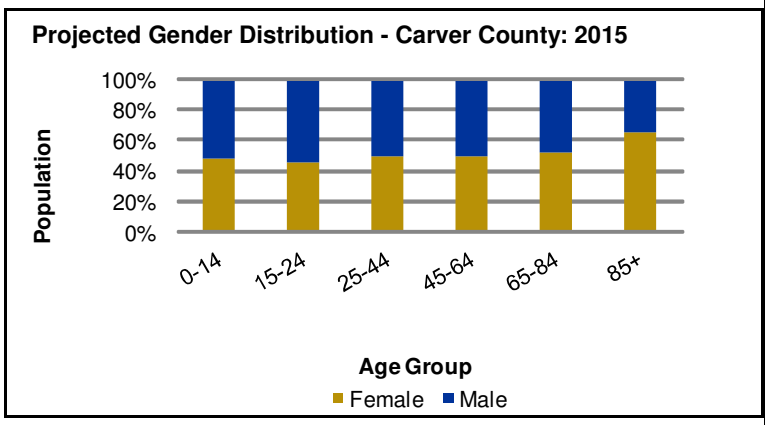
Become familiar with the needs of older populations, as well as individuals from diverse backgrounds, and develop strategies to accommodate them including: referrals to transportation services, allowing more time for patient encounters, and providing patient education materials in alternative formats.

Gender

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

Variations appear when the data are viewed by age range:

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

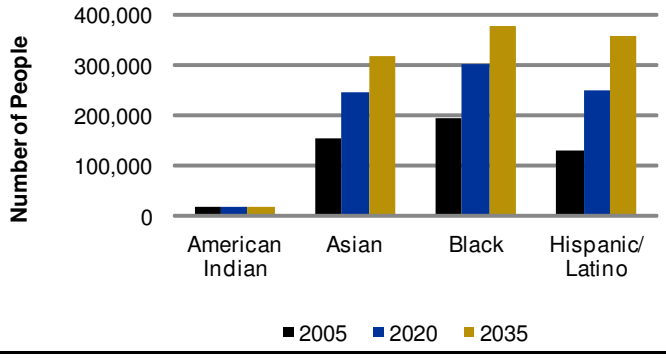


Race

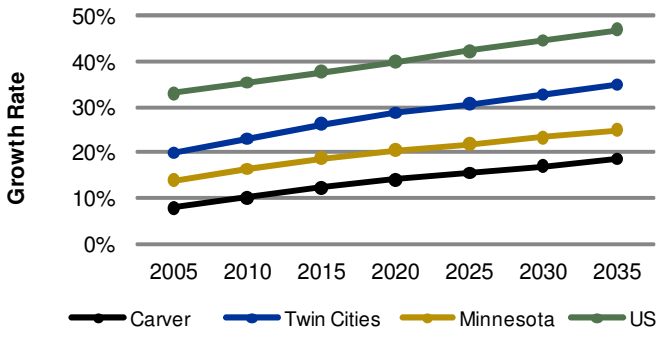
Minnesota's population is considerably less diverse than the US population. Minnesota's populations of color accounted for 14 percent of the population in 2007 compared to 34 percent of the national population. However, populations of color are growing faster in Minnesota, 28 percent compared to 19 percent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

In the Twin Cities metro area between 2005 and 2015, the population is expected to grow 9 percent. The white population is not expected to change while populations of color are expected to grow 44.5 percent. Growth will be most notable in the Hispanic/Latino population (62.4%). Growth in populations of color in Carver County (108.1%) will exceed the national growth rate of 47.1 percent.

Projected Populations of Color - Twin Cities: 2005-2035



Projected Growth Rates for Populations of Color: 2005-2035



What providers need to know:

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

Suggestions:

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

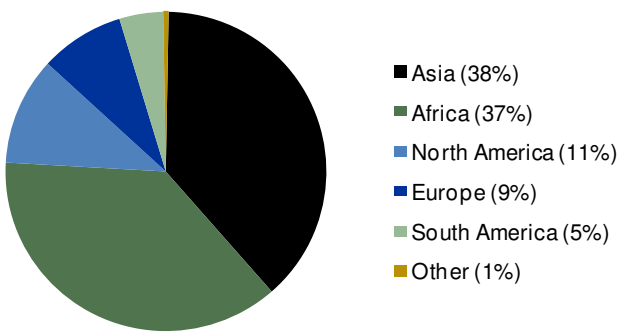
Foreign Born

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

What providers need to know:

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

Foreign Born Population by Region of Birth - Minnesota: 2007



Suggestions:

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

Socioecomonic Status

Education • Income • Occupation

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

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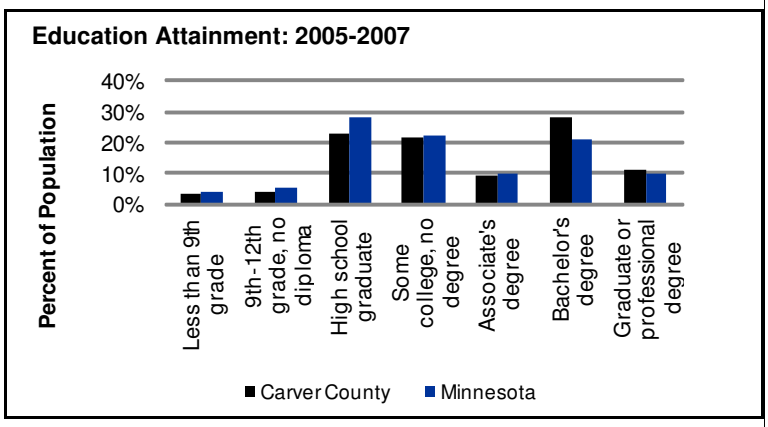
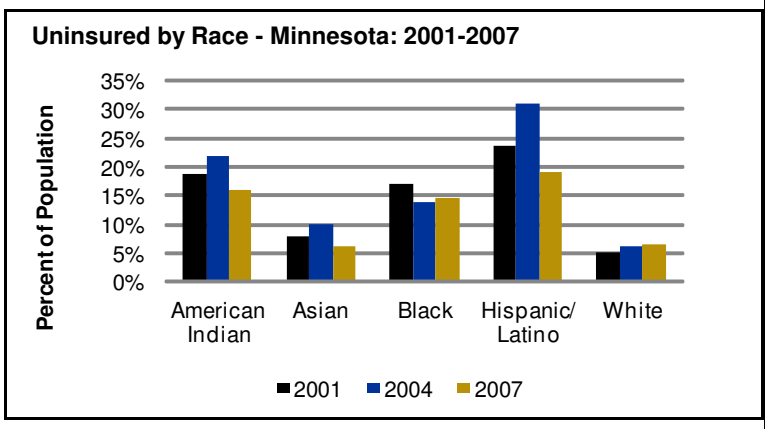


Education

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

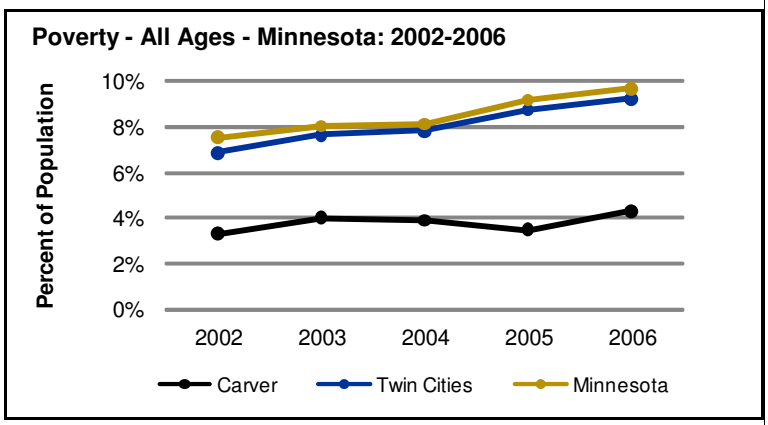
In Carver County, for all races, historic data indicate a higher percentage of individuals receiving at least a high school diploma compared to state level data. Attainment rates of a Bachelor's degree or greater in Carver County were higher than state level rates.



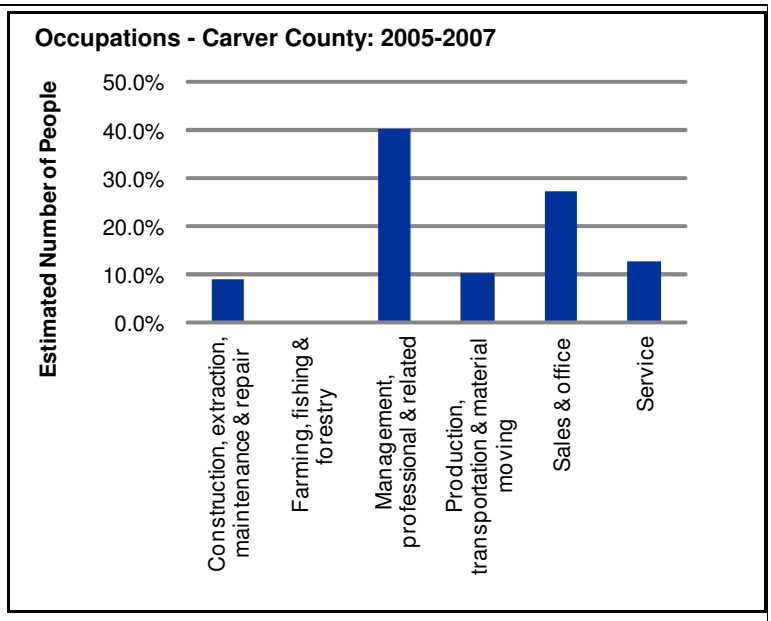
Income

In Carver County, the median household income based on 2005-2007 estimates was $78,035. Income level influences an individual's access to health care (as measured by rates of uninsurance) and is used to determine poverty status, which may determine eligibility for various assistance programs.

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



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



Occupation

According to 2005-2007 estimates, 76.6 percent of the population in Carver County over 16 years of age were employed. Individuals in office-based occupations are at risk for repetitive stress injuries and musculoskeletal disorders due to the sedentary nature of this work.

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

What providers need to know:

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

Suggestions:

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

Health Status Data Birth Rate • Morbidity

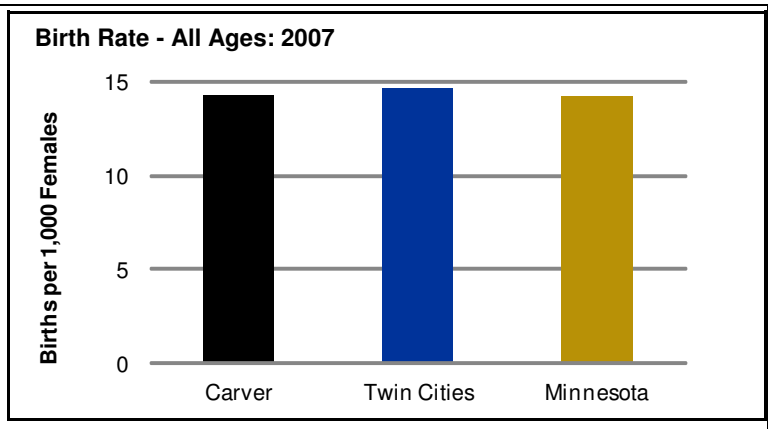
The health status data concerning birth rates and factors contributing to the incidence of disease revealed the following:

- A need for increased efforts to provide prenatal care in the general population as well as an awareness of birth trends in populations of color.
- Greater potential for engagement in behaviors which increase the burden of poor health in populations of color.

Birth Rate

Carver County's birth rate of 14.3 per 1,000 population is on par with the regional and state-level rates of 14.7 and 14.2 respectively. In 2007, prenatal care was received in the first trimester for 92.6 percent of cases compared to 94.4 percent in 2003.

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

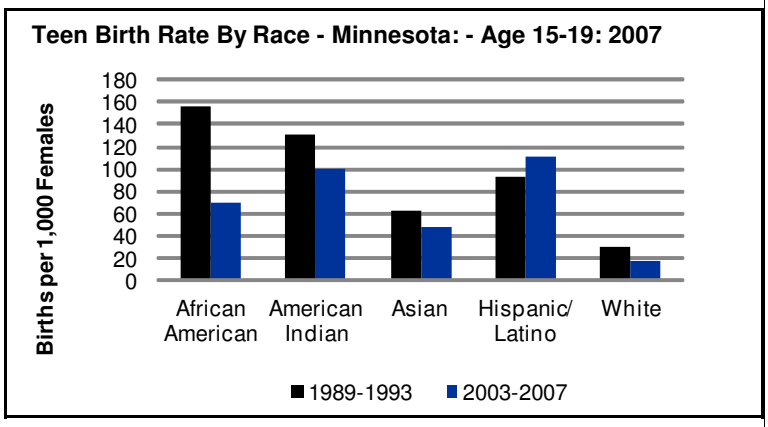


Morbidity

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

What providers need to know:

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



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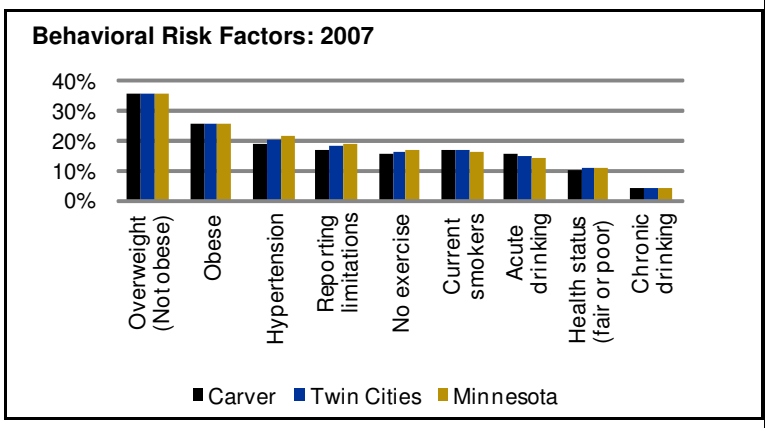

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Contact us for assistance with your quality improvement and patient safety needs related to reducing health care disparities.

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

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

2901 Metro Drive, Suite 400
Bloomington, MN 55425-1525

(952) 854-3306 telephone

(952) 853-8503 fax

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

info@stratishealth.org

ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix B

Scott County Profile

Community Health Needs Assessment
and Implementation Plan 2014–2016

ST. FRANCIS
Regional Medical Center

Scott County

(Twin Cities Region)

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

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

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

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

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

Demographics Age • Gender • Race • Foreign Born

Demographic data reveal the following state-level trends:

- Minnesota's population is projected to grow substantially by 2035, with slight growth in the younger age groups and substantial growth in the older age groups. These changes will influence the overall age composition of the state.
- Gender is evenly distributed across age groups, with notable exception in the older age groups which have larger proportions of females.
- Minnesota's population continues to become more diverse. Between 2000 and 2007, the Asian, black, and Hispanic/Latino populations increased at a faster pace than the white population.

StratisHealth

CULTURE CARE CONNECTION

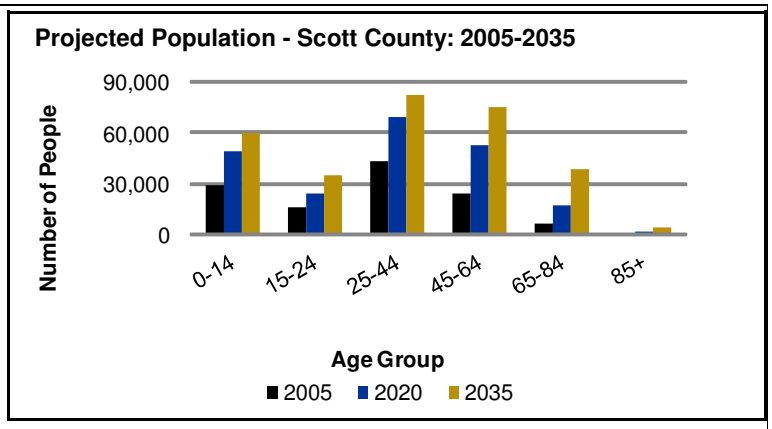
Funding provided by UCare

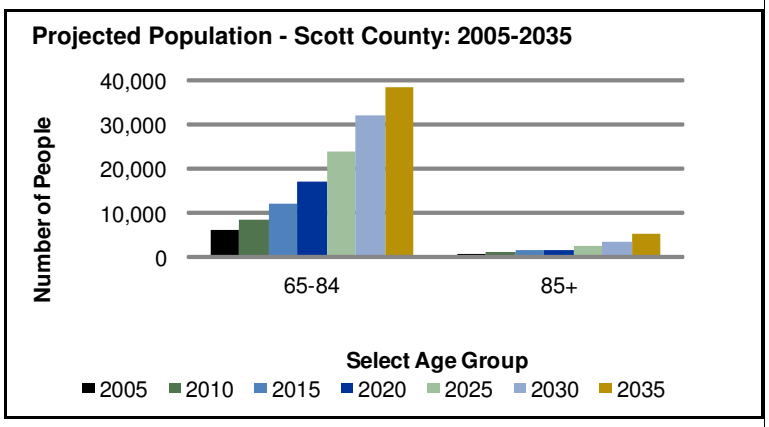
Age

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

Population projections:

- 14 and under to rise 108%
- 15 to 24 to rise 117%
- 25 to 44 to rise 89%
- 45 to 64 to rise 208%
- 65 to 84 to rise 517%
- 85 and above to 478%





What providers need to know:

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

Suggestions:

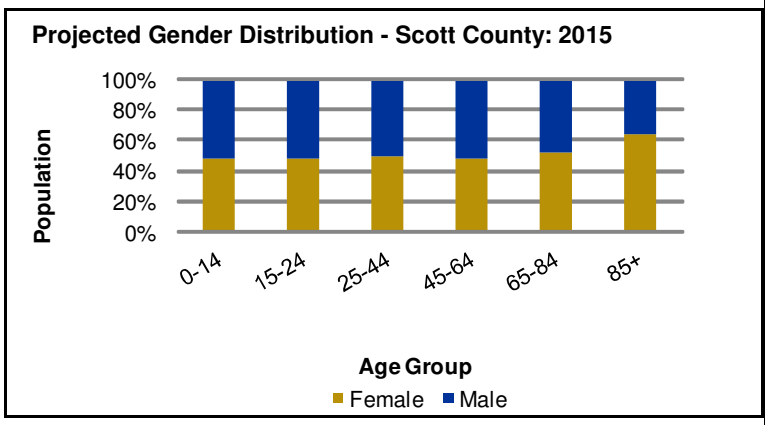
Become familiar with the needs of older populations, as well as individuals from diverse backgrounds, and develop strategies to accommodate them including: referrals to transportation services, allowing more time for patient encounters, and providing patient education materials in alternative formats.

Gender

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

Variations appear when the data are viewed by age range:

- 15 to 24: 48% female, 52% male
- 65 to 84: 52% female, 48% male
- 85 and above: 65% female, 35% male



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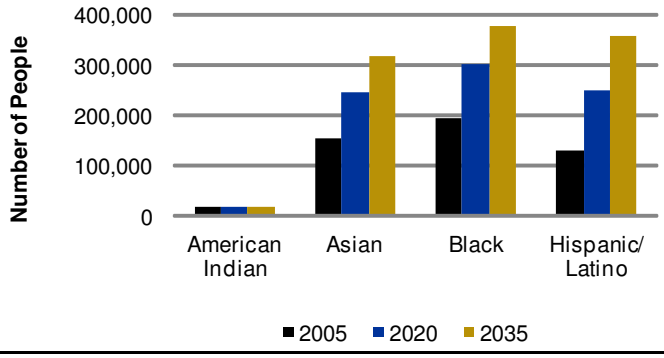

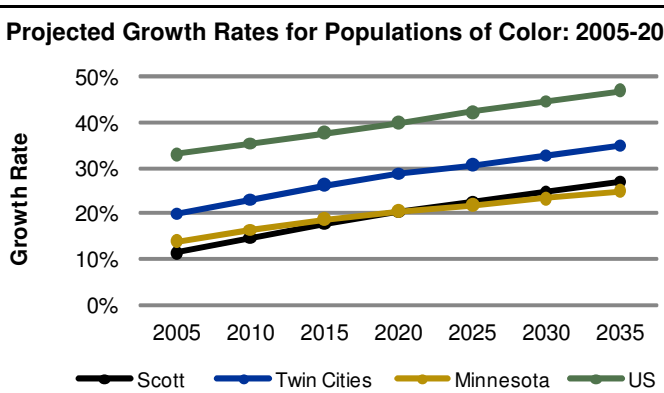

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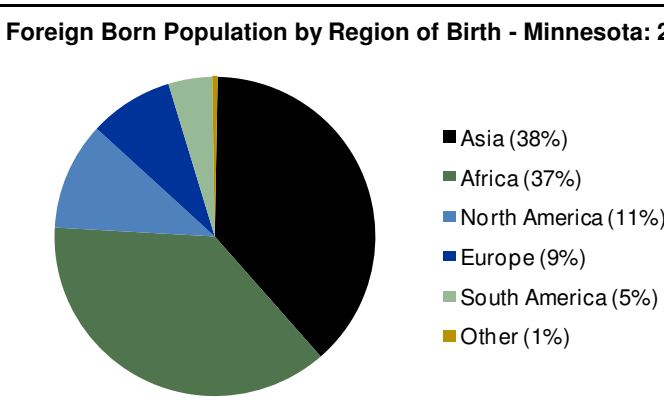

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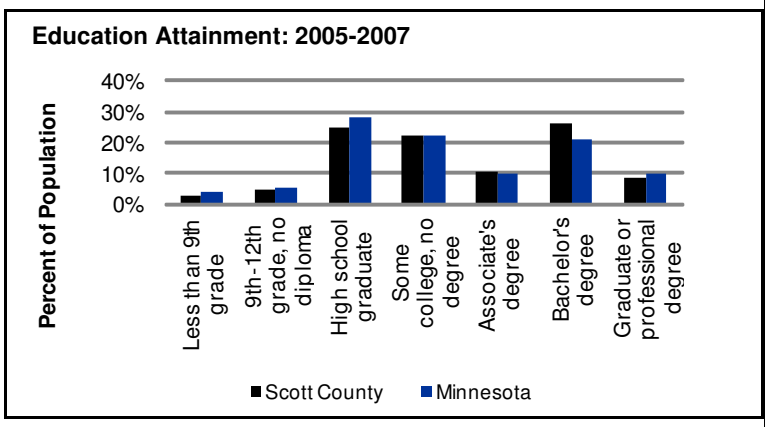

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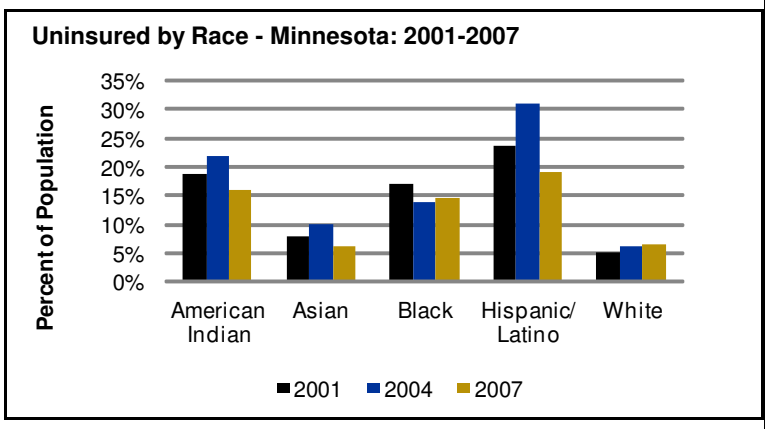

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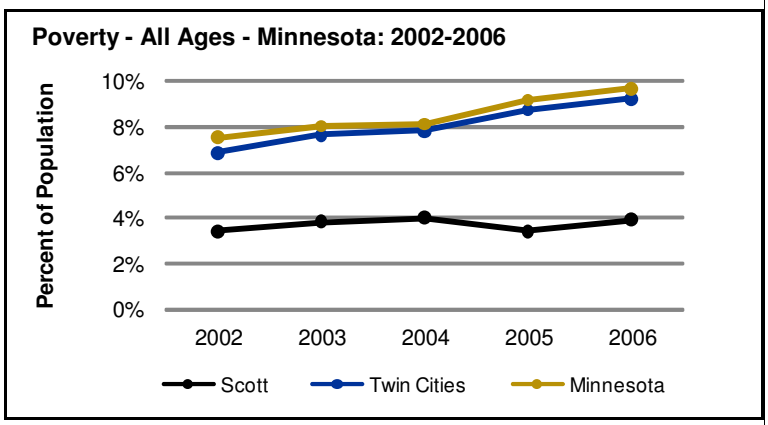

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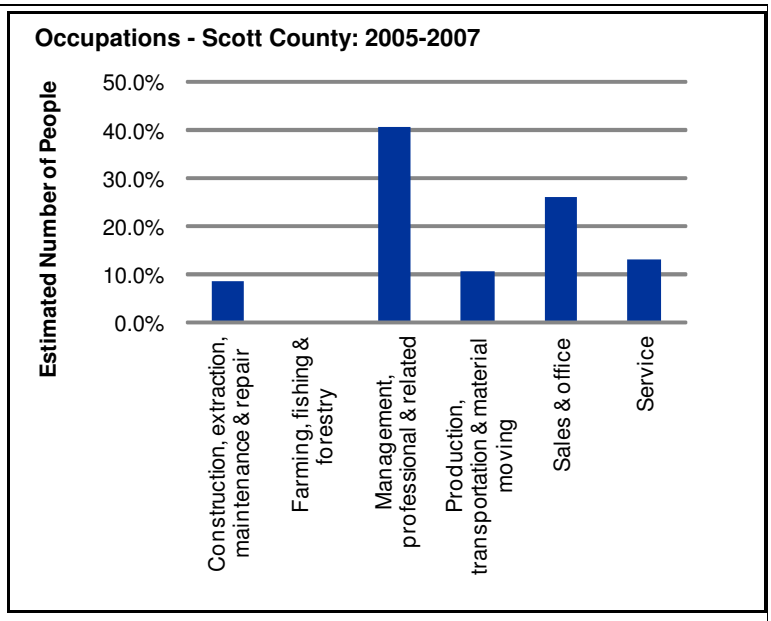

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Birth Rate

Scott County's birth rate of 17.2 per 1,000 population is higher than the regional and state-level rates of 14.7 and 14.2 respectively. In 2007, prenatal care was received in the first trimester for 89.5 percent of cases compared to 90.4 percent in 2003.

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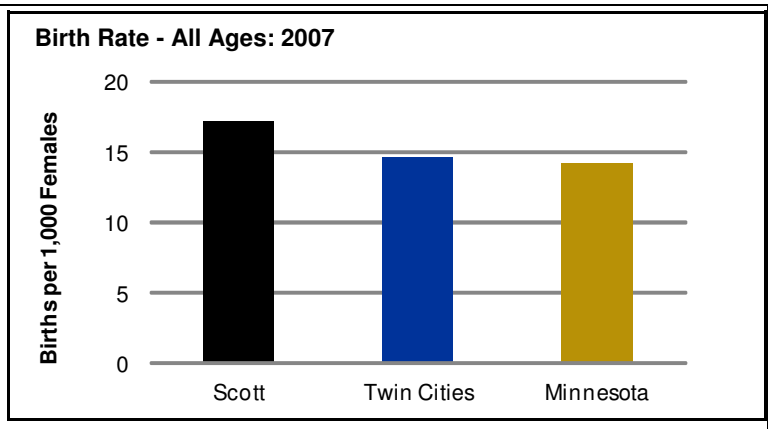

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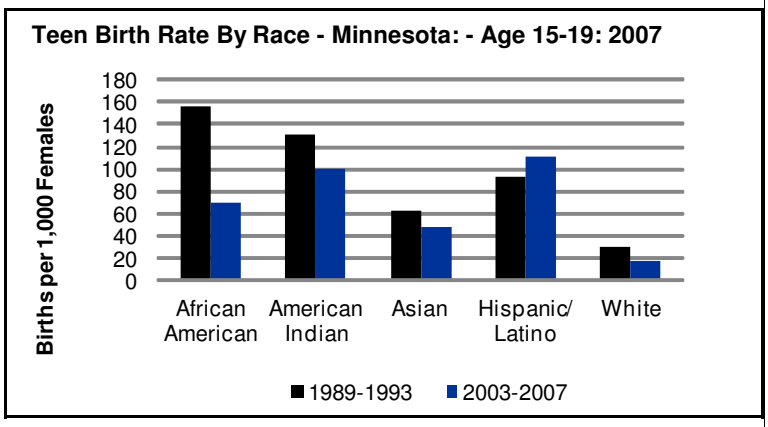

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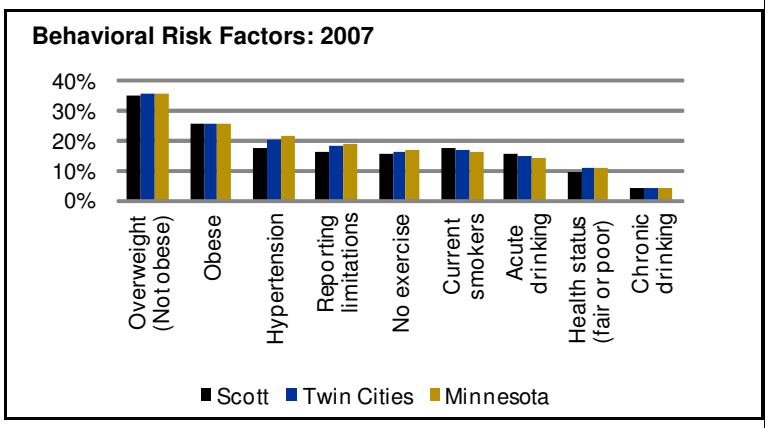

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Stratis Health works with the health care community as a quality improvement expert, educational consultant, convenor, facilitator, and data resource.

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ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix C

Community Partners

Community Health Needs Assessment
and Implementation Plan 2014–2016

St. Francis
Regional Medical Center

St. Francis Regional Hospital CHNA Participants

Jennifer Deschaine	Director of Public Health, Scott County
Brad Tabke	Mayor, Shakopee
Stacy Ward, RN	Carver-Scott Breastfeeding Coalition, West Suburban Teen Clinic (now myHealth)
Dee Dee Francis	Dietician, Saint Francis Regional Medical Center
Mike Baumgartner	President, Saint Francis Regional Medical Center
Katy Boone	Public Health Planning and Promotion Supervisor, Carver County
Yvonne Anderson	Marketing Director, Saints Health Foundation
Jennifer Deschaine	Director of Public Health, Scott County
Karrie Snyder	AMC Crossroads, Chaska and Shakopee
Jeff Foss	Manager, Valley Rehabilitation
Dan Grosskopf	Manager Chanhassen and Savage Clinics, Quello Clinics
Brad Tabke	Mayor, Shakopee
Terry Hassan	Community Outreach Coordinator, CAP Agency and Translator, RVNC
Barbara Zell	Executive Director, River Valley Nursing Center
Mary Hernandez	Intercultural Liaison- Hispanic Community, Co-creator of Esperanza at New Creation Lutheran Church, Community Leader, Shakopee Schools
Joan Gunderson	School Nurse, Shakopee Schools
Connie Robertson	Director of Clinical Services, myHealth(formally West Suburban Teen Clinic)
Beth Loechler	Executive Director, FISH (Families and Individuals Sharing Hope)
Jenny Nagy	Community Involvement Coordinator, Prior Lake-Savage Community Education
Jamie Stolee, RN	Patient Care Manager, Emergency Department, St. Francis Regional Medical Center

Moderators: John Salisbury and Tamara Severtson

ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix D

Full Indicator List

Community Health Needs Assessment
and Implementation Plan 2014–2016

ST. FRANCIS
Regional Medical Center

County-Leading Health Indicators

People and Place

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
People and Place	1. Total population	Census	5,303,925	128,928	91,042
People and Place	2. Population by age and sex	Census	Table I		
People and Place	3. Number of females aged 15-44	Census	1,045,681	27,432	17,999
People and Place	4. Number of births	MDH MCHS	70,617		
People and Place	5. Birth rate	MDH MCHS	13.4	16.0	13.6
People and Place	6. School enrollment for prekindergarten – 12th grade	Census	837,640	21,751	15,853
People and Place	7. Number and percent of children under age 5	Census	355,504/6.7	10,676/8.2%	6,725/7.4%
People and Place	8. Number and percent of children aged 0-19	Census	1,431,211/26.9	41,768/32.1%	29,167/32%
People and Place	9. Child (under 15 years) dependency ratio (per 100 population 15-64)	Census	29.5	38.1	37.2
People and Place	10. Number of households	Census	2,108,843	45,108	32,891
People and Place	11. Number of deaths	MDH MCHS	37,801	496	405

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
People and Place	12. Total population by race and ethnicity	Census	Table II		
People and Place	13. Number of prekindergarten – 12th grade students by race/ethnicity	MDE	Table III		
People and Place	14. Percent of prekindergarten – 12th grade students with limited English proficiency	MDE	7.3%	5.8%	3.7%
People and Place	15. Number and percent of people aged 65 years and older	Census	683,121/12.9%	10.016/7.7%	6,029/21.1%
People and Place	16. Elderly (65+ years) dependency ratio (per 100 population 15-64)	Census	19%	11.5%	12.7%
People and Place/Opportunity for Health	17. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	5.4%	6.9%
People and Place	18. Arsenic levels in MN	Arsenic MDH	n/a		
People and Place	19. Radon levels by zone (low, moderate, high)	US EPA	High/moderate	High	High

Opportunity for Health

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
Opportunity for Health	20. Four year high school graduation rate	MDE	76.9%	86.7	78.7%
Opportunity for Health	21. High school dropout rate	MDE	4.8%	3.5%	4.1%
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%	31.1%	29.2%
Opportunity for Health	23. Percent of prekindergarten – 12th grade students receiving special education	MDE	14.6%	13.5%	13%
Opportunity for Health	24. 2010 Unemployed rate - annual average	MN DEED	7.3%	6.7%	6.6%
Opportunity for Health	25. Total per capita income	Census	$42,953	$38,435	$51,601
Opportunity for Health	26. Percent of prekindergarten – 12th grade students eligible for free and reduced meals	MDE	35.5%	19.2%	17.5
Opportunity for Health	27. Percent of people under 18 years living in poverty	Census	11.4%	5.9%	5.5%
Opportunity for Health	28. Percent of all ages living in poverty	Census	11.6%	4.8%	5%
Opportunity for Health	29. Percent of people of all ages living at or below 200% of poverty	Census 5 yr ACS	25.5%	13.1%	14%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
Opportunity for Health	30. Percent of housing occupied by owner	Census 5 yr ACS	78.1%	88.4%	87.6&
Opportunity for Health	31.Percent of births to unmarried mothers	MDH MCHS	33.5%	19.6%	15.1%
Opportunity for Health	32. Carbon monoxide poisoning (hospitalizations and ED visits age adjusted rates per 100,000)	MNHDD	6.54/.63	1.7/1.6	0/0
Opportunity for Health	33. Percent of dwellings built before 1940	Census 2000	3.2%	7.6%	12.8%
Opportunity for Health	34. Percent of birth cohort tested with elevated blood lead levels	MDH Lead	.5%	.22%	.27%
Opportunity for Health	35. COPD hospitalizations (age adjusted rate per 10,000)	MNHDD	31.5	37	20
Opportunity for Health	36. Percent of children under 18 living in single parent-headed households	Census 5 yr ACS	26.1%	14.4%	15.2%
Opportunity for Health/People and Place	37. Percent of households in which the resident is 65 and over and living alone	Census	9.7%	5.4%	6.9%
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%	4%
Opportunity for Health	39. Number of children under 18 years arrested for violent crimes (Part 1) per 1,000 population 10 - 17 years old	MN DPS	20.5	12	15.6

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
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%	4%	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%	22%	24%
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%`	22%	18%
Opportunity for Health/Healthy Living	43. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	3.2	4.4
Opportunity for Health	44. Number of physicians per 10,000 population	MDH ORHPC	27	9	18
Opportunity for Health	45. Number of dentists per 100,000	MDH ORHPC	61.4	52 total	34 total
Opportunity for Health	46. Percent currently uninsured	MDH MNHAS	9%	8%	7%
Opportunity for Health/Healthy Living	47. Percent of mothers who initiated prenatal care in the 1st trimester	MDH MCHS	85.9%	89.2%	92.6%

Healthy Living

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
Healthy Living	48. Birth rate per 1,000 population	MDH MCHS	13.4	16	13.6
Healthy Living	49. Number of births	MDH MCHS	70,617		
Healthy Living	50. Percent of births by race/ethnicity of mother	MDH MCHS	Table IV		
Healthy Living	60. Percent of mothers who smoked during pregnancy	MDH MCHS	9.8%	4.6%	4%
Healthy Living	61. Percent of births to unmarried mothers	MDH MCHS	33.5%	19.6%	15.1%
Healthy Living/Opportunity for Health	62. Percent of mothers who initiated prenatal care in the 1st trimester	MDH MCHS	85.9 %	89.2%	92.6%
Healthy Living	63. Percent of births that were born premature, less than 37 weeks gestation (singleton births)	MDH MCHS	7.8%	7.8%	6.7%
Healthy Living	64. Percent of birth born low birth weight, less than 2,500 grams (singleton births)	MDH MCHS	4.8%	4.3%	3.5%
Healthy Living	65. Number of infant deaths	MDH MCHS	429		
Healthy Living	66. Percent of 9th and 12th graders who participate in religious activities one or more times per week	MSS	43%/28%	46%/28%	51%/30%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
Healthy Living	67. Teen birth rate per 1,000 females aged 15-19 years	MDH MCHS	26.6	17.3	10.4
Healthy Living/Opportunity for Health	68. Rate of children in out of home care per 1,000 (aged 0-17)	MN DHS	8.8	3.2%	9.3
Healthy Living	69. Percent of 9th graders who ate five or more servings of fruit, fruit juice, or and vegetables yesterday	MSS	18%	17%	21%
Healthy Living	70. Percent of 9th graders who drank three or more glasses of pop or soda yesterday	MSS	14%	11%	12%
Healthy Living	71. Percent of adults who consumed five or more servings of fruits and vegetables per yesterday	Local Surveys		37.6%	36.5%
Healthy Living	72. Percent of adults who reported 30+ minutes of moderate physical activity on five or more days per week	Local Surveys		42.4%	43.4%
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%	62%	61%
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%	74%	76%
Healthy Living	75. Percent of 9th graders who spend six or more hours per week watching TV, DVDs or videos	MSS	44%	44%	44%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
Healthy Living	76. Percent of adults who are excessive drinkers (binge+ heavy)	Local Surveys	20.2%	22%	10%
Healthy Living	77. Percent of 9th graders who engaged in binge drinking in the last two weeks	MSS	10%	11%	8%
Healthy Living	78. Percent of 9th graders who used alcohol one or more times in the last 12 months	MSS	32%	35%	26%
Healthy Living	79. Percent of 9th graders who used alcohol one or more times in the 30 days	MSS	19%	22%	17%
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%/19%	3%/21%
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%	14%
Healthy Living	82. Percent of 9th graders who smoked cigarettes during the last 30 days	MSS	9%	10%	9%
Healthy Living	83. Percent of adults who are current smokers	Local Surveys	16.8%	12.4%	12.4%
Healthy Living	84. Percent of 9th graders who used chewing tobacco, snuff, or dip during the last 30 days	MSS	5%	3%	5%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
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%	15%
Healthy Living	87. Percent of 9th graders who used marijuana one or more times in the last 30 days	MSS	10%	11%	11%
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%	56.1%	56.8%
Healthy Living	91. Percent of 9th and 12th graders who have ever had sexual intercourse	MSS	20%/51%	18%/50%	16%/47%
Healthy Living	92. Among sexually active 9TH and 12th grade students: percent reporting always using a condom	MSS	56%/45%	56%/46%	57%/43%
Healthy Living	93. Percent of 9th graders who report always wearing a seatbelt when riding in a car	MSS	66%	67%	66%
Healthy Living	94. Percent of 9th graders who have felt nervous, worried, or upset all or most of the time during the last 30 days	MSS	13%	14%	12%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
Healthy Living	95. Percent of 9th graders who feel that people care about them very much or quite a bit (parents, other adult relatives, teacher/other adults, religious or spiritual leaders, other adults in the community, friends)	MSS	Table V		
Healthy Living	96. Percent of 9th graders who felt sad all or most of the time in the last month	MSS	14%	14%	12%
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%	41%	42%
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%	40%
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%	48%	48%
Healthy Living	100. Percent of 9th graders who had suicidal thoughts in last year	MSS	17%	19%	13%
Healthy Living	101. Percent of 9th graders who tried to kill themselves in the last year	MSS	3%	3%	3%

Chronic Diseases and Conditions

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
Chronic Dis. and Cond.	102. Percent of 9th graders who are overweight but not obese according to BMI	MSS	13%	14%	11%
Chronic Dis. and Cond.	103. Percent of 9th graders who are obese according to BMI	MSS	9%	7%	7%
Chronic Dis. and Cond.	104. Percent of adults who are overweight according to BMI	Local Surveys	38.1%	40.1%	25.9%
Chronic Dis. and Cond.	105. Percent of adults who are obese according to BMI	Local Surveys	24.7%	19.9%	20.9%
Chronic Dis. and Cond.	106.Percent of WIC children under aged 2-5 years who are obese according to BMI	MDH WIC	13.1%	11.8%	9.3%
Chronic Dis. and Cond.	107. Leading causes of death - age adjusted rates per 100,000 (e.g. cancer, heart disease, stroke)	MDH MCHS	Table VI		
Chronic Dis. and Cond.	108. Asthma hospitalizations (age adjusted rate per 10,000)	MNHDD	7.5	6.9	5.8
Chronic Dis. and Cond.	109. Cancer incidence per 100,000 (all cancer types combined, age adjusted rate per 100,000)	MDH MCSS	474.9	476.4	462.2
Chronic Dis. and Cond.	110. Breast cancer incidence (age adjusted rate per 100,000)	MDH MCSS	127.3	134	121.1
Chronic Dis. and Cond.	111. Heart attack hospitalizations (age adjusted rate per 10,000)	MNHDD	27.3	33	26
Chronic Dis. and Cond.	112. Heart disease prevalence	Local Surveys	4.9%	3.1%	3.3%

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
Chronic Dis. and Cond.	113. Stroke prevalence	Local Surveys	1.8%	2.3%	2.7%
Chronic Dis. and Cond.	114. Diabetes prevalence	Local Surveys	6.2%	4.1%	5%

Infectious Disease

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Scott	Carver
Infectious Disease	115. STD numbers (e.g. chlamydia, gonorrhea)	MDH IDEPC	Table VII		
Infectious Disease	116. Number of tuberculosis cases	MDH IDEPC	135	5	0
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	Scott	Carver
Injury and Violence	118. Years of potential life lost before age 65 (e.g. due to injury or violence)	MDH MCHS	30,010	435	328
Injury and Violence	119. Unintentional injury death - age adjusted rate per 100,000	MDH MCHS	36	36.5	37.5
Injury and Violence	120. Percent of motor vehicle injuries and deaths that are related to alcohol	MN DPS	31.9%/8%	12.5%/11.3%	33.3%/9%
Injury and Violence	121. Percent of 9th graders who report that someone they were going out with has ever hit, hurt, threatened or forced them to have sex	MSS	10%	10%	9%
Injury and Violence	122. Rate of children maltreatment per 1,000 children aged 0-17	MN DHS	17.6	12.5	11.4
Injury and Violence	123. Suicide deaths	MDH MCHS	599	11	7

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**

Scott

0-4	5,314	5,362	10,676
5-9	5,912	5,634	11,546
10-14	5,537	5,339	10,876
15-17	3,148	2,982	6,130

18-19	1,353	1,187	2,540
20-24	2,900	2,740	5,640
25-29	4,000	4,242	8,242
30-34	4,708	5,114	9,822
35-39	5,302	5,511	10,813
40-44	5,728	5,656	11,384
45-49	5,724	5,624	11,348
50-54	4,767	4,406	9,173
55-59	3,366	3,316	6,682
60-64	2,438	2,602	5,040
65-69	1,766	1,853	3,619
70-74	1,118	1,232	2,350
75-79	789	886	1,675
80-84	446	690	1,136
85&up	399	837	1,236
Total	**64,715**	**65,213**	**129,928**

Carver

0-4	3,433	3,292	6,725
5-9	4,070	3,832	7,902
10-14	4,091	3,897	7,988
15-17	2,306	2,284	4,590
18-19	1,067	895	1,962
20-24	1,989	1,942	3,931
25-29	2,483	2,542	5,025
30-34	2,866	2,939	5,805
35-39	3,178	3,346	6,524
40-44	3,865	4,051	7,916
45-49	4,332	4,332	8,664
50-54	3,634	3,559	7,193
55-59	2,683	2,665	5,348

60-64	1,882	1,880	3,762
65-69	1,200	1,285	2,485
70-74	820	855	1,675
75-79	578	786	1,364
80-84	432	651	1,083
85&up	327	773	1,100
Total	**45,236**	**45,806**	**91,042**

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)**
MN	4,524,062	274,412	60,916	216,390	125,145	250,258
Scott	112,212	3376	1072	7444	2938	5771
Carver	84,450	1,124	208	2,493	1,436	3,515

TABLE III

Number of prekindergarten – 12th grade students by race/ethnicity	**White**	**African American**	**American Indian**	**Asian**	**Hispanic**	**Total**
MN	622,725	83,779	18,486	54,559	58,091	837,640
Scott	18,108	780	240	1,404	1,219	21,751
Carver	13,939	405	63	531	915	15,853

TABLE IV

Percent of births by race/ethnicity of mother	**White**	**African American**	**American Indian**	**Asian**	**Latina**
MN	74.5	9.4	2.1	6.9	8.0
Scott	81.6	4.5	1.2	7.7	5.7
Carver	89.1	1.4	.3	4.6	6.3

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
MN	45	55	42	86	78
Scott	43	55	41	87	79
Carver	44	59	45	87	79

TABLE VI

Leading causes of death - age adjusted rates per 100,000 (e.g. cancer, heart disease, stroke)	Heart Disease	Cancer	Stroke
MN	121.81	169.08	34.14
Scott	122.8	172.8	41.2
Carver	124.4	153	30.9

TABLE VII

STD numbers,	Chlamydia	Gonorrhea	Primary/Secondary Syphilis	Syphilis - All Stages	HIV
MN	15,294	2,119	149	347	331
Scott	205	15	2	2	4
Carver	87	5	0	2	3

TABLE VIII

Vector borne diseases	**Campylo-bacteriosis**	**Giardiasis**	**Lyme Disease**	**Human Anaplasmosis**	**West Nile**	**Salmo-nellosis**	**Shigellosis**
MN	1,007	846	1293	720	8	695	66
Scott	13	5	9	4	0	19	0
Carver	18	10	9	6	0	5	1

Local Surveys

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

Local Survey Websites

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

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

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

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

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

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

Acronyms

Atlas Online - Minnesota Center for Rural Policy and Development

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

MCHT - Minnesota County Health Tables

MDE - Minnesota Department of Education Data Center

MDH Arsenic - Minnesota Department of Health, Well Management

MDH HEP - Minnesota Department of Health, Health Economics Program

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

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

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

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

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

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

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

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

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

MN DHS - Minnesota Department of Human Services

MN DPS - Minnesota Department of Public Safety

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

MPHDA - Minnesota Public Health Data Access

MSS - Minnesota Student Survey

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

US EPA - US Environmental Protection Agency

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

ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix E

Hanlon Process

Community Health Needs Assessment
and Implementation Plan 2014–2016

ST. FRANCIS
Regional Medical Center

First Things First: Prioritizing Health Problems

Introduction

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

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

Getting Started

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

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

Table 1.1: Commonly Used Prioritization Criteria[ii]

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

Prioritization in Practice

The following section highlights five prioritization methods:

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

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

Multi-voting Technique [iii]

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

Step-by-Step Instructions:

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

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

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

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

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

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

~~to healthcare services~~			

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

Strategy Grids [iv]

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

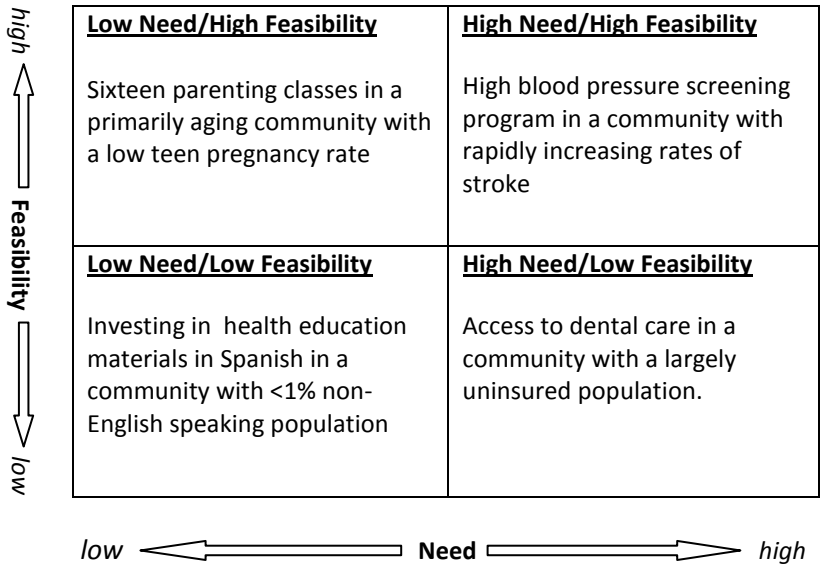
The strategy grid below provides an example of an LHD's effort to refocus efforts towards programs that will feasibly result in the greatest impact. Refer to the example strategy grid below while working through the step-by-step instructions.

Step-by-Step Instructions:

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

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

Strategy Grid



Nominal Group Technique [v]

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

Step-by-Step Instructions:

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

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

John Doe County Health Department: Nominal Group Technique Example

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

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

Table 3.1: Count of Staff Responses to QI Focus Areas

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

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

The Hanlon Method [vi]

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

Step-by-Step Instructions:

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

Table 4.1

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

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

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

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

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

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

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

    D = [A + (2 x B)] x C
    Where: D = Priority Score
    A = Size of health problem ranking
    B = Seriousness of health problem ranking
    C = Effectiveness of intervention ranking

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

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

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

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

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

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

Table 4.2: MCHD Hanlon Priority Scoring

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

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

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

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

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

Prioritization Matrix [iv]

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

Step-by-Step Instructions:

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

Table 5.1: Example Prioritization Matrix

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

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

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

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

Lawrence-Douglas County Health Department: Example Prioritization Matrix

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

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

Table 5.2: LDCHD Prioritization Matrix

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

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

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

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

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

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

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

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

Conclusion

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

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Appendices

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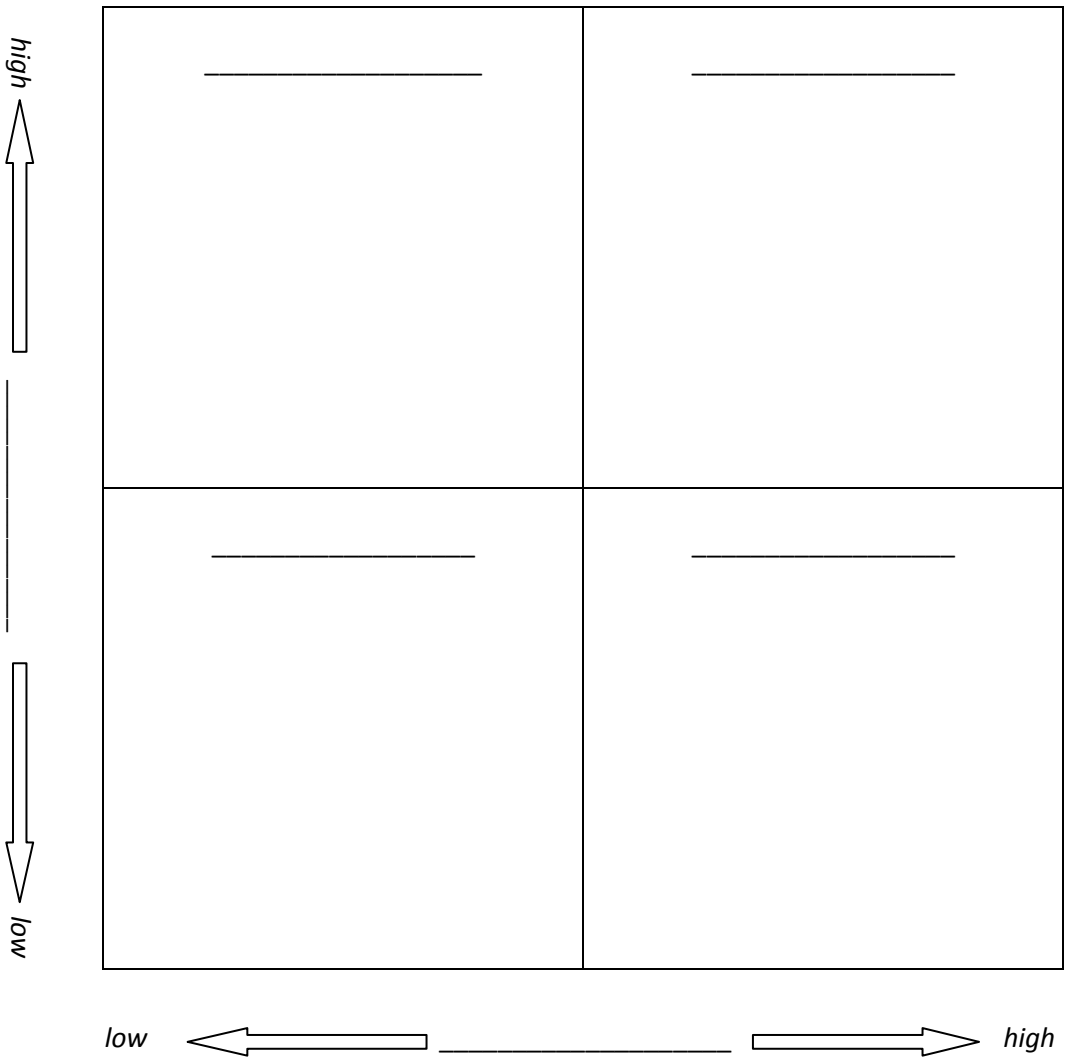
3 Round Multi-voting Template

Health Indicator	Round 1 Vote	Round 2 Vote	Round 3 Vote

Instructions:

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

Strategy Grid



Instructions:

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

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Hanlon Method Worksheet

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

Instructions:

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

Prioritization Matrix

Health Indicator	_____	_____	_____	Priority Score

Instructions:

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

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

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

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

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

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

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

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Appendix F

Prioritization Sheet

Community Health Needs Assessment
and Implementation Plan 2014–2016

ST. FRANCIS
Regional Medical Center

Regional

Access to Care	Size	Seriousness	Effectiveness	Priority Score
Group 1	9	9	3	
Group 2	6	7	6	
Group 3	7	5	4	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	7.333333333	7	4.333333333	**92.44444444**

Clinical Preventive Svc	Size	Seriousness	Effectiveness	Priority Score
Group 1	8	8	5	
Group 2	9	8	8	
Group 3	7	7	6	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	8	7.666666667	6.333333333	**147.7777778**

Mental Health	Size	Seriousness	Effectiveness	Priority Score
Group 1	9	9	3	
Group 2	8	9	8	
Group 3	8	10	5	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	8.333333333	9.333333333	5.333333333	**144**

Nutrition and Physical	Size	Seriousness	Effectiveness	Priority Score
Group 1	8	8	4	
Group 2	8	8	5	
Group 3	9	9	4	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	8.333333333	8.333333333	4.333333333	**108.3333333**

Substance Abuse	Size	Seriousness	Effectiveness	Priority Score
Group 1	8	9	3	
Group 2	9	9	7	
Group 3	10	10	3	
Group 4				
Group 5				
# of Groups	3	3	3	
Total	9	9.333333333	4.333333333	**119.8888889**

ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix G

Justification Sheet

Community Health Needs Assessment
and Implementation Plan 2014–2016

ST. FRANCIS
Regional Medical Center

Notes from SW Metro Meeting

Clinical Prevention

Role of Allina – leader and partner – ability to reach larger population – and connect to wider population

Cost – downstream, cost effective, ability to address populations

Vulnerable populations – seniors

Mental Health

Fits with the missions, what is the role—partner supporter of existing efforts, economic impact—impacts whole community—harder to measure—fewer police calls, connected to substance abuse, eating disorders, interventions require more specialty care- initial increase in cost—spreading of costs. Location of services- beds?

Substance Abuse

Fits with mission, very specialized subset of health care- ongoing struggle, hospital deals with effects of substance abuse—role more of as a partner, and a supporter of other services, opportunity for educational awareness—takes a lot of time address—leads into other areas- emergency care. Always front-end cost, decrease costs down the line. Effects youth and elders—leads to vulnerable populations

Nutrition/Physical Activity

As mission shifts to acute care to prevention this is important, does Allina have the expertise to address this? Leader (developing bariatric program), supporter, partner. Costs could be a lot, could be not lot depending on resources- depends on partnerships—how is the funded? Difficult to assess. Hard to implement.- not an immediate result, more partnerships and access. Must have a family-centered approach. Potential for cost—chronic disease outcomes. Hard to do stuff on a local level—without food reform on a national level.

Access

Fits in the mission- role as partner, leader supporter. Cost—higher cost intervention—cost of doing nothing—chronic disease. Impact on vulnerable populations. Free clinic? Can't do anything here. Free access to emergency room.

Clinical prevention—maybe lower—doing a lot already—people who don't get in.

CHOICES

1. Mental Health/Substance abuse- Combination of two priorities

3. Nutrition/Physical Health

2. Access

4. Preventive Services—top ranked priority according to Hanlon but moved to the bottom of the list due to a consensus that Allina Health is already doing a lot within its service area within existing structures to effectively address this issue. Also by focusing on Access as a top priority you would be bringing people into those preventative services.

ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix H

Framing CHNA Health Disparities

Community Health Needs Assessment and Implementation Plan 2014–2016

ST. FRANCIS
Regional Medical Center

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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ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix I

Community Dialogue Report

Community Health Needs Assessment
and Implementation Plan 2014–2016

ST. FRANCIS
Regional Medical Center

ALLINA HEALTH COMMUNITY DIALOGUE

SOUTH METRO

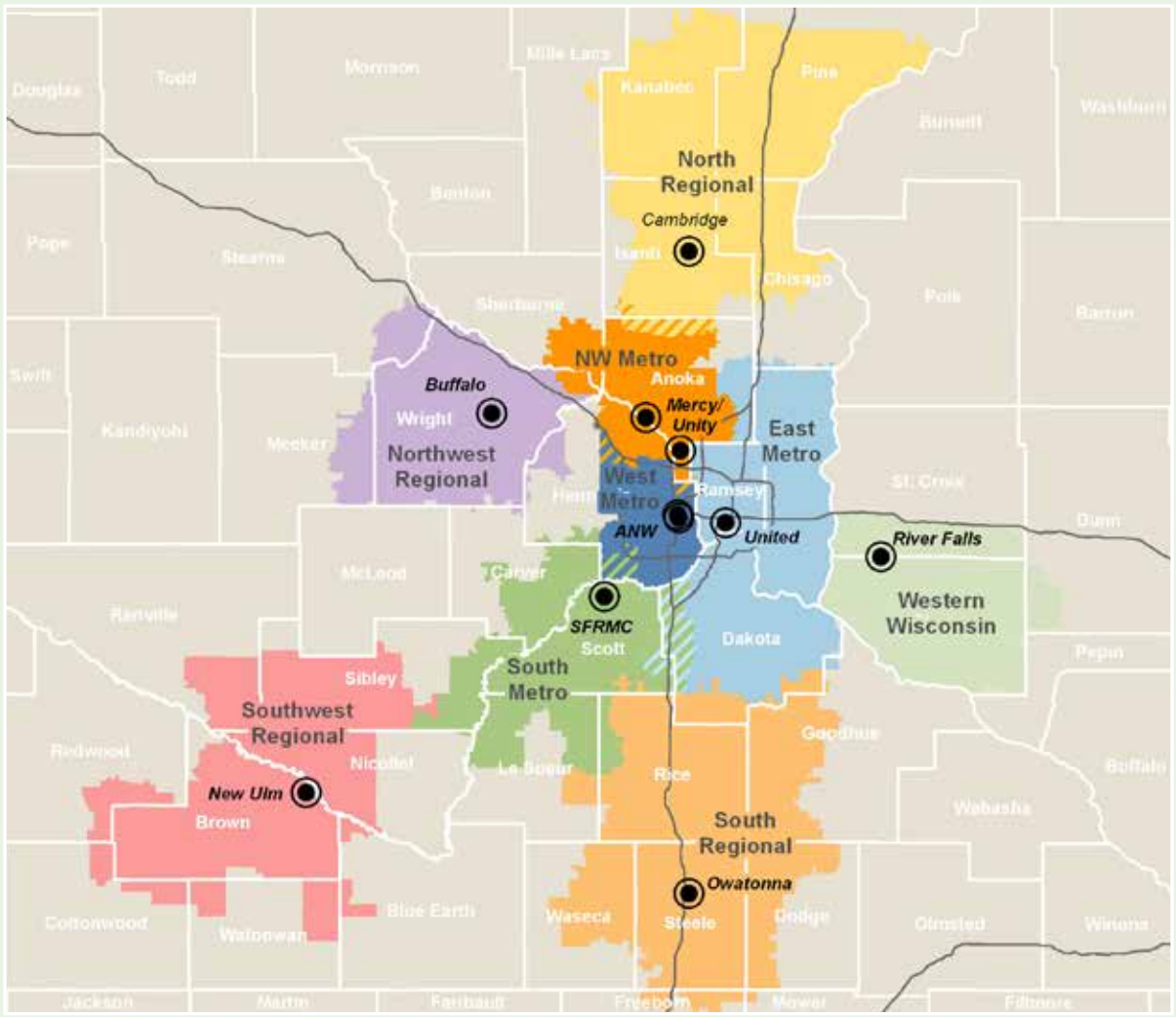
APRIL 2013

Allina Health

Improving health in our community

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

Allina Health Community Benefit & Engagement Regional Map



Introduction

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

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

The needs assessment at St. Francis Regional Medical Center, part of the South 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:

- MENTAL HEALTH/SUBSTANCE ABUSE,
- PHYSICAL ACTIVITY AND NUTRITION,
- AND ACCESS TO CARE.

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-four people participated.

This summary highlights the findings from the 2013 dialogues in the South Metro Region, which includes St. Francis Regional Medical Center.

In March 2013, St. Francis Regional Medical Center and Allina Health convened two Community Dialogues in the South 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 mental health/ substance abuse, physical activity and nutrition, and access to care.

The following summarizes key themes identified through analysis of individual discussion guides, completed by participants prior to engaging in the dialogue. In addition, where possible, themes from the dialogues are also included in the analysis. The information presented in this summary reflects the perspectives of a relatively small number of community members, and may not fully convey the diversity of experiences and opinions of residents who live in the South 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

Shakopee (March 13)

Eleven community members participated in the March 13 Shakopee community dialogue. The majority were between 45 and 64 years of age. Half of the participants reported living in a small town and the other half reported living in a suburban community. Several participants indicated representing the health care and nonprofit sectors. Participants also cited an array of expertise in health topics, including chronic disease management/ treatment/prevention, nutrition, health disparities, mental health, and physical activity. Nearly all the participants reported representing and/or working with adults (25-64). Additionally, many participants specified working with and/or representing white residents, young adults (18-24), children/youth (6-17), and parents of children.

Shakopee (March 15)

Thirteen community members participated in the March 15 Shakopee community dialogue. Nearly all of the participants were between 25 and 44 or 45 and 64 years of age. Many participants indicated representing the education sector. To a lesser extent, participants cited representing the nonprofit and healthcare sectors. They also identified an array of expertise in health topics, such as nutrition, physical activity, and mental health. Several participants also cited working with and/or representing children/ youth (6-17), young adults (18-24), and adults (24-64).

Community impact

MENTAL HEALTH/ SUBSTANCE ABUSE

Participants were asked to reflect on how mental health/substance abuse impacts people in their community. They indicated the negative impact mental health issues have on families and how mental health is not widely discussed as a result of the stigma that surrounds mental illness. A participant cited the adverse effect of cyber bulling on mental health. Participants also referenced a series of barriers related to mental health, such as a lack of awareness of mental health issues in schools and law enforcement agencies and a limited number of extended stay facilities for people who need treatment.

PHYSICAL ACTIVITY AND NUTRITION

Participants were asked to reflect on how physical activity and nutrition impacts people in their community. They reported that the rate of obesity is high and that obesity is associated with lower socioeconomic status. Many participants referenced a deficiency of education in the community regarding proper nutrition and physical activity. Participants also cited the barrier low income families face regarding the high cost of paying for healthy foods and gym memberships. Participants called for an increased focus on providing health information that reaches all community members and generating more programs for youth.

ACCESS TO CARE

Participants were asked to reflect on how access to care impacts people in their community. They noted the increased costs associated with treating chronic illnesses such as diabetes. Many participants referenced barriers to accessing care, such as: issues involving transportation, inability to pay for medical services, lack of affordable care, the absence of "health literacy", and lack of care in rural areas. A participant specifically highlighted how it is difficult for undocumented and low income individuals to access care.

Addressing health concerns in the community

MENTAL HEALTH/ SUBSTANCE ABUSE

Participants were asked to reflect on what should be done to address mental health/substance abuse. They shared a range of ideas focused on promoting resources and expanding education and services, such as:

- Giving more people information on where to access mental health services
- Providing public education in an effort to de-stigmatize mental illness
- Increasing the number of providers in Scott County focused on adolescent mental health and substance abuse
- Having churches involved in helping to prevent and treat substance abuse

PHYSICAL ACTIVITY AND NUTRITION

Participants were asked to reflect on what should be done to address physical activity and nutrition. Participants suggested a variety of approaches encompassing increased opportunities and outreach efforts, such as:

- Creating an awareness campaign, similar to what was done in New Ulm
- Providing free healthy cooking classes so low income families could participant
- Having nutrition education on soil depletion, nutrient rich diets, synthetic fertilizers, and pesticides
- Offering classes to the Latino community in multiple locations for easy access

ACCESS TO CARE

Participants were asked to reflect on what should be done to address access to care. They shared the importance of increasing access to services and proving education. They recommended a variety of approaches, such as:

- Increasing knowledge about how to access care, particularly for the undocumented population
- Offering transportation assistance for individuals who are unable to drive
- Creating a volunteer driver program
- Publicizing where people can access preventative and chronic health care treatment

How Allina Health can help address health concerns

MENTAL HEALTH/ SUBSTANCE ABUSE

Participants were asked to reflect on how Allina Health could help address mental health/substance abuse. They reported that Allina Health could help address mental health/substance abuse through providing education and outreach, expanding services and supports, and collaborating with the community. Participants specifically suggested:

- Increasing communication with schools, community centers, and public entities.
- Creating an onsite counseling center that addresses adolescent mental health and substance abuse.
- Having walk-in crisis care for teens.
- Collaborating with Park Nicollet/Health Partners, the Sioux community, and other community organizations.

PHYSICAL ACTIVITY AND NUTRITION

Participants were asked to reflect on how Allina Health could help address physical activity and nutrition. They shared that Allina Health could help address physical activity and nutrition through outreach and increased collaboration with the local community. Participants specifically noted:

- Having trailers with games and activities that could be circulated around different neighborhoods.
- Creating partnerships with local leaders and community groups that would align Allina's health and wellness expertise with the group's social connections to maximize exposure.
- Supporting community food programs that provide whole foods.
- Increasing access to health clubs.

ACCESS TO CARE

Participants were asked to reflect on how Allina Health could help address access to care. They indicated that Allina Health could help address access to care by expanding services and supports. Participants specifically referenced:

- Supporting free clinics that are needed in the community.
- Continuing free training activities.
- Creating a community paramedic program focused on community health prevention.

Conclusion

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

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

Allina Health

allinahealth.org

ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix J

Community Assets Inventory

Community Health Needs Assessment
and Implementation Plan 2014–2016

St. Francis
Regional Medical Center

2013 Allina Health Community Health Needs Assessment

Regional Inventory

Mental Health and Substance Abuse

Program/Service Name	Program/Service Description	Location of Activity • hospital • clinic • community	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
Scott County Mental Health Service	Providing assessment, therapy and consultation services to residents of Scott County 1 part time child psychiatrist 1 part time adult psychiatrist 20 therapists (range in FTEs all licensed Masters and above) - one of the therapists provides counseling in Spanish and English -individual, couples and family therapy counseling -group therapy -medication/psychiatric consultations -crisis intervention and emergency assessments	Community Government Center (East Building, 3rd floor) 200 Fourth Ave W Shakopee, MN 55379	Scott County Residents Provider for most health plans including Medical Assistance and Medicare For those without insurance, sliding fee based on income if available to Scott County residents.	Dr. Terry Raddatz traddatz@co.scott.mn.us Mental Health: 952-445-7751	Scott County Health and Human Services Mental Health

	-mental health diagnosis and evaluations including clinical interviews, mental status examinations and psychological testing -consultation services to schools, course services, hospital and other community programs and agencies -community education. Access by: call mental health intake center 952-496-8481 and be seen by a therapist the same day. Before 8am and after 4:30pm call 952-442-7601 for emergency mental health services.				
First Street Center (Mental Health)	Provide mental health assessment, therapy and psychiatry to adults (including seniors), adolescents and children in carver County Case management, chemical health and crisis services. Provide services to those with situation or shirt-term emotional problems as well as those with more chronic or long-term mental and	Community 540 E. First Street Waconia, MN 55387 952-442-4437 Satellite office: 102 E. 2nd St. Suite 110B, Chaska, MN 55317	Carver County Residents Group insurance policies must provide coverage for outpatient mental health services. Medicare and Medical Assistance also provide	Don Heywood, Behavioral health Manager	Carver County

	chemical health problems. Access: call 952-442-4437. Limited number of evening appointments available in addition to regular business hours.		coverage. Sliding fee scale for Caver County residents available for those without insurance and for those unable to pay the full fee.		
My Health for Teens & Young Adults	Licensed mental health professionals help clients work through issues like depression, anxiety, stress, family issues and more. Individual counseling Group Counseling Family Counseling Classes for parents and professions 2 counselors = 1 FTE in Mental Health Same day access	Community Hopkins Clinic: 15 8th Ave S Hopkins, MN 55343 Excelsior Clinic 478 2nd St. Excelsior, MN 55331	Low or no cost to individuals ages 12-23 and their families. No one is turned away if they can't pay.	952-474-3251 Myhealth.org	
St. Mary's Health Clinics – Spanish language providers	In partnership with Scott County Mental Health Center Must be St. Mary's patient to qualify: -no one over 65	Shakopee location	No cost	Use St. Mary's access number	

	-must be denied MA coverage -uninsured/underinsured				
School Health Services and Specialized Services		Schools			
Successful Students	Provide educational opportunities at annual events Work for strengthening communication between local school districts and clinic providers	Community Schools	Parents Educators	Dr. Tim Johanson, Dr. Cindy Harvath, Scott Hare (School Representative), Tamara Severtson	SFRMC Local school districts Metropolitan Pediatrics (Metro Peds) Park Nicollet Clinic
Per CAP Agency Resources Guide book: Mental Health	-Catholic Charities -Counseling Services and Intake -Center for Victims of Torture -Children's Home Society and Family Services -Crisis Connection (Phone counseling and referral s- 24 hour crisis line) -Crisis Nursery (Scott and Caver) -Dakota County Crisis Response Unit -Emily Program (eating disorders) -Fairview Mental Health Intake				

	-First Street Center (above) -Gambling Hotline -LifeSpan of Minnesota -Lutheran Social Services (Minneapolis) -Minnesota Mental Health Clinic -Recovery, Inc. (self-help mental health) -Scott county Mental Health (above) -Wilder Child guidance Clinics (St. Paul) -Washburn Center for Children				
Allina Mental Health Services		Dr. Jennifer Service Gayle MacBride, PhD, LP Kari Badali, PA-C, MS Dan Kessler	Clinic	Kathy Burville, RN, Clinic Manager Kathy.burville@allina.com Dan Kessler	Allina Health Services/Mental Health Clinical Service line
Mental Health Crisis Services	Crisis intervention to residents of Scott and Carver Counties. Available 24 hours a day, 7 days a week. Telephone crisis		Mobile – community, clinic, home, anywhere necessary	Melanie Warm mwarm@co.carver.mn.us	Scott County Human Services Carver County Public Health SFRMC Ridgeview Medical Center

	intervention and mobile on-site response to assess and stabilize immediate crisis. For more information call: 952-442-7601				
5 Star Recovery				Chaska	
Haven					
Hazelden				Chaska	
**Coming soon: Day Treatment	Day treatment for students in District 112 schools (others?)			212 Medical Center Chaska, MN	Prairie Care Ridgeview Medical Center District 112 Schools
SFRMC No More Tears	No More Tears is an educational program for teens regarding the effects of drinking/driving and distracted driving.			Susan Berens Susan3.berens@allina.com	SFRMC Shakopee Schools New Prague Schools Jordan Schools
SFRMC Sleep Hygiene Education	Included in English language CPR Anytime classes		Community Hospital	Greg Jones gregory.jones@allina.com	SFRMC Allina Heart Safe Communities American Heart Association
Financial support: SFRMC and Allina Health	Prescription Assistance Program		Community	Jen Romero	CAP Agency

	Scott County Meth Task Force				
	Burnsville Women of Today (Veterans)				
	Anti-bullying retreat (4Word Momentum Respect Retreat) for all Prior Lake-Savage 7th grade students (1700 students)				
	Southern Valley Alliance for Battered Women				
Neighborhood Health Connection	Creating/Strengthening Social Relationships				
Carver County Mental Health Consortium	Quarterly educational forums throughout Carver County -special emphasis on suicide preventions, especially in teens and teens/stress issues				Broad range of partners including: Mental Health Crisis Team Hospitals/Clinics Carver County Mental Health Carver County Public Health Local Advisory Council Carver County Schools

					Faith community
Scott County Health Care Collaborative	Mental health focus, project to be determined: - access to services - suicide - reducing stigma associated with mental illness				Broad range of partners including: Hospitals Clinics Individual providers Payors Public health Mental health Schools
CSN (Consumer/Survivor Network)	Promoting recovery and wellness CSN (Consumer/Survivor Network)/ Mental Health Local Advisory Council			Jamie Stolee represents St. Francis Jamie.stolee@allina.com	
In Reach Program	Provides concentrated case management for patients readmitted through the St. Francis Emergency Department			Jamie Stolee Jamie.stollee@allina.com	SFRMC – Emergency Department and Quality/Safety Local social service providers Local clinics

Nutrition and Physical Activity

Program/Service Name	Program/Service Description	Location of Activity • hospital • clinic • community	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
GoCarverGo.com	Collection of resources				

GoScottGo.com	Collection of resources				
MN Extension	Simply Good Eating	Community		Gloria Wolf	MN Extension
SFRMC	Be Fit Employee Wellness programming	Hospital	SFRMC employees	Michelle Enderson Michelle.enderson@allina.com Michael Morris Michael.morris@allna.com	
SFRMC	ECFC Spring Break Challenge	Community	Staff and teachers	Michelle Enderson	ECFE
SFRMC	Nutrition and Diabetes Education community presentations and screenings Including Healthy Eating messages in CPR Anytime for Spanish speaking classes	Community Community	Varies Spanish-speaking residents in our service area	Nancy Menth Nancy.menth@allina.com (Manager Diabetes/Nutrition) Greg Jones Gregory.jones@allna.com	Varies
SFRMC Diabetes Prevention Program	Diabetes Prevention Program DPP also being done at Prior Lake YMCA Not Me (DPP) also being done at St. Mary's Health Clinics in partnership w/ SFRMC	Community		Nancy Menth Nancy.menth@allina.com	
Living Well With	Evidence based program	Hospital –	Any adult living	Kari Nelson	Allina Health

Chronic Conditions	helping people living with chronic conditions receive support, find practical ways to deal with pain and fatigue, discover better nutrition and exercise choices, and learn better ways to talk with doctor and family about their health.	conference rooms Offered twice/year Late September-early November April-May	with a chronic condition	Kari.nelson@allina.com	Shakopee Clinic
SFRMC Breastfeeding Support	Program providing support and education to mother's on their breastfeeding journey. Support provided in person and over the telephone. Mothers do not need to deliver at St. Francis to receive services.	Hospital and Community	Mothers interested in breastfeeding	Kris Beuch Kris.beuch@allina.com	SFRMC
Carver Scott Breastfeeding Coalition					SFRMC Ridgeview Carver County Public Health Scott County Human Services
Blooma Yoga @ SFRMC	Yoga program for moms and mother/baby classes			Susan Colvin Susan.colvin@allina.com	SFRMC Blooma Yoga

SFRMC	Latina Yoga/Nutrition Also includes yoga classes for young children.	Community	Women	Michelle Enderson Michelle.enderson@allina.com Patti Richards Prichard@shakopee.k12.mn.us	Shakopee ECFE SFRMC Blooma Yoga
NEW WORK - POTENTIAL SFRMC	Somali Women's Exercise Classes	Community	Women	Michelle Enderson Michelle.enderson@allina.com	Shakopee African Community Agency SFRMC St. John's Lutheran Church
SFRMC	Halloween Candy Buy Back	Hospital	Children	Michael Morris Michael.morris@allina.com	Allina Medical Clinic- Shakopee Park Nicollet Clinic Park Dental Shakopee Kaleidoscope Scholarship Fund
Valley Rehab Services	Community presentations and screenings			Cindy Hagen Cindy.hagen@allina.com	Varies
Allina Health Health Powered Kids	Program for children pre-school through young teens	Community	Preschool-young teens	Tamara Severtson Tamara.severtson@allina.com	Varies
SFRMC Financial Support	Esperanza Preschool		Preschool children		
	Esperanza Soccer				
	Esperanza Yoga		Women		

	TLC Soccer		School age children		
	Middle School Mania		Prior Lake Middle School Aged children		
	Jordan Elementary Healthy Snack Cart		Jordan School Aged children		
	Run and Read		Shakopee grade school		
	Good to Go Kids		Shakopee grade school and teens		
	STARS		Shakopee disabled teens		
Allina Health	Neighborhood Health Connection (Seniors)				
	FreeBikes4Kids				
	School Health Connection				
	Health Powered Kids				
	District 112 Summer Soccer program	Community	120 students		
	Good To Go Kids				
	TEFC Community Garden (Lakeville)				
St. Francis Financial Support	Safe Routes to School – speed signs: Shakopee Jordan Belle Plaine Savage Chaska Prior Lake	Community		Tamara Severtson Tamara.severtson@allina.com Paul Espey Paul.espey@allina.com	SFRMC Local law enforcement agencies
Programs to	Food Shelves:				

reduce hunger	CAP Agency 360 Communities Mission Outpost @ Prince of Peace Walk on Waters Ministry (Savage) Bountiful Basket (Chaska) Jordan Area Food Shelf Belle Plaine Food Shelf PROP Discovery Church School backpack programs: Jordan Schools Good To Go Kids Community Meals: Loaves and Fishes (Shakopee) St. John's Lutheran (Chaska) Purchasing programs: Fare-For-All				

	Other: WIC SFRMC Community Gardens – food shelf support Community Gardens – donating to food shelves Lakeville TEFC Food Shelves – providing gardening boxes for people to garden at home Mission Outpost (Prince of Peace)				
Worksite Wellness Program throughout the community	Generally sponsored by employer/insurance provider				
School Services	Health Classes Personal Wellness/Exercise Intramural Sports Athletics				
Community Education/Parks and Recreation	Classes Fitness Facilities, some services free Chanhassen Community				

	Center Chaska Community Center Shakopee Community Center				
Fitness Facilities	Prior Lake YMCA				

Increase Access to Care for Uninsured

Program/Service Name	Program/Service Description	Location of Activity • hospital • clinic • community	Target Population/ Population Served	Contact Name, Phone Number and Email Address	Community Partners
River Valley Nursing Center	Public Health Nursing Social service and health referrals MA enrollment Free Walk in 11 hours/week total	Community: Shakopee, Chaska	Uninsured/underinsured Scott and Eastern Carver County	Barbara Zell Baforte44@aol.com	CAP Agency St. Mary's Health Clinics Scott Co. Public Health Carver Co. Public Health Park Nicollet AMC SFRMC
St. Mary's Health Clinics					
Scott County Mobile Health					
Allina Health Partners Care Program					
Charity Care programs of other systems: Park Nicollet Fairview Mayo Ridgeview					

Financial counseling					
	Target CVS Walgreens Minute Clinic				
Love In the Name of Christ @ Christ Victorious	Mobile Dental				
Scott Co. Public Health dental resources					
Financial Support	River Valley Nursing Center				
	St. Mary's Health Clinic				
	Scott-Carver Project Community Connect				
	CAP Agency Prescription Assistance Program				

ST. FRANCIS REGIONAL MEDICAL CENTER
SOUTH METRO REGION

Appendix K

CADCA's Seven Strategies for Community Change

Community Health Needs Assessment and Implementation Plan 2014–2016

ST. FRANCIS
Regional Medical Center

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).