2012 - 2015

COMMUNITY HEALTH IMPROVEMENT PLAN

for Hennepin County Residents

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

Appendix 2
The MAPP Process Details

COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP
Convene ~ Catalyze ~ Collaborate

Hennepin

CITY OF
BLOOMINGTON
MINNESOTA

CITY OF EDINA, MINNESOTA
INCORPORATED 1888

RICHFIELD

Minneapolis
City of Lakes

Appendix Contents

Introduction to the Process

The CHIP partners followed the Mobilizing for Action through Planning and Partnership (MAPP) process to guide their planning. MAPP is a nationally recognized process for improving community health that was developed by the National Association of County and City Health Officials (NACCHO). It offers a framework and a set of tools for convening community-wide planning for improving community health.   It provides a systematic way of bringing collective wisdom together to develop better partnerships across the community, prioritize key health issues facing the community and to identify actionable steps that can be taken by better alignment of resources and assets across sectors and organizations. MAPP is not an agency-focused assessment tool; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of various entities that make up and support the local public health systems.

The MAPP process has six phases. The figure below shows the six phases in a linear fashion down the middle of the graphic. Four arrows surround the linear process to illustrate that the four MAPP assessments inform the entire MAPP process.

Six Phases of MAPP:

1. Organize for success & partnership development

2. Visioning

3. Four MAPP assessments

4. Identify strategic issues

5. Formulate goals and strategies

6. Take action
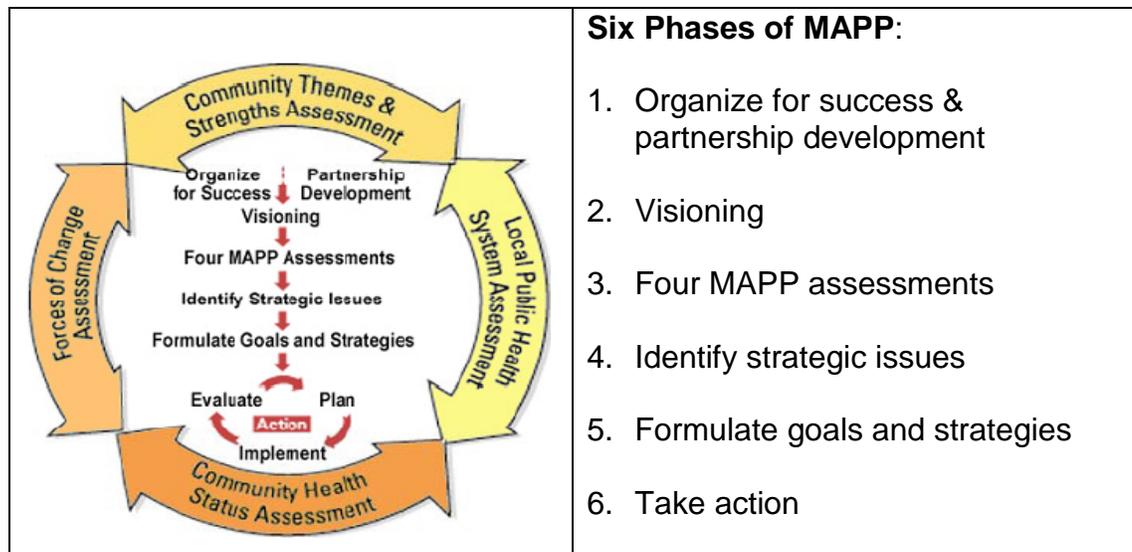
Beginning in December of 2011, Hennepin County Human Services and Public Health Department (HSPHD) began to replicate and adapt the MAPP model for use in the community health improvement planning process in Hennepin.

The four MAPP Assessments were integrated into the CHIP forum series and provided the bulk of data that informed our strategies and goals. The diagram below, starting at the bottom of the pyramid demonstrate steps in the MAPP process. The first part of the CHIP planning process reached the point of setting GOALS for each strategic issue and is at the point of determining "HOW issues will be addressed".
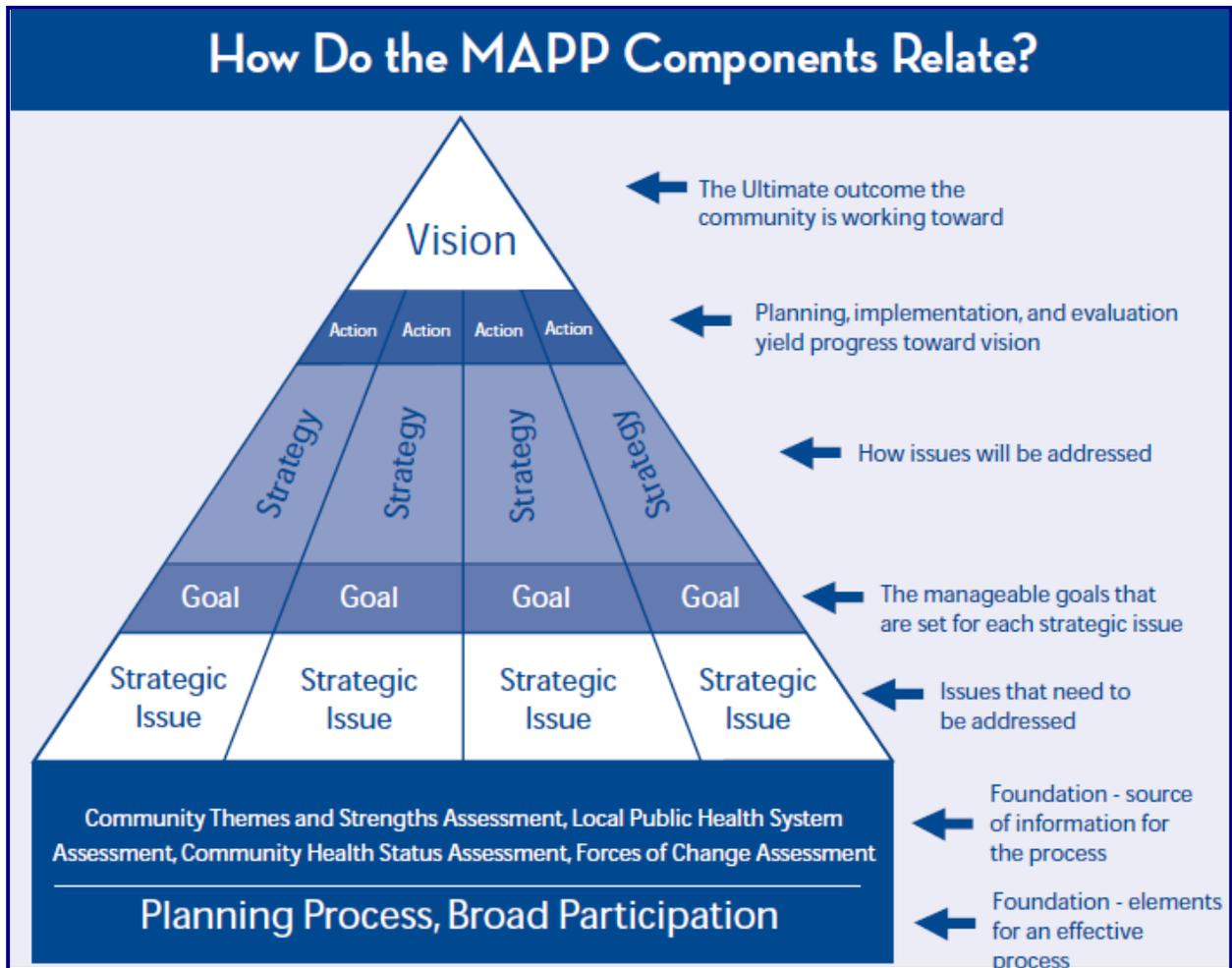
The pages that follow provide timeline for the CHIP activities and an overview of the MAPP processes followed by the CHIP process. The sequence of events and approach to each phase was tailored to meet the requirements of the local CHIP process.

The MAPP roadmap leads to a healthier community!

8-Month Timeline: MAPP-based Community Health Improvement Planning for 2012-2015

Each of the MAPP phases are described in detail in the sections that follow

Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June – July 2012
Plan and Execute Phase 1, Initiate work on Community Health Status Assessment of Phase 3 Design plan and approach for Phase 2, 3, 4, 5						
	Prepare for Phase 2, Phase 3, Phase 4, Phase 5					
		Execute Phase 2, Phase 3, Phase 4, Phase 5 (to be completed fall 2013)				
					Plan for Phase 6	
						Complete Phase 5 Execute Phase 6 Finalize CHIP documentation
Note: Specific strategies and action steps for 2013 will be developed in the fall of 2012. Implementation is targeted to begin January 2013. New action steps will be adopted annually for the following year's action cycle (2014 and 2015).						

I. MAPP PHASE 1: ORGANIZE FOR SUCCESS AND PARTNERSHIP DEVELOPMENT

Phase 1 Purpose

This phase identifies who should be involved in the process, how to approach them and how to organize the partnership involvement.

A. Organizing

In the early weeks of this process, project staff reviewed foundational documents: the MAPP Handbook, Public Health Accreditation Board (PHAB) requirements regarding community health improvement plans, and Affordable Care Act requirements for hospitals regarding community needs assessments. They also reviewed CHIP documents and MAPP work done by others including group phone conferences with CHIP personnel in Milwaukee, Wisconsin and Wichita, Kansas.

A work plan was developed that would complete a community health improvement planning process within the next eight months. The work plan detailed specific activities to accomplish the MAPP Phases. It also established an internal project administrative structure within Hennepin and a partnership structure among the three convening public health department partners.

Project Planning Approach. During the organizing phase, the CHIP project staff proposed an approach to the planning process that would include the following:

1. Dividing the process into two segments:
   - Part one – the assessment and planning phase - that would include the community health assessment and the MAPP assessments. It would bring the process to the point of identifying strategic health issues and high level goals for action.
   - Part two – the action phase – which would focus on moving into action and establishing partnered work. It would include issue-specific action teams that would identify target objectives and strategies and take action to move towards the targeted goals.
2. Distributing a CHIP Survey to gather input from a large number of community stakeholders.
3. Hosting a three-part forum series that would allow concentrated, in-person conversations about the key elements of the community health improvement plan

4. Convening focus groups, if needed, between forums or during the action phase to elicit input from stakeholders that did not participate in either of the other avenues for input or to capture more specific information. [These were not convened during the assessment and planning phase – but could be during the action phase.]

B. Stakeholder Identification & Recruitment

CHIP project staff created a recruitment plan and timeline to engage underline stakeholders in the community to participate in the CHIP work. Key messages for stakeholder engagement were developed along with tools, scripts, contact and email lists, a dedicated email address and project contact, tracking documentation, and internal electronic filing processes. A staffing plan and work assignments were developed to engage participants over the next few months which included coordinated efforts across the three health departments.

CHIP Leadership Group. In the very beginning, it was clear that the CHIP process would benefit hugely from a CHIP Leadership Group that could provide guidance to the process, participate in the planning, and provide leadership to engage others in the community to move to aligned and collective action.

A group of 18 well respected individuals was recruited to help develop the plan and become community champions to move forward. In addition to the five convening health boards, the CHIP Leadership Group included community leaders from sectors that are involved in health-related activities such as hospitals, health plans, federally qualified health centers, cultural groups, schools, mental health, businesses involved in health-related work, health research and quality improvement, academics, charitable organizations, and housing and homelessness. (Group list is in Appendix 1.)

The CHIP Leadership Group was asked to commit from January through June 2012 (the Assessment and Planning Phase of the CHIP process) and to determine at the end of that period whether they would transition to the CHIP Steering Committee that would guide the Action Phase of the work through 2015. The CHIP Leadership Group met six times between February and June 2012. Three additional task force meetings of Leadership Group and CHIP project staff were held to do between-meeting work.

Their CHARGE was: *to provide support and guidance to the five convening community health boards serving Hennepin County in their efforts to identify and take action on priority health issues that*

- *Are important to diverse communities, leaders, and sectors across the community*
- *Have the potential to be improved by collaborative efforts.*

The Leadership Group tasks included:
1. Providing input and guidance on community engagement plans and approaches.
2. Providing input on themes, community strengths, forces of change and other discussions that will help shape the development of a community health improvement plan
3. Enhancing and completing work initiated at the stakeholder forums.
4. Assisting project staff to engage key community leaders to participate in the community development of a health improvement plan.
5. Promoting the importance of a community-adopted health improvement plan and public-private-community partnerships to work together for greater impact.
6. Assisting project staff to take the final recommendations of the CHIP back to their own organizations for action and incorporation into their agency's work plan, as appropriate

CHIP Survey Participants. Project staff from all three convening health boards identified target sectors, stakeholder agencies, and individual representatives that contribute to the health and wellbeing of residents of Hennepin County as potential participants in the CHIP survey. Names of contacts were identified from across the geography of the county and from within the different health board jurisdictions. Each of the partner health departments identified stakeholders for engagement. Some providers and vendors that hold human service and public health contracts with the health departments were included in the stakeholder pool.

The initial list developed to receive a CHIP survey was of more than 2,000 organizations. The selection of participating organizations for the survey was coordinated with a parallel local public health stakeholder engagement process for public health emergency preparedness. By coordinating the selection of community contacts – as well as the design and execution of surveys executed for each process – it was hoped that the contacted stakeholders would understand the reason for the two surveys and engagement efforts in such a close timeframe.

CHIP Forum Participants. The invitation list for forum participation was determined through a process that included interested survey respondents and expanded to include

representatives identified by the CHIP Leadership Group and the three health departments. Given capacity limitations, particular attention was given to ensure that invited participants were drawn from stakeholder organizations that served diverse populations in terms of age, culture, are of the county served, and business sectors.

Sector Representation. By the end of the CHIP process, a solid cross-sector representation of organizations had participated - in the survey, the CHIP forum series, or both. Organizations came from these types of organizations:

Behavioral health / chemical health	Home care
Business	Hospitals & health systems
Charitable Organizations	Housing
Childcare	Human services
Clinics	Local government
Community coalitions	Long-term care
Community leaders	Mental health
Cultural Groups or Leaders	Policy or advocacy groups
Dependent adult services	Public health
Early childhood	Public health advisory
Environmental health	Schools
Faith based	Services to seniors or disabled
Food providers	Social services
Health plans	Visiting nurses
Health promotion	Wellness programs
Health research & quality	

C. Assessment of Resource Needs

Dedicated project staff were identified from each of the three convening health departments that would work in various aspects of the CHIP initiative. Hennepin committed to serving as a coordinating entity for the process and allocated two dedicated positions full time plus an internal CHIP workgroup, an administrative group, and the Public Health Assessment Team to work on aspects of the initiative. They also agreed to provide the financial support for the forum costs. Minneapolis and Bloomington each identified data and assessment personnel and staff that would work together between forums on needed synthesis activities. All three agencies identified an administrative lead that served on the 3-agency administrative oversight committee for the CHIP process.

II. MAPP PHASE 2: VISIONING

Phase 2 Purpose

This phase involves a collaborative and creative approach that leads to a shared community vision and common values.

A. The CHIP Survey

The CHIP survey included questions about a vision for health in our community. Question 1 on the survey specifically asked respondents to identify three characteristics of a healthy community. The characteristics most frequently identified were:

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

They were followed closely by these three:

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

B. CHIP Forum 1

The first CHIP forum was devoted to the sharing of the Community Health Assessment information and development of a <u>shared community vision</u> for health. The MAPP assessment questions participants were to answer were:

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

Sixty-nine participants attended Forum 1. Participants were assigned to different workshop groups based on their sector. This was done to maintain sector and geographical balance across the groups in order to gather diverse perspectives of a healthy community from the participants. Under the expert facilitation of the Technology of Participation (ToP®) facilitators, four parallel consensus workshops (15-25 individuals each) were held. Note takers were assigned to each group of participants in order to capture the richness of the information and conversation.

At the end of Forum 1, participants had identified the 'important characteristics of a healthy community' along with themes related to the characteristics that were important to them. The results of the four workshops were merged by project staff from the three health

departments - - along with the results from question 1 on the CHIP survey. The merged results were forwarded to the CHIP Leadership Group for discussion and modification. Instead of a vision statement, the Leadership Group determined to list the characteristics and maintain the themes developed by the forum participants. This listing was returned to Forum 2 and received support and positive responses from the forum participants. Below is the vision for a healthy community developed during this process. A healthy community has the following characteristics:

Safety
Environments that Foster Health
Community Connectedness & Engagement * Economic Vitality
Equitably Accessible High Quality Infrastructure * Basic Needs are Met
Quality Educational Opportunities * Good Physical & Mental Health
Multi-sector Leaders Promote the Common Good
Active Participation in Creating Health

The themes associated with each of these characteristics follow.

CHIP Characteristic of a Healthy Community & Related Themes from CHIP Forum 1 and the 2012 CHIP Survey	

Safety	Environments that Foster Health
- Free from crime - Free from hazards - Free of violence - People looking out for each other - Residents feel emotionally and physically safe - Respectful dispute resolution - Safe housing - Safe neighborhoods - Safe schools	- Access to green spaces - Accessible public transportation - Attractive and heartening spaces - Clean air, water & land - Community promotes a green & sustainable environment - Equitable access to healthy food - Healthy indoor environments - Planning and zoning that fosters health & clean environments - Promotes physical activity - Spaces accessible by all - Walk-able / bike-able access to goods & services

Community Connectedness & Engagement	Equitably Accessible High Quality Infrastructure
• Care and support for vulnerable persons, youth, homeless • Community gathering spaces • Cross cultural connectedness & pride • Diversity is embraced • Good community communication • Informed residents • Intergenerational connectedness • Lack of isolation • Opportunities to contribute to the community • Participation in community governance • Relationships thrive • Residents are proud & productive • Residents, businesses & faith Communities invested in community success • Respect & value for all • Schools are a part of & contribute to the community • Sense of belonging • Strong support systems (family, friends, co-workers) • Strong volunteer base • Tolerant & accepting	• Abundant, affordable, healthy housing • Accessible, affordable, culturally appropriate healthcare systems • Easy & affordable public transportation • Options for healthy aging in your community of choice • Quality & affordable pre-school & day care • Quality educational opportunities for all ages exist: Pre-K to higher education, vocational & employment re-training, community education • Sources for healthy & culturally diverse foods

- Equitable: affordable, culturally appropriate, geographically available, accessible
- High Quality: comprehensive, culturally appropriate, available, accessible

Basic Needs are Met	Economic Vitality

• All residents are able to meet their own basic Needs
• Residents have equitable access to resources and services to meet their basic needs:
    o Food
    o Shelter/housing
    o Transportation
    o Healthcare
    o Employment
    o Childcare
    o Education
    o Special needs services
	• Diversified & healthy business environment
	• Economic development
	• Economic justice: equitable employment and business opportunities for all populations
	• Economic security: able to meet basic needs & thrive
	• Employment opportunities for all
	• Living wage jobs
	• Low unemployment
	• Strong volunteer base
	• Child care options

Quality Educational Opportunities	Multi-sector Leaders Promote the Common Good
• Community values lifelong learning • Early childhood services to prepare children for kindergarten are available • Education promotes health • Education supports gainful employment • Educational systems are successful at preparing their students for their next step • Educational systems support individual and community potential • Libraries are available to all • Opportunities for lifelong learning exist • Quality educational opportunities for all ages exist: Pre-K through higher ed., vocational & employment re-training, community education • Schools successfully support young adults to graduate from high school • Social media supports education	• Accountable • Aligned with others • Efficient in delivery of and administration of resources • Engaged • Establish policies and infrastructures that support people to meet basic needs and reach their full potential • Good and effective leadership that operate with vision and values that promote health • Good policies that work for all • Infrastructure to make being healthy "easy" • Input from diverse members of the community is value and incorporated • Leaders in all sectors of the community take ownership for promoting health • Policies protect most vulnerable • Policy makers understand how their decision-making impacts health • Public & private partnerships • Seamless systems / coordinated efforts across multiple sectors

Good Physical & Mental Health	Active Participation in Creating Health

• Chronic diseases are managed
 	
• Community is educated about mental health issues and services
 	
• Comprehensive physical and mental health services that promote well being
 	
• Culturally competent services
 	
• Equitable access to quality affordable health care & mental health services
 	
• Health equity / health disparities are eliminated
 	
• Low incidence of disease and mortality
 	
• Preventive care is easily accessible & utilized
	• Community is educated about factors that impact health
	
	• Creating real opportunities to inspire people
	
	• Culture of building on strengths & abundance; empowerment, positivity, and individual potential
	
	• Individuals & families assume responsibility for their own health
	    o Are alcohol and drug free,
	    o Are tobacco free
	    o Consume healthy food
	    o Focus on preventing illness & staying well
	    o Have an active lifestyle
	    o Have vision and values for their own health
	    o Make healthy choices
	
	• Individuals and systems have a holistic approach to health: emotional, mental, physical, dental
	
	• Modeling good behavior
	
	• Promoting equitable social & political capital for all
	
	• Replacing hopelessness with hope
	
	• Seeing potential amidst risks
	
	• Social & economic conditions that negatively impact health are addressed (e.g. unemployment, lack of education, poverty, unstable housing, etc.)
	
	• Vision and values guide action to promote health

III. MAPP PHASE 3: THE FOUR ASSESSMENTS

Phase 3 Purpose

The MAPP Assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods. It helps communities analyze health issues through multiple lenses.

The four MAPP assessments are:

1. Community Health Status Assessment
2. Community Themes and Strengths Assessment
3. Forces of Change Assessment
4. Local Public Health System Assessment

During the CHIP process in Hennepin, aspects of these assessments were completed at different times in different venues – and not necessarily all at once or in a stepped order. For the purposes of this MAPP Appendix, we will describe "*what we did*" related to each assessment.

A. Assessment 1: The Community Health Status Assessment

Purpose: The Community Health Status Assessment provides quantitative data on a broad array of health indicators, including quality of life, behavioral risk factors, and other measures that reflect a broad definition of health.

This assessment answers the questions:

- *How healthy are our residents?*
- *What does the health status of our community look like?*

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

Each agency took responsibility for different aspects of the data review, documentation and presentations to stakeholders.   The Hennepin County Human Services and Public Health Assessment Team pulled data from multiple sources to create a set 60 community health assessment indicators – which reflect current health status in Hennepin.

Assessment and Data. Staff from the data and assessment areas of the three health departments reviewed recently collected quantitative and qualitative health data collected by a variety of sources, including local, state and federal. They created, executed and analyzed the CHIP survey that was distributed to community organizations as part of the assessment. They also provided assessment data to the CHIP forum stakeholders. Between forums, they researched data and information relevant to the forum outputs (e.g. on strategic health issues and potential goal statements.) Copies of the CHIP Survey questions can be found in the Data Appendix.

1. *SHAPE.* A primary source for the CHIP Community Health Assessment data was the <u>2010 Survey of the Health of All the Population and the Environment (SHAPE)</u> which is Hennepin's fourth survey of residents and the factors that affect their health. *SHAPE* is a nationally recognized survey that provides data on a broad range of health topics for many local geographic areas and demographic subgroups within the county. It has an adult and a child component to the survey.
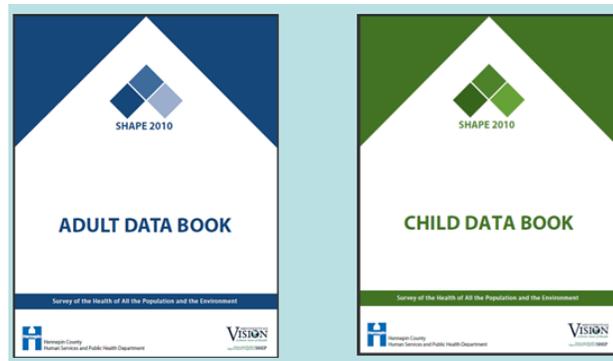
SHAPE was previously done in 1998, 2002, and 2006 and has been extensively used for public health policy and planning. It allows for comparisons over time to monitor for trends in health status. For the CHIP MAPP process, we utilized the results from SHAPE survey that was conducted in 2010. The response rate was similar for both adult and child groups and was approximately 23%. The topic areas and types of questions asked in the survey were developed as a result of community input that was sought in previous versions.

Since 1998, *SHAPE* has collected information on the following health topics or domains:
   o Overall health
   o Health care access and utilization
   o Healthy lifestyle and behaviors
   o Social-environmental factors

The *SHAPE 2010 - Adult Data Book* summarizes the responses of the more than 7,000 respondents from the *SHAPE 2010 - Adult Survey*.   It includes questions about health status, health care access and utilization, healthy lifestyles such as exercise, the foods we eat and socio-environmental factors like perception of the neighborhood, food and housing insecurity to name a few.   Results in this data book are presented for Hennepin County as a whole and for ten geographic areas.

The *SHAPE 2010 – Child Data Book* summarizes the responses from nearly 2,200 participants in the *SHAPE 2010 – Child Survey*.   For children, the survey has questions about visits to the doctor, common illnesses, and the foods they eat. For younger children, there will be questions about "school readiness" and child care. For older children, there are questions about after school activities, "family connectedness" and how much exercise they get. Results in this data book are presented for Hennepin as a whole and for two geographic areas within the county. The data are also reported by demographic variables including gender, age, grade level and household income.

More information on SHAPE can be found on the Hennepin County Public Health Data website: **www.hennepin.us/PublicHealthData**

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

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

Community Health Assessment Data Domains

- Access to health services
- Demographic information
- Environmental quality
- Injury and violence
- Maternal, infant, and child health
- Mental health

- Nutrition, obesity & physical activity
- Overall health
- Preventive services
- Reproductive and sexual health
- Social determinants
- Tobacco and substance abuse

Development of the Health Indicators. The Assessment Team sought various ways to develop a list of health indicators that represented the priority areas in Hennepin County, the state of Minnesota and nationally. They referred to the Institute of Medicine health indicators list, Minnesota' statewide health assessment and the national objectives outlined in Healthy People 2010 and 2020.

To share meaningful information with stakeholders, the team created fact sheets for each indicator. This sheet describes what the indicator means, why it is important to Hennepin County, its distribution by demographic variables such as age, income level and has technical notes for audiences interested in more details. It includes a short online "report card" of how we're doing in Hennepin on this indicator. These fact sheets provide a snap shot of the current health status of our residents with respect to the health indicators.

3. **Sharing data with participants.** At forums 1 and 3, representatives of the assessment teams from each of the three local health boards presented data from different sources to the participants as described in Part III of the plan document. Each speaker provided few examples of the various aspects of data such as trends, geographic distributions, racial and ethnic differences, total number of people affected. Each participant received the SHAPE 2010 Adult and Child Data books and other data resources at Forum 1. Forum 3 participants were introduced to Healthy People 2020 goals for the priority strategic health issues selected during this process.

These two assessments are listed together because the discussions about them were merged during the CHIP forums.

1. **Assessment Purposes and Questions**

   Assessment 2: Stakeholder Themes and Strengths Assessment

   Purpose: To gather community thoughts, opinions and concerns that provide the greatest insight regarding how the community perceives quality of life and the issues most important to the community.

   Assessment 3: Forces of Change Assessment

   Purpose: This assessment is aimed at identifying forces - such as trends, factors, or events - that are or will be influencing the health and quality of life of the community and the work of the local public health system.

   These two assessments answer the following questions:
   - *How is quality of life perceived in our community?*
   - *What is important to our community and our stakeholders?*
   - *What assets do we have that can be used to improve community health?*
   - *How can we improve and better coordinate public health activities?*
   - *What forces are or will be influencing the health and quality of life of the community and the work of the local public health system?*

   CHIP Forum 2 was focused on addressing these most of these questions. Sixty-four stakeholders participated in these discussions.

2. **Quality of life and what is important.** Questions about quality of life and what is important to the community were specifically addressed in both the CHIP survey as well as at the first two CHIP forums which focused on visioning characteristics of a healthy community and what needs to change to achieve that vision.

   The consensus workshops at Forum 2 discussed what needs to be in place or changed over the course of the next few years to move towards the healthy community vision

created in Forum 1. The specific question discussed was: *What innovative, substantial actions will move us closer to our vision of a healthy community?*

The top issues for change identified included the following.

- Invest in early childhood
- Develop equitable opportunities
- Promote healthy choices
- Get leadership support
- Engage the community
- Address healthcare access
- Implement policy, system & environmental changes
- Collaborate & coordinate

3. **Themes.** Through a review of results of the consensus workshops of Forums 1 and 2, the notes taken during forum conversations, and the survey results, project staff mined the data for "themes" that were consistently raised throughout the CHIP planning process. This information was used to help determine which strategic health issues were of most importance to the forum participants and which areas within those issues could be targets for action.

4. **Environmental Scan: Strengths and Assets.** At Forum 2, the Top® facilitators guided CHIP stakeholders through an environmental scan that identified stakeholders' thoughts regarding strengths, weaknesses, opportunities and threats as well as anticipated changes to our environment that could impact health.

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

Strengths & Assets	
People & Community	**Infrastructure and Systems**
o Above average interest in health	o Abundant green space
o Accessible politicians	o Employment opportunities
o Active lifestyles	o Excellent nonprofit healthcare system
o Can-do attitude	o Existing partnerships
o Compromisers	o Good collaborations
o Diverse community with strong leadership	o High level of corporate responsibility
o Energy and desire to grow and improve	o High quality healthcare and resources
o Engaged residents	o Leadership commitment
o knowledgeable-growing senior population	o Many healthy food resources
o Moving from "doing for" to empowering	o Parks and recreation
o Passion	o Relatively wealthy with good infrastructure
o Problem solvers	o Similar initiatives coming together
o Seekers of common understanding	o Strong educational system
o Sense of pride & caring about each other	o Strong non-profit system
o Strong commitment to open space	o Strong public health and social service organizations
o Strong engaged faith communities	o Vibrant community organizations
o Strong immigrant-lead organizations	o Well established organizations and resources
o Strong volunteer base	
o Welcoming state for immigrants	
o Well-educated residents	

Opportunities	
People & Community	**Infrastructure and Systems**
o Awareness of health issues = position for action	o Build on connections with hospitals
o Collaboration potential	o Build on successes
o Communities of color ready to be at the table	o Expand active learning programs
o Creativity	o Health planning in hospitals
o Informal caregiving as a resource	o Healthcare reform offers new opportunities
o Intentionally engage more diverse communities	o Healthy living infrastructure being enhanced
o Learning from different cultures	o High level of corporate responsibility- (funding, wellness programs)
o Many of us identifying things the same way	o Hospitals & health plans with aligned planning cycles
o Optimism	o More common mediums/technology
o Prevention isn't seen as "fluff"	o Multi-sector approaches
o Seniors as a resource	o Municipalities are engaging in health
	o Nutrition movement: local foods, school lunch changes
	o Officials ready to take action
	o Prevention in legislation
	o Research showing link of social conditions to health
	o Sharing resources
	o Social media
	o Technology tools a force to bring efforts together
	o Using media as partners

Weaknesses	
People & Community	**Infrastructure and Systems**
o Attitude of scarcity, not abundance	o Areas of the community without services
o Attitudes and behaviors	o Childhood poverty
o Don't link the value of health & need for health insurance	o Complicated healthcare system
o Interconnectedness not recognized	o Cuts to safety net services & schools
o Minnesota values are being eroded	o Difficult to link so many different community groups
o Not enough emphasis on prevention	o Disparities in educational success & graduation rates
o Partisanship & politics	o Duplication/overlap in communications
o Resistance to change	o Focus on health care vs. healthy living
o Too many without health coverage	o Foundations lead agenda of non-profits
o Under representation of communities of color in planning	o Haven't ended homelessness
o Value of public health not recognized	o Health disparities continue
	o Inadequate communications between systems
	o Intervening with children too late
	o Intervening with seniors too late
	o Lack of cooperation among organizations
	o Mental health system & correctional system broken
	o Need more business in conversation
	o Not closing the disparity gap
	o Not enough affordable housing
	o Not enough data on the disparities faced
	o Not investing in children
	o Operate in silos
	o Pilot mentality
	o Program focus driven by grant focus
	o Sustainability of programs at risk
	o Systems are weakness based and not strength
	o Too many one size fits all solutions
	o Unaffordable healthcare
	o Unpredictable funding

Threats	
People & Community	**Infrastructure and Systems**
o Aging population	o Advertising & marketing works for & against us
o Burnout	o Budget cuts
o Drug culture	o Change takes time
o Hard to engage people due to poverty or busyness	o Funding for public health too low
o Lose of sense of common good	o Impact of aging population on our systems
o Mental health not viewed as part of health	o Increases in unemployment
o Mental health seen as a sickness/still seen as taboo	o Institutional brain drain as boomers retire
o Pessimism	o Issues are moving targets
o Polarizing politics	o Lack of educated workforce
o Seniors retiring into poverty	o Lack of sustainability for positive programs
o Uninformed elected officials	o Not everyone has same opportunities to be part of change
o Violence	o Once size fits all solutions
	o Pays well to care for sick people
	o Potential to lose the gains of healthcare reform
	o Poverty impacts
	o Profit motives
	o Too much electronic communication – losing human contact

C. Assessment 4: Local Public Health System (LPHS) Assessment

Purpose: This assessment is intended to identify strengths and weaknesses in the provision of public health services in order to improve and better coordinate public health activities.

The LPHS assessment answers the following questions:

What are the components, activities, competencies, and capacities of our local public health system?

How are the 10 Essential Public Health Services *being provided to our community?*

To assist with this assessment, the CDC, in collaboration with other national partners, developed an instrument under the National Public Health Performance Standards Program to assess the Local Public Health System.

Essential Public Health Services

1. **Monitor health status to identify community health problems.**
2. **Diagnose and investigate health problems and health hazards in the community.**
3. **Inform, educate, and empower people about health issues.**
4. **Mobilize community partnerships to identify and solve health problems.**
5. **Develop policies and plans that support individual and community health efforts.**
6. **Enforce laws and regulations that protect health and ensure safety.**
7. **Link people to needed personal health services and assure the provision of health care when otherwise unavailable.**
8. **Assure a competent public and personal health care workforce.**
9. **Evaluate effectiveness, accessibility and quality of personal and population-based health services.**
10. **Research for new insights and innovative solutions to health problems.**

Members of the CHIP project team reviewed the CDC instrument in order to gauge the type questions asked and the best way to approach this assessment. This instrument's questions mirrored those in self-assessments that the local health departments had recently completed using the Public Health Accreditation Board's (PHAB) self-assessment tool. Both Hennepin and Bloomington had completed a PHAB self-assessment within the past two years. Additionally, two of the local health departments, Hennepin and Minneapolis, have each initiated the process during 2012 to seek formal accreditation from PHAB. Bloomington is considering pursuing PHAB accreditation within the next 1-2 years.   Please see details below.

1. **Update on local public health department assessments**

   Each of the local health boards periodically conducts and participates in assessments that monitor their capacities and performance in various local public health duties. Below are summaries of recent self-assessment work plus additional activities that are occurring across the region that promote ongoing assessment of the local community health or public health system.

   Local Assessment Activities.

   Community Health Assessment and Action Planning process (CHAAP). During the planning cycle, 2005-2010, local health departments, at the direction of the Minnesota Department of Health, utilized the Community Health Assessment and Action Planning process or "CHAAP" to:

   - Assess and prioritize the health needs of their communities
   - Assess and prioritize their own internal capacity to meet those health needs; and
   - Develop action plans (a local community health improvement plan and capacity improvement plan) to meet those needs.

   This process included community health assessment and planning components, a capacity self-assessment, and an action plan designed around the six areas of public health responsibility.   All three health departments have used the work of the CHAAP as their local community health improvement planning efforts through 2010. It was implemented fully by 2010 although some elements of the plan were implemented earlier than that. The CHAAP plan goals and objectives are being monitored and evaluated while the departments work within the CHIP process to identify local goals and objectives for action for the next planning cycle.

   The current work of the 2012 Community Health Improvement Partnership (CHIP) is the next evolution of a local community health improvement planning process for 2012-2015.   It has expanded beyond individual jurisdictional boundaries of the three public health departments (five health boards). This collaborative process, which includes the hospitals, health plans, clinics, and other community stakeholders, nicely positions the local "community health system" to align improvement plans across agencies and sectors.

   Hennepin. In 2010, Hennepin County Human Services and Public Health (HSPHD) participated as a BETA test site for the Public Health Accreditation Board (PHAB) – to test PHAB's assessment tool. The elements reviewed within the PHAB assessment

mirror the CDC local public health system assessment tool in many areas and focus on a health department's execution of the essential public health services as compared to national standards. Aspects of Hennepin's CHAAP self-assessment and activities were included in this review. Within the summary report of HSPHD's BETA test, PHAB evaluators noted that Hennepin operates in an area with five municipal health departments – which they acknowledged to require considerable coordination to remain productive and efficient. They also noted the strong relationship between HSPHD and the Minnesota Department of Health.

Site reviewers described HSPHD to be a "well-run organization with experienced and skilled leadership and a committed and competent staff". Of the 10 public health domains reviewed, six scored at or above 90% with four scoring 100%. Of the 202 possible points, HSPHD received 180 or 89%. Areas identified for improvement included the following:

- Strengthen work in identification of gaps in access to healthcare services.
- Strengthen documentation and analysis regarding regulatory services activities.
- Strengthen documentation of quality improvement activities and linkage between quality improvement efforts being taken within the parent organization and the quality improvement activities occurring at the public health program level.

HSPHD has strengthened its internal quality improvement team and is addressing the other areas of improvement noted. HSPHD is submitting for official PHAB accreditation in September 2012 and expects to have addressed documentation gaps identified in the Beta Test.

Bloomington. In fall of 2011, the Bloomington Division of Public Health completed the self-assessment for Public Health Accreditation. Their assessment revealed that their three areas of greatest improvement were related to:

- Development of the Community Health Improvement Plan
- Development of a Strategic Plan
- Development of a Quality Improvement Plan

Their work in the CHIP is addressing the first - working on the Community Health Improvement Plan - as a joint project with the five community health boards in Hennepin County. Their Strategic Plan should be completed by spring 2013.   The Quality Improvement Plan will be developed during 2013. They found, overall, that the

self-assessment process was very useful as they prioritize their work in preparation for accreditation and to fulfill the 2015 Minnesota Local Public Health assessment and planning requirements.

Minneapolis. Minneapolis also regularly conducts self-assessments as part of City Business Planning and as participants in the Minnesota Department of Health Community Health Assessment and Action Planning Process (CHAAP). As part of both processes, community stakeholders are engaged and elected officials approve the results. Minneapolis CHAAP was most recently completed in 2008. Three areas for focus and investment were identified: Health Literacy; Youth Violence Prevention; and Teen Pregnancy Prevention. Focused work with community partners in each of these areas continues. The current 5-year business plan, completed in 2010, was built on the results of CHAAP.

One additional element was identified by the community: the need to more clearly articulate the way in which the public health agency related to the community. This need led the department to develop a new set of statements titled "The Way We Work" which are included in all versions of the department's mission, vision, and goals. Additionally, we meet regularly with Hennepin County Public Health to review a grid of responsibilities between the two agencies. This process provides opportunity to clarify agency roles, identify lead agencies, evaluate overlap, and identify gaps in service delivery.

Local Technical Assistance Review. All three partner health departments participate in an annual review of their public health emergency preparedness planning and capacity – by either Centers for Disease Control and Prevention or Minnesota Department of Health personnel. These assessments review 12 planning elements for evidence of overall readiness to manage, distribute and dispense medications and other needed materials during a public health emergency.

Regional Activities related to Assessment of the Local Community Health System.
State Community Health Services Advisory Committee (SCHSAC). In addition to local assessments, Minnesota's state and local health departments meet together quarterly as a State Community Health Services Advisory Committee (SCHSAC). SCHSAC is a statewide advisory body that is convened by the Commissioner of Health and comprised

of locally elected officials and Local Public Health Directors. The purpose of SCHSAC is to advise, consult with, and make recommendations to the Commissioner of Health on matters related to the development, funding and evaluation of community health services in Minnesota. Each of the local health boards currently has representation at SCHSAC or on one of the SCHSAC subcommittees.

Metro Local Public Health Association (MLPHA). The local health boards also participate in MLPHA, an association of the twin cities metro local public health departments (7 county and 4 city health departments). This group coordinates and collaborates on public health planning and policy development – and has members on the statewide Local Public Health Association (LPHA).

Annual Local Health Department Reporting: PPMRS.   The five health boards also do internal assessments annually and report to the Minnesota Department of Health (MDH) on six areas of public health responsibility and work that they are doing on health communities and healthy behaviors. Each year, the MDH requires local health boards to submit information via their Local Public Health Planning and Performance Measurement Reporting System (PPMRS). This process is intended to collect information about key aspects of Minnesota's public health system; provide consistent and accurate information that can be used to improve the delivery of public health; and provide accountability for the requirements of the Minnesota Local Public Health Act.

2. **CHIP Discussions on the Local Public Health System**

In addition to the local self-assessments, the Local Public Health System Assessment for the CHIP process focused on discussions around two areas: the informal public health system in Hennepin and the environmental scan of strengths and weaknesses noted in the previous section.

Local Community Health System – CHIP Leadership Group.
The CHIP Leadership Group had a discussion about the Local Public Health System (LPHS) at its March 13 meeting. They grappled with what a LPHS means within Hennepin. Schools and healthcare providers were clearly part of the LPHS they but wondered if other organizations think of themselves as part of this "system". They guessed that many who ARE part of this informal system would tend to think of this as something that only local public health (or government) "owns".   They identified one of the challenges as getting more stakeholders to own their role in this system and to

name what it is that they contribute and that the Forums should assist in starting to address that.

They reviewed a visual of what the CDC documents as a sample LPHS and felt it was not inclusive enough. They felt that it ASSUMES that people have food and housing and basic needs met. It doesn't address people in severe poverty who struggle with barriers to health. They also talked in terms of a local "community health system" that is focused on prevention and *creating health* and that there is a continuum of service from meeting basic needs to creating environments that makes being healthy possible to preventing health problems from occurring to identifying problems early to repairing damage and restoring health, when needed.

The Leadership Group preferred to use the phrase "community health" rather than public health and agreed to this statement: *Any organization that contributes to the health of community is considered part of our local community health system.* They further agreed that besides local public health and providers of health care, the local community health system includes other organizations that help people. A subcommittee of the Leadership Group met to come up with a better way to visually represent our local community health system and to prepare to present it to the Forum stakeholders.

Local Community Health System – CHIP Forum Participants. Forum 2 participants were asked to identify potential contributors to public health and health improvement in the county. They were introduced to the idea that these contributors together make up an informal network or interconnected web of providers and resources that currently contribute to our community's health. They were then asked to identify the top contributors to this network that would be considered the local "community health system" for this county.

Below is a merging of their ideas into a "Word Cloud" (created in WORDLE) – which represents the more frequently identified contributors in larger text. This visual illustrates how the CHIP forum participants see the contributors to our local community health system. Further discussions about the local community health system may occur as the partnership becomes more established and the local health boards complete their accreditation reviews. A focus of discussion could be: what do other organizations contribute to the delivery of the 10 Essential Public Health Services?

IV. MAPP PHASE 4: IDENTIFY STRATEGIC HEALTH ISSUES

Phase 4 Purpose

The purpose of this assessment is to identify strategic health issues for 2012 - 2015 using the information gathered from the four assessments to determine the issues the community must address in order to reach its vision.

Strategic issues are critical challenges or policy issues that must be addressed in order for a community to achieve its vision of a healthy community. Strategic issues are the foundation upon which strategies are developed. They should be built upon the results of the previous MAPP phases and the information that has been gathered.

Strategic Health Issue Selection. Between Forums 2 and 3, public health staff analyzed themes from the CHIP survey results and the previous forum consensus workshops to find strategic health issues most frequently mentioned. The lists of themes identified from the survey and the forums were weighted based on the frequency that they were identified. Themes were clustered using the 11 *Healthy People 2020* health domains that framed the health data in Forum 1 and in the Community Health Assessment indicators. These five strategic health issues received top ratings.

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

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

V. MAPP PHASE 5: FORMULATE GOALS AND STRATEGIES

Phase 5 Purpose

The purpose of this phase is to specify goals for each of the strategic health issues identified in MAPP Phase 4.

Goals set forth a common direction and target for the anticipated end result. **Strategies,** which in this CHIP process are to be developed during the Action Phase, will describe which actions the community partners will take to move forward towards those goals.

Identifying Priority Goals for Action. After discussing the proposed Strategic Health issues put forward by the CHIP Leadership Group, Forum 3 participants were asked to help identify high level goal areas for each of the three stand-alone strategic health issues.

- Maternal, Infant, & Child Health
- Mental Health –*changed later to "Social and Emotional Wellbeing "*
- Nutrition, Obesity & Physical Activity

Goals and strategies for Health care Access and Social Determinants were to be discussed and determined during the action phase by the action teams. Goals were requested to be broad and overarching but specific enough to enable development of objectives and strategies by the CHIP action teams.

Forum participants were provided information about *Healthy People 2020* goals that related to the targeted strategic health issues that were adopted. Through a ToP® facilitated discussion, three groups were asked to rate the related *Health People 2020* goals in terms of strategic importance and ability to implement corrective strategies for each of the goals using the matrix below. The expectation was that goals rated as high in importance might be goals to target for action and that those rated as and high in ease of implementation would be ones that could be identified for early action.

Community Health Improvement Partnership
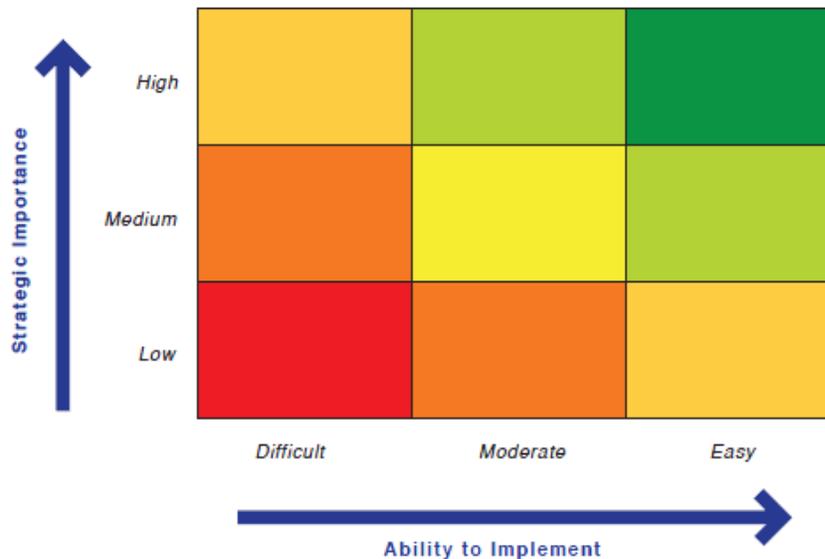
This process was not as easy as it might have been. In part, goal statements from *Healthy People 2020* did not easily match the words and themes that forum participants had been identifying in their previous discussions. Many of the goal statements were disease focused and less prevention oriented. And social conditions that impacted health were mostly absent. Some of the groups had more challenges than others with some being able to rate all listed goals for all strategic health issue areas; other groups were only able to partially complete the assignment.

All ratings were summarized and the findings from the consensus workshops were to be forwarded to the CHIP Leadership Group to finalize goals for action.

A subcommittee of the CHIP Leadership Group met to evaluate the outcomes of Forum 3 and discussion options for goal statements for the CHIP initiative. Representatives from each of the convening health departments as well as CHIP Leadership Group members participated in the discussion. Themes of the CHIP Survey and three forums were once again reviewed and categorized under the three primary strategic health issues. They are listed here.

1. Maternal Child Health (MCH)
   - Access to affordable child care
   - Early childhood investment
   - Preventive care
   - Safety
   - School age investment

2. <u>Mental Health (MH) / Social & Emotional Well-being (S&EWB)</u>
   - Community / social connectedness
   - Mental health promotion
   - Mental health care access

3. <u>Nutrition, Obesity & Physical Activity (NOPA)</u>
   - Healthy food
   - Active living

The subcommittee also received a sample listing of goal statements from CHIP plans from other jurisdictions across the country that were related to our strategic health issues.

The subcommittee forwarded the following goal statements to the CHIP Leadership Group for consideration:

1. <u>Maternal Child Health (MCH) Goals</u>

   - Increase access to quality, safe & affordable child care options
   - Ensure that all infants, children & teens have the opportunity for healthy development
   - Increase access to and utilization of maternal & child prevention care
   - Increase the proportion of children who are ready for school in all five domains of healthy development:
     - o physical development
     - o social-emotional development
     - o approaches to learning
     - o language, and
     - o cognitive development
   - Support all mothers & children are physically safe and feel emotionally secure

2. <u>Mental Health (MH) / Social & Emotional Well-being Goals</u>
   - Increase community & social connectedness
   - Increase access to services to improve mental, social & emotional well-being
   - Increase emotional security for children

3. <u>Nutrition, Obesity & Physical Activity (NOPA) Goals</u>
   - Improve nutrition
   - Increase physical activity
   - Improve physical environments & infrastructure that supports/fosters:
     - Physical Activity
     - Nutrition
   - Increase the proportion of people at a healthy weight and decrease the proportion of people who are obese/overweight

At the June Leadership Group meeting, three goal statements were adopted:
1. Maternal and Child Health: Increase childhood school readiness
2. Mental Health: Increase community & social connectedness
3. Nutrition, Obesity and Physical Activity: Increase regular physical activity and proper nutrition through improvements to the physical environment

They also re-affirmed the strategic health issues related to Health Care Access and Social Conditions that impact Health – but determined to not select specific goals for these.

The CHIP Leadership Group has forwarded the selected goals to the action teams that will meet this fall to identify strategies for action.   They have also asked that ALL proposed goal statements that were considered be forwarded to the action teams – so that these ideas not get lost – and so that any that are sub-goals of those selected, could be considered as part of the strategy discussion.   They have also asked each CHIP action team to include strategies for these cross-cutting issues across the CHIP work.

VI. MAPP PHASE 6: ACTION PHASE

Phase 6 Purpose

The purpose of MAPP Phase 6 is to position the CHIP initiative to move into action.

Action Teams

The MAPP action phase includes planning, implementation, and evaluation of a community's health improvement plan. As mentioned in the CHIP Plan document, three action teams will begin meeting in early fall 2012:

- Maternal and Child Health: School Readiness Action Team
- Nutrition, Obesity and Physical Activity Action Team
- Social and Emotional Well Being: Community & Social Connectedness Action Team

At the end of the spring CHIP Forums, 24 organizations indicated a commitment to continue participating on one or more of the action teams.   More participants will be recruited as these teams identify their strategies for action.   At the last CHIP forum, participants were asked to identify community organizations and/or individuals that they thought could enhance the CHIP action work.   Those recommended will be forwarded to the action teams when they initially convene and will be sent information about the CHIP process and plan and information about the action teams that are forming.

ToP$^{®}$ facilitators will assist these teams through an Action Planning Workshop to help them select priorities for action and a timeline to accomplish targeted objectives by the end of 2013. With support from CHIP project staff and representatives from the partner health departments and hospitals, these teams will evaluate opportunities for alignment across organizations, assess gaps, and identify policy issues and opportunities that if addressed together, could make a difference. They will develop a plan that will move them quickly to action – and ideally to success within the first year.   Measurable objectives with time-framed targets and improvement strategies will be identified for the initial CHIP action cycle September 2012 – December 2013. The initial cycle of action will be evaluated at the six month and one year mark – using performance targets set by the action teams and CHIP Steering Committee. The need for new strategies and action steps will be assessed annually in preparation for the next action cycles in 2014 and 2015.

Steering Committee

Nearly all members of the CHIP Leadership Group have committed to transition to the CHIP Steering Committee that will guide the action phase of the CHIP initiative. Several of these leaders will also be joining the CHIP action teams. In addition to the three action teams, the Steering Committee will establish a data and evaluation subcommittee that will assist the initiative to identify objectives for data collection and evaluation and to help support a common approach to measuring impact across the action teams.

Administration

Hennepin County Human Services and Public Health will serve as the facilitator of the next phase of the CHIP work under the guidance of the Steering Committee and will support the action teams. The other community health boards will serve on the CHIP Steering Committee and as technical experts on the CHIP action teams.

Over the next few months, project staff will be establishing shared electronic files for the action teams and a public site for posting products of the CHIP initiative for Hennepin County.

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