Olmsted County, Minnesota Community Health Improvement Plan: Supplemental Document 2021 - 2023

A Collaborative Community Effort Led by:
Olmsted County Public Health Services,
Olmsted Medical Center, and Mayo Clinic

December 2020

A. Assessment and Planning Requirements

Nonprofit Hospitals

Effective for tax years beginning after March 23, 2013, a federal law, as set forth by the Patient Protection and Affordable Care Act (PPACA), requires hospitals that are tax exempt under 501(c)(3) of the Internal Revenue Code to conduct a community health needs assessment and adopt an implementation strategy that addresses each of the significant needs identified every three years in order to maintain their tax-exempt status.

Local Public Health

A thorough and valid community health assessment and health improvement plan are customary practices and are core functions of public health. Additionally, health assessments and health improvement plans are a national standard for all public health departments. Since the passage of the Local Public Health Act in 1976, Minnesota community health boards (CHBs) have been required to engage in a community health improvement process, beginning with a community health assessment.

Additional information can be found on the Minnesota Department of Health's website: Local Public Health Assessment and Planning Cycle: 2015-2019

Public Health Accreditation

Olmsted County Public Health Services is a nationally accredited local health department through the Public Health Accreditation Board (PHAB)—a national voluntary accreditation program for public health agencies. The goal of the voluntary national accreditation program is to improve and protect the health of the public by advancing the quality and performance of public health departments. Accreditation standards define the expectations for all public health departments—for a public health department to be accredited, it must meet stringent requirements for the 10 essential services of the core public health functions and demonstrate a commitment to constant improvement. Specifically, to meet national accreditation related to CHIP activities, local public health agencies are required to conduct a comprehensive planning process resulting in a community health improvement plan that includes a broad participation of community partners; uses assessment data to identify priority issues; develops and implements strategies for action; and establishes accountability to ensure measurable health improvement.

Additional information can be found within the Public Health Accreditation Board's Standard and Measures Version 1.5 Guide.

B. Guiding Frameworks

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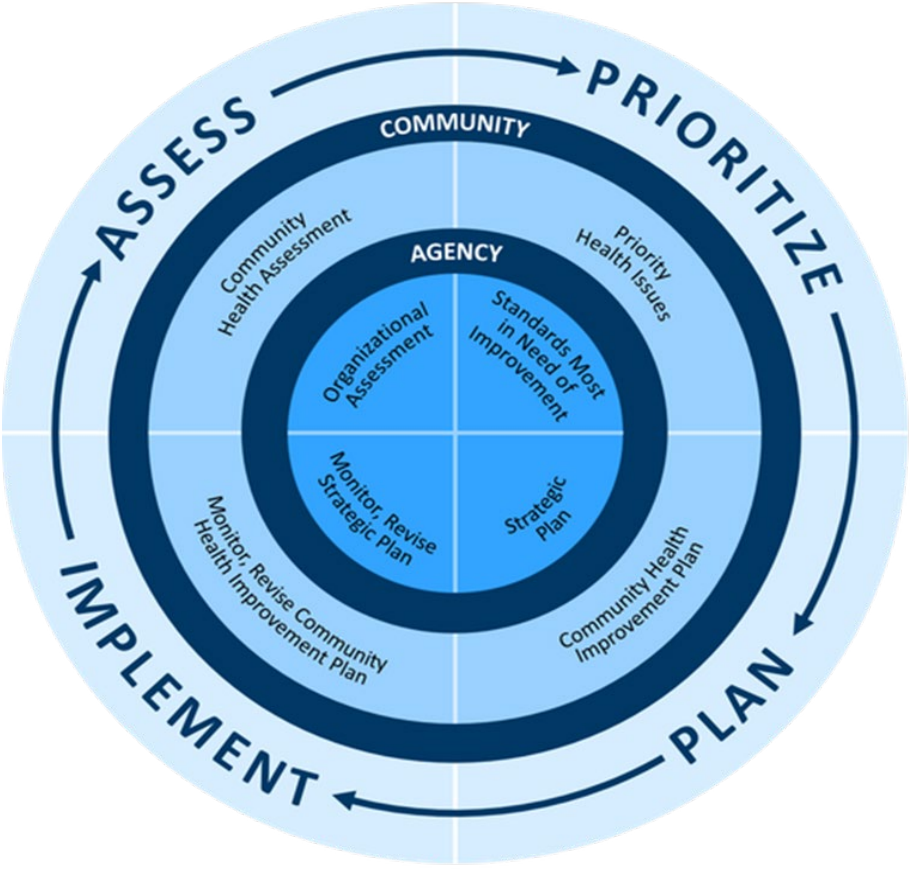
B. MN Local Public Health Assessment & Planning Process

Minnesota Local Public Health Assessment and Planning Process



This model is created by the Minnesota Department of Health (MDH). These phases are developed through MDH and their partners and describes the health assessment and planning process at both community and agency levels.

B. Collective Impact

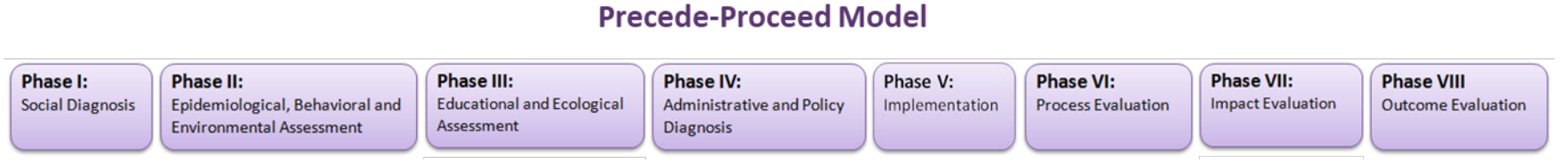
Collective impact is the commitment of a group of actors from different sectors to a common agenda for solving a complex social problem. In order to create lasting solutions to social problems on a large scale, organizations need to coordinate their efforts and work together around a clearly defined goal.

B. Mobilizing for Action through Planning & Partnerships

Mobilizing for Action through Planning and Partnerships (MAPP)

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

B. Precede-Proceed Model



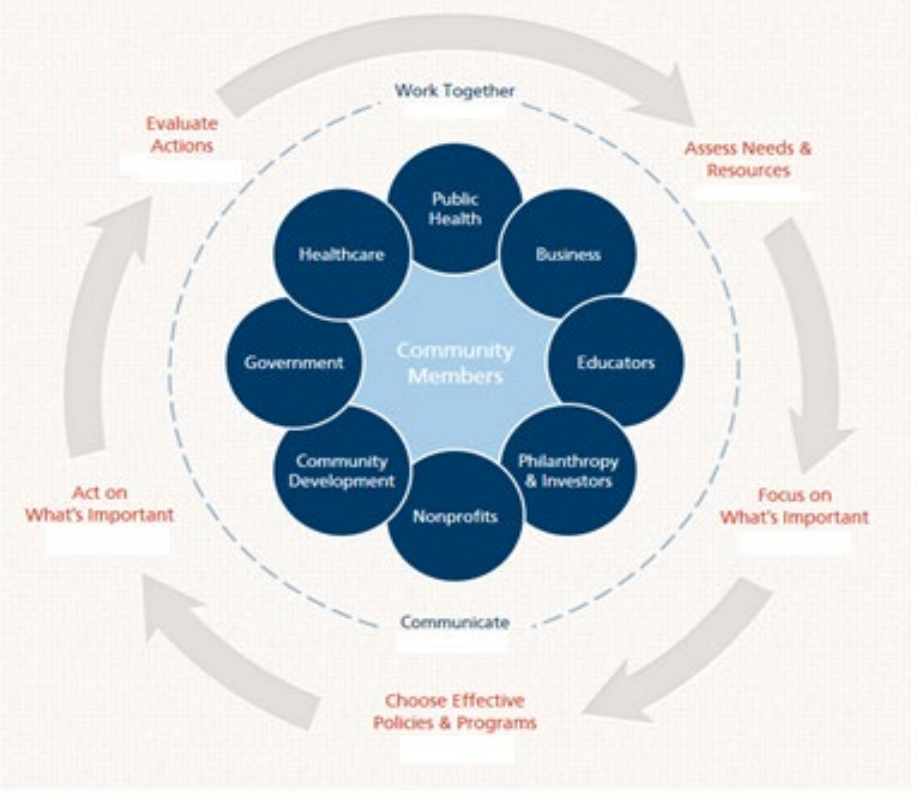
Precede-Proceed was developed for use in public health. Its basic principles, however, transfer to other community issues as well. In the latter half of the 20th Century, as medical advances eliminated many infectious diseases, the leading causes of disability and death in the developed world changed to chronic conditions—heart disease, stroke, cancer, diabetes. The focus of health maintenance, therefore, shifted from the **treatment** of disease to the prevention of these conditions, and, more recently, to the active **promotion** of behaviors and attitudes–-proper diet, exercise, and reduction of stress, for instance—that in themselves do much to maintain health and improve the length and quality of life.

Behind PRECEDE-PROCEED lie some assumptions about the prevention of illness and promotion of health, and, by extension, about other community issues as well. These include:

- Since the health-promoting behaviors and activities that individuals engage in are almost always voluntary, carrying out health promotion must involve those whose behavior or actions you want to change. Precede-Proceed should be a participatory process, involving all stakeholders—those affected by the issue or condition in question—from the beginning.
- Health is, by its very nature, a community issue. It is influenced by community attitudes, shaped by the community environment (physical, social, political, and economic), and colored by community history.
- Health is an integral part of a larger context, probably most clearly defined as quality of life; it's within that context that it must be considered. It is only one of many factors that make life better or worse for individuals and the community. It therefore influences, and is influenced by, much more than seems directly connected to it.

B. County Health Rankings & Roadmaps

County Health Rankings and Roadmaps



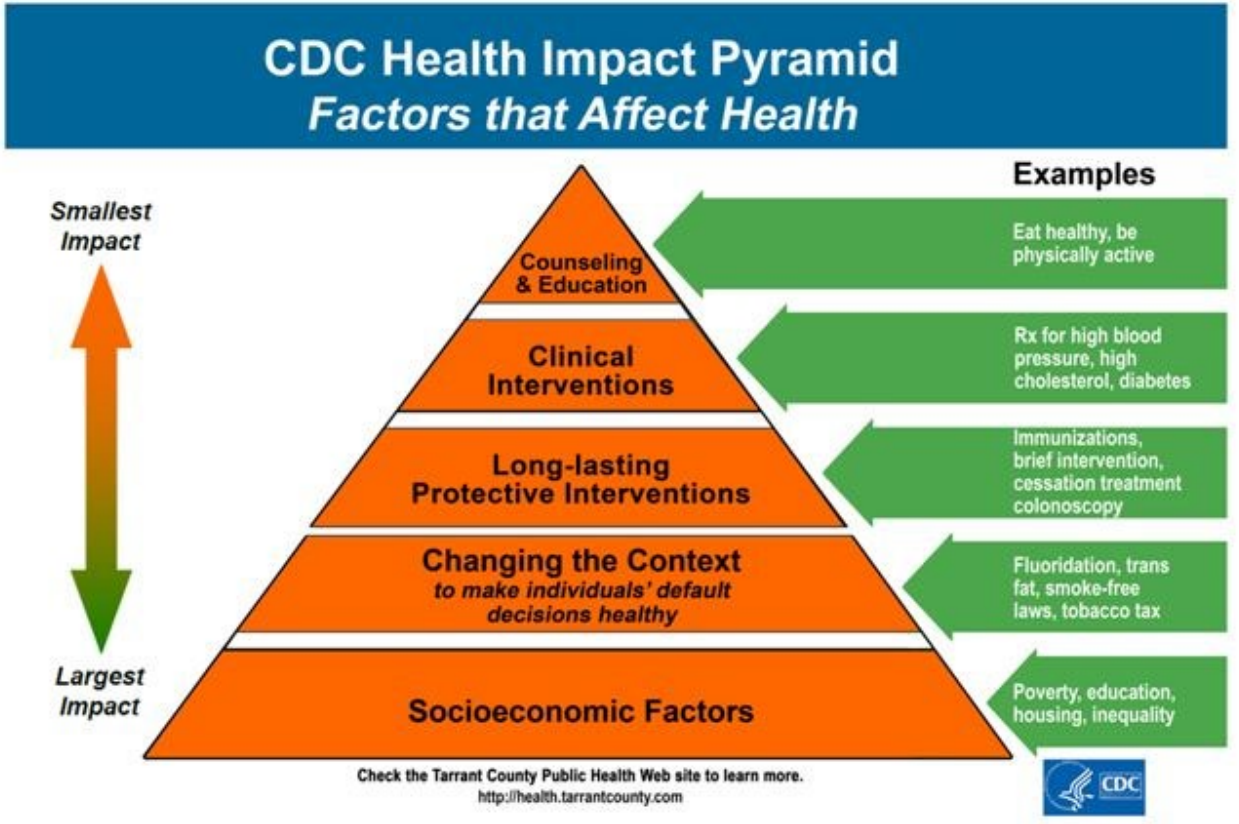
Each step on the Action Cycle is a critical piece of making communities healthier. There is a guide for each step that describes key activities within each step and provides suggested tools, resources, and additional reading. You can start at Assess or enter the cycle at any step. Work Together and Communicate sit inside because they are needed through the Cycle.

B. 10 Essential Public Health Services

The 10 Essential Public Health Services describe activities that communities, including the CHAP process, incorporate. The framework was adapted in 2020 to its newest version.

B. CDC Health Impact Pyramid

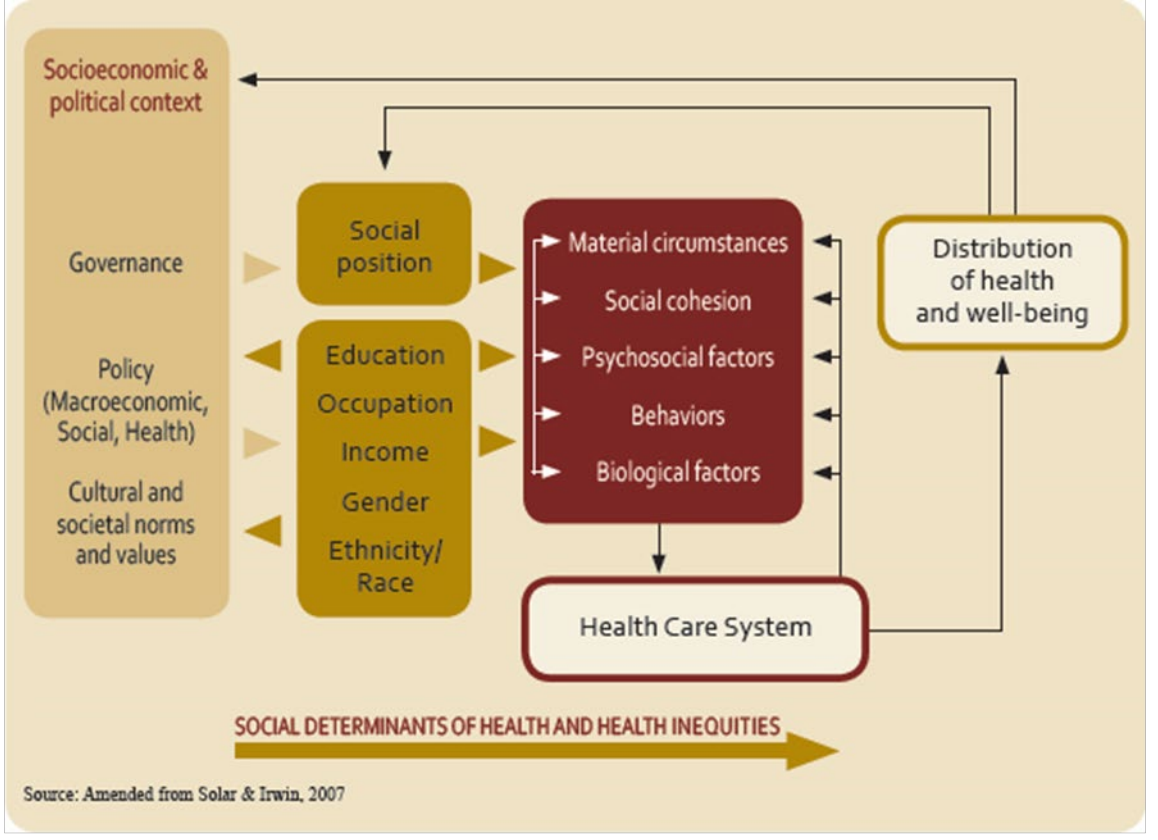
CDC Health Impact Pyramid



The CDC Health Impact Pyramid demonstrates activities affecting health in terms of impact level. The top of the pyramid has the smallest impact to population health, while the bottom of the pyramid has the largest impact. The CHAP process involves strategies focusing on the lower three tiers of the pyramid to have the largest impact on population health.

B. Social Determinants of Health

Social Determinants of Health



World Health Organization's Social Determinants of Health Conceptual Framework

Social Determinants of Health (SDOH) truly define an individual's and population's health. Factors such as education, genetics, and health care, among others, explain someone's health status. Thus, the CHAP process focuses on impacting the SDOH and minimizing inequities for creating long-lasting change for health outcomes in the community.

C. Community Health Priority Workgroups Update

Two 2018-2020 CHIP priorities are continuing into 2021-23: mental health and financial stress. During the 2018-20 CHIP, both the mental health and financial stress workgroups sunsetted in 2018 due to overlapping existing efforts around the two issues at the time.

While efforts to address mental health, financial stress, and substance use will continue with the 2021-23 CHIP, it has not yet been decided if workgroups will form or other approaches will be implemented. The CHAP Core Group and Coalition for Community Health Integration (CCHI) will determine the direction once further data collection is conducted in early 2021.

Additionally, the CHAP process continues to incorporate community voice in multiple ways, including through two workgroups: the Data Subgroup and Community Engagement Workgroup. These teams are instrumental in expanding community involvement throughout the process and with each priority. Each of the groups consists of a large range of partners within the three core organizations, along with a variety of local and key community partners.

D. Contributing Organizations

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D. Organizations

Coalition for Community Health Integration (CCHI)		
Blue Cross Blue Shield	Mayo Clinic	Olmsted County Health, Housing and Human Services
Olmsted County Public Health Services	Olmsted Medical Center	Rochester Area Foundation
Rochester Public Schools	UCare	United Way of Olmsted County
Zumbro Valley Health Center		

Olmsted County CHAP Process Core Group Planning Team
Mayo Clinic
Olmsted County Public Health Services
Olmsted Medical Center

***Olmsted County Public Health Services is a department within a larger division called Olmsted County Health, Housing and Human Services; representatives of both are included in the CHAP process**

CHAP Process Data Subgroup
Cradle 2 Career
Destination Medical Center
Family Service Rochester
Mayo Clinic
Olmsted County Health, Housing and Human Services*
Olmsted County Public Health Services
Olmsted Medical Center
United Way of Olmsted County

CHAP Process Community Engagement Workgroup
Diversity Council
Olmsted County Health, Housing and Human Services
Olmsted County Public Health Services
United Way of Olmsted County

D. Health Assessment & Planning Partnership

Health Assessment & Planning Partnership (HAPP)		
Augsburg University	Mayo Clinic	Salvation Army
Catholic Charities, Diocese of Winona	Minnesota Department of Health	Seasons Hospice
Channel One Regional Food Bank	National Alliance on Mental Illness (NAMI) SE MN	SE Minnesota Area on Aging
Community Health Service, Inc.	Olmsted County Health, Housing and Human Services Administration (HHH)	State Legislators
Community Members	Olmsted County Public Health Services (OCPHS)	The Arc of Southeastern Minnesota
Destination Medical Center EDA	Olmsted Medical Center	Three Rivers Community Action
Diversity Council	Rochester Area Family YMCA	UCare
Elder Network	Rochester Area Foundation	United Way of Olmsted County
Families First of Minnesota	Rochester Clinic	Zumbro Valley Health Center
Family Service Rochester	Rochester Public Library	Zumbro Valley Medical Society
Intercultural Mutual Assistance Association (IMAA)	Rochester Public Schools	

E. Community Strengths

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E. Mental Health

Community strengths were identified through three Forces of Change events in early 2020. These events were specific to each community priority. The purpose of these events was to bring subject matter experts from Olmsted County (both professional and lived experience) together to better understand the community context and strengths for each of the priorities.

Mental Health	
Community Health Services	Interfaith Hospitality Network
Crest	Lutheran Social Services
Crisis Response	Master Leasing Program
Extension/Dept of Ag	NAMI
Fernbrook	Now POW Website
Gage East Apartments	Project Community Connect
Health Access Minnesota	Project Legacy
Homeless Coalition	Social Media
Housing Stabilization Services	

E. Financial Stress

Financial Stress		
4H	Families First Rochester	RAF
AARP	Family Promise	Remjoy/Elder Care
Area Agency on Aging	Father Project	Rochester Public Transportation
Bear Creek Church	GRH/Housing Support Dollars	St. Vincent
Boys and Girls Club	HUD	Taxpayers
Center City	ICI	The Landing
Channel One	Jeremiah Project	Towers Park
City of Rochester	Next Chapter Ministries	Uber and Lyft
COC- Continuum of Care	Olmsted County Legal Assistance	VOLA
Community Health Workers	Olmsted County Veteran Services	Women's Shelter
Diversity Council	Parent Aware	YMCA

E. Substance Use

Substance Use		
Alcohol Anonymous	Fountain Centers	PFS- Partnership for Success
Blue Stem	Medical Assisted Treatment	Policy Assisted Recovery
Common Ground	Minnesota Adult and Teen Challenge	Rochester Police Department
Correction and Suicide Services	Narcotics Anonymous	Rural Co
Cronan House	New Beginnings	School Based Services
Data Sources	NuWay	Silver Creek Corners
Docs Recovery House	Olmsted County	SPF- SIG
Drug Court	Olmsted County DFO	Student Groups
Drugs Recovery House	Olmsted County Public Health Services	The Pride Institute
Empower CTC	P and I State Grant	

E. Two or More Priorities

Two or More Priorities	
Community Schools	Olmsted County Sheriff's Office
Cradle 2 Career	OMC
Dorothy Day	Pathways to Prosperity
Elder Network	Rochester Community Warming Center
Family Service Rochester	Rochester Police Department
First Homes	RPS
Habitat for Humanity	Salvation Army
Housing Coalition Alliance	School Districts
IMAA	State of Minnesota
Mayo	Three Rivers Community Action
Olmsted County Family Support and Assistance	Zumbro Valley Health Center
Olmsted County HRA	

F. Prioritization Process

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F. Overview & Methodology

OVERVIEW

Prioritization took place between May and July of 2019, through facilitated sessions and utilizing online tools. Each indicator was scored on objective (what the data says) and subjective (perception of the issue) factors. Objective scores were predetermined and approved through the CHAP Data Subgroup. The results from each of the subjective prioritization sessions were combined with the objective scores to determine an overall numerical ranking of the health indicators. Additionally, at the end of each subjective session, participants were asked to provide their individual ranking of the current indicators, as well as suggesting missing or emerging indicators. This cycle, additional data was available to consider in selecting the top community health priorities from the CHNA Community Survey, listening sessions, and conversations with Olmsted County Health, Housing, and Human services staff. The ultimate goal of the prioritization sessions was to identify the Olmsted County's top health priorities.

METHODOLOGY

The prioritization process included two sets of processes: objective and subjective, that were developed and approved by the CHAP Data Subgroup and Community Engagement Workgroup. Objective and subjective scores were combined for an overall score for each indicator. The overall score was determined by combining the objective (40%) and subjective (60%) scores. All CHNA indicators, except for mortality indicators, were prioritized.

OBJECTIVE

The objective scoring was approved by the CHAP Data Subgroup in June 2019. Each indicator was rated on three factors:
Affected - What portion of the at-risk population is actually affected by the problem?

1. = Minimal amount of the population is affected (0-9%)
2. = Sporadic amount of the population is affected (10-29%)
3. = Moderate amount of the population is affected (30-69%)
4. = Most of the population is affected (70-89%)
5. = Nearly all or all of the population is affected (90-100%)

F. Methodology (Cont.)

Trend Data - Has this problem changed over time and what is expected in the future?

- 0 = Not known
- 1 = Any Right Direction Movement
- 3 = No Movement & Low Investment
- 4 = No Movement & High Investment
- 5 = Any Wrong Direction Movement

Disparities - Reviewing local data, does this indicator disproportionately affect certain demographic Groups in our community (race/ethnicity, gender, education, income, and birthplace).

- 0 = Not Known or None
- 1 = 1 Disparity
- 2 = 2 Disparities
- 3 = 3 Disparities
- 4 = 4 Disparities
- 5 = 5 Disparities

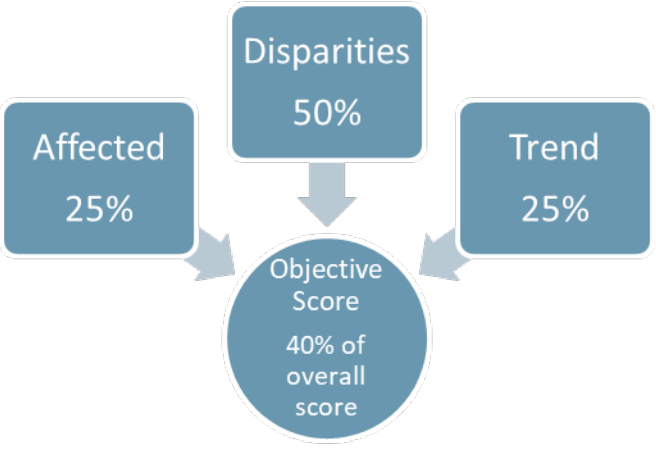
Affected and trend data were weighted so each contributed 25% to the objective score. Disparities were weighted to contribute 50% to the score. They were added together to produce an overall objective score for each indicator.

PROCESS IMPROVEMENT

The initial objective framework had one additional factor to rate each indicator on:

- Premature Death - What are the years of potential life lost (YPLL) from this problem?
  - 0 = Not Known
  - 1 = Minimal YPLL
  - 2 = Sporadic YPLL
  - 3 = Moderate YPLL
  - 4 = Significant YPLL
  - 5 = Extreme/Severe YPLL

During the objective prioritization session, the CHAP Data Subgroup decided not to rate the indicators on the 'premature death' factor due to different interpretations of the question and confusion among members.



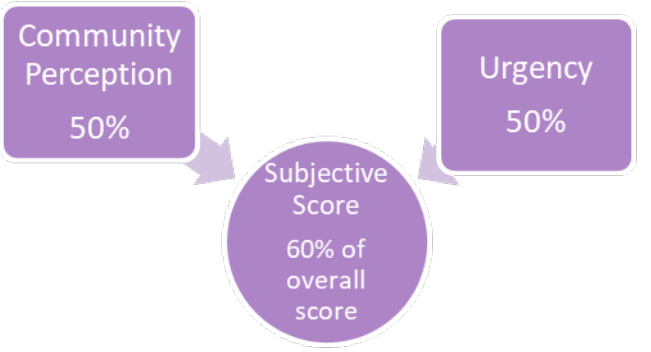
SUBJECTIVE

The goal of the subjective prioritization process was to get community members, partners, and organizations to provide their perception on each of the indicators. Prioritization data was collected in real-time using iClickers or through SurveyMonkey. Participants were provided the opportunity to review definitions and provide framing before the session started. In total, 384 community members participated.

F. Methodology (Cont. 2)

Participants in each of the sessions were asked their opinion on two subjective factors:

- Community Perception – (Indicator) is an issue our community
  - 1 = Strongly Disagree
  - 2 = Disagree
  - 3 = Agree
  - 4 = Strongly Agree
  - 5 = I Don't Know
- Urgency – Our community needs to start now (1-3 years) to address (Indicator)
  - 1 = Strongly Disagree
  - 2 = Disagree
  - 3 = Agree
  - 4 = Strongly Agree
  - 5 = I Don't Know



After each subjective factor, the voting results were displayed. Scores for each subjective factor (community's perception and urgency) were weighted equally (50%) and added together to produce an overall subjective score for each indicator. Those that indicated "I Don't Know" were not in included in the scoring.

At the end of each session, participants were asked to provide their individual input regarding CHNA indicators. They were given a ballot with all the indicators and asked to circle their top five CHNA indicators. The ballot also provided space to list any new, emerging or missing indicators for the CHAP Data Subgroup to consider for future assessment processes.

ADDITIONAL DATA FOR CONSIDERATION

This cycle allowed for the opportunity to look at all the data that has been collected over the last year to make prioritization recommendations. While this data was not meant to replace the prioritization process, it provided more insight when considering the top health priorities.

With the administration of the 2018 Community survey, there was an opportunity to include a prioritization question: "To what extent do you feel each concern is a threat or issue in Olmsted County?" for both the random mailed survey (n=584) and the convenience survey (n=1089).

As part of the prioritization process, instead of participating in a prioritization session or completing the prioritization survey, Olmsted County Health, Housing, and Human Services staff (n=250) participated in a dot activity. Staff were given three dots and asked to vote for what they believed were the top three health issues.

In the spring of 2019, listening sessions (n=184) were conducted and the top themes that emerged were considered during prioritization.

Olmsted County Public Health Services has partnered with UMR Co-Lab students to complete their own assessment process focused on 18-24 years. The top priorities identified from their efforts were shared. For more information about UMR Co-Lab please see appendix H.

IDENTIFYING THE TOP PRIORITIES

The CHAP Core Group, CHAP Data Subgroup, and Community Engagement Workgroup met in July 2019 to review all prioritization data and consider the following questions to identify the top ten priorities:

- Should all prioritization data be used?
- Are all prioritization data equal?
- What limitations does the prioritization data have?

F. Methodology (Cont. 3)

With the top 10 priorities identified, CCHI was able to provide input in August 2019. Each CCHI organization was asked to rank the top 10 for each of the following questions from 1 the most agreement to 10 the least agreement:

- Our community has the collective ability to impact this health issue.
- My organization is willing to prioritize this health issue to make change happen.
- My organization is willing to commit resources to address this health issue collaboratively.

All of this feedback was brought to the CHAP Core Group to consider. The CHAP Core Group was in agreement that the Community Health Improvement Plan (CHIP) will focus on three priorities: Mental Health, Financial Stress, and Substance Use.

PRIORITIZATION SESSIONS DEMOGRAPHICS

Organization/Group	Number of Participants
Community Health Forum	36
Public Health Services Advisory Board	11
Community Service Advisory Board	23
Youth Commission	6
Olmsted County Public Health Services Strategic Management Committee	11
Olmsted Medical Center	112
Mayo Clinic	38
IMAA	23
Crenlo	10
Online Link	114
Total	384

Residence	% of Participants
Rochester	85%
Olmsted County	15%

Race/Ethnicity	% of Participants
Hispanic/Latino	3%
White	70.5%
Not White	29.5%

Age	% of Participants
18 and Under	1.7%
19-34	17.8%
35-49	30.7%
50-64	39.9%
65+	9.8%

G. Community Health Priorities

Alignment with State and National Priorities

Community Health Priority	Olmsted County Priority Goal	Healthy Minnesota 2022: Statewide Health Improvement Framework	Healthy People 2030 Goals
Mental Health	Every Olmsted County resident has the opportunities and resources available to them to achieve their optimal mental health	Key Condition: Positive early life experience Key Condition: Supportive systems	Mental Health and Mental Disorders: Improve mental health through prevention, and by ensuring access to appropriate, quality mental health services, including treatment
Substance Use	Reduce substance use among Olmsted County residents	Key Condition: Positive early life experience Key Condition: Supportive systems	Drug and Alcohol Use: Reduce substance use through reducing overdose deaths, and proportions of individuals who have used drugs, marijuana, prescription drugs, and participated in binge drinking
Financial Stress	Reduce the percentage of Olmsted County residents burdened by financial stress.	Priority 1: The opportunity to be healthy is available everywhere and for everyone Priority 2: Places and systems are designed for health and well-being Key Condition: Economic well-being	Economic Stability: Create social and physical environments that promote good health for all through reducing poverty, increasing steady employment and policies to help people pay for food, housing, healthcare, and education

H. Commitment to Health Equity

Health Equity is an essential component of the CHAP process; without equitable health solutions, optimal community health cannot be achieved.

The CHAP process adopted the following definition for health equity: *We believe in conditions that give everyone the potential to reach their highest level of well-being. This requires valuing all individuals and populations equally. It means addressing inequities in the places where people are born, grow, live, learn, work, and age.*

The CHAP process mobilizes the community and our resources to improve community health for all through several means, including:

- The Health Assessment Planning Partnership (HAPP), which consists of professionals and residents from all sectors of the community, works to continually improve the community's health through assessment, planning, and implementation efforts
- Networking opportunities through HAPP, community forums, and other activities that engage professionals involved in public health work
- The CHAP Data Subgroup and the CHAP Community Engagement Workgroup, which consist of professionals and residents who improve the process through their expertise and advice in data collection, evaluation, and community engagement of all populations

The CHAP process uses its influence to help adopt and implement evidence-based public health practice, cultural competence, health equity and effective community engagement in multiple ways:

- Partnerships with key community organizations, including the Diversity Council and Intercultural Mutual Assistance Association (IMAA), provides valuable insight into culturally competent practices and health equitable solutions
- Collaboration between healthcare and public health offers increased opportunity to use evidence-based practice in strategies addressing community health priorities
- The Community Engagement Workgroup identifies means for effective community engagement around top health concerns, along with innovative ways to integrate community voice into the CHAP process
- A dedication to diverse representation across all sectors, and a continuation of this expectation moving forward
- Health equity is a CHAP core value, demonstrating commitment to incorporating equitable practice into all CHAP activities

Additionally, the CHAP Core Group is interested in exploring collaborative efforts with leaders from other health departments in Southeastern Minnesota. The expectation is that, through this networking opportunity, health equity will be a critical piece of discussion, including reevaluating metrics and local goals.

I. Additional Data Sources

Agency for Healthcare Research and Quality
Alzheimer's Association
American Medical Association
American Physical Therapy Association
American Public Health Association
Center for Compassion and Altruism Research and Education, Stanford Medicine
Center on Budget and Policy Priorities
Centers for Disease Control & Prevention
    Behavioral Risk Factor Surveillance System
    FluVax View
    National Center for Environmental Health
    Mortality Data Report
    National Center for Health Statistics
    National Vital Statistics System
    WONDER
    Youth Risk Behavior Surveillance System
Centers for Medicare & Medicaid Services
City of Rochester Minnesota
Comprehensive Housing Needs Assessment for Olmsted County, Minnesota
County Health Rankings & Roadmaps
Feeding America
Governor's Highway Safety Association
Health Policy Institute, Georgetown University
Healthy People 2020
Human Trafficking Institute
Institute on Aging
International Labour Organization
Kentucky University
Massachusetts Institute of Technology Living Wage Calculator
Mayo Clinic.org
Minnesota Adult Tobacco Survey, ClearWay Minnesota
Minnesota Department of Agriculture
Minnesota Department of Education
Minnesota Department of Health
    Center for Health Statistics
    Data Access
    Electronic Data Surveillance System
    Minnesota Student Survey
Minnesota Homeless Study mnhomless.org
Minnesota Housing Partnership
Minnesota Pollution Control Agency
Minnesota State Demographic Center
National Academics of Sciences, Engineering, & Medicine
National Alliance to End Homelessness
National Cancer Institute
National Center for Healthy Housing, Milken Institute School of Public Health, the George Washington University
National Healthcare for the Homeless Council
National Human Trafficking Hotline
National Institute of Health
National Research Council and Institute of Medicine
Olmsted County Environmental Resources
Olmsted County Planning Department
Olmsted County Public Health Services Water Lab
RAND Corporation

I. Additional Data Sources (Cont.)

Robert Wood Johnson Foundation
Rochester Community Education
Rochester Epidemiology Project
Rochester Minnesota Salvation Army
Rochester Police Department
RNeighbors
SE Minnesota Safe Harbor
SE Minnesota Immunization Information Connection
Social Connectedness and Health, Wilder Research, 2012
Substance Use in Minnesota (SUMN.org)
University of California, Merced
United States Bureau of Labor Statistics
United Nations Office on Drugs and Crime
United States Census Bureau
    American Fact Finder
United States Department of Education
    Center for Education Statistics
United States Department of Health and Human Services
United States Department of Housing and Urban Development
Wilder Homeless Needs Assessment
World Health Organization